Legislative Assembly
Tuesday, 6 August 2019
[page 4975]

VOLUNTARY ASSISTED DYING BILL 2019
Notice of Motion to Introduce

Notice of motion given by Mr R.H. Cook (Minister for Health).

Legislative Assembly
Wednesday, 7 August 2019
[page 5134]

VOLUNTARY ASSISTED DYING BILL 2019
Introduction and First Reading

Bill introduced, on motion by Mr R.H. Cook (Minister for Health), and read a first time.
Explanatory memorandum presented by the minister.

Second Reading

MR R.H. COOK (Kwinana — Minister for Health) [3.26 pm]: I move —

That the bill be now read a second time.

The bill before members today deals with the introduction of voluntary assisted dying in Western Australia. This government is exceptionally proud of this landmark piece of legislation. This bill provides a safe and compassionate approach to voluntary assisted dying and a workable legal framework that will address an issue for which the community has consistently expressed support over many years. The bill reflects the extensive consultation conducted in the state over the last two years, and indeed globally on this issue over the last 25 years. Voluntary assisted dying is not a matter of a choice between life and death. It is a choice for those who are going to die, for whom death is inevitable and imminent, but who can exercise the autonomy which is at the heart of what it is to be human—the exercise of free will.

On 15 July 2019, Kerry Robertson became the first person to end her life under the Victorian voluntary assisted dying laws. Her two daughters said of their mother’s death —

Palliative care did their job as well as they could. But it had been a long battle. She was tired, the pain was intolerable and there was no quality of life left for her.

We were there with her; her favourite music was playing in the background and she was surrounded by love. She left this world with courage and grace, knowing how much she is loved.

This does not seem to be an unreasonable expectation. It embodies compassion and relief from unbearable suffering, and it embodies respect—that is, choice for the dying person. Death comes to us all. For some in our community the death to which they will succumb will require us to really examine what it means to be compassionate. The bill will challenge members to consider the views of their communities and also to inform themselves of the facts and the myths associated with voluntary assisted dying. As we enter this debate, I ask that all members do so respectfully and in good faith, and to conduct themselves with dignity. It will take leadership and courage to introduce voluntary assisted dying in Western Australia.

In August 2017, the Western Australian Parliament appointed a joint select committee to inquire into end-of-life choices. The Joint Select Committee on End of Life Choices ran for a year and received over 700 submissions. It held 81 hearings and heard from more than 130 witnesses. A year later the committee tabled its report—“My Life, My Choice”. The report reflected the broad community agreement about the importance of individual autonomy and choice over end-of-life matters. The committee recommended that the government introduce legislation for voluntary assisted dying and to have regard to the framework recommended in its report. I take this opportunity to recognise the considerable work undertaken by the committee members and, in particular, acknowledge the contribution of the chair, the member for Morley and also Hon Colin Holt, MLC, the member for South West Region. I also place on record my thanks to those courageous Western Australians who gave evidence to the committee and shared deeply personal stories of their loved ones in their final days.

Extracted from finalised Hansard
The government responded to the report and supported all the committee recommendations. Work is underway to improve the quality of advance health directives, and to strengthen and resource palliative care services. I would like to address palliative care in more detail. As members will be aware, I will be hosting a palliative care summit on 24 August this year and I look forward to continuing to work with the sector. In the context of this debate, members will not be considering voluntary assisted dying instead of palliative care. We are considering the compassion we should show those people for whom palliative care does not relieve their suffering. Palliative Care Australia has acknowledged that although pain and other symptoms can be helped, complete relief from suffering is not always possible, even with optimal palliative care. Equally, when members of the Australian Medical Association were surveyed on this issue in 2016, 67.9 per cent of respondents agreed that there are patients for whom palliative care or other end-of-life-care services cannot adequately alleviate their suffering. There have been significant advances in end-of-life care and as a community we are indebted to the professionalism and expertise of doctors, nurses, carers and other health professionals who provide palliative care across our state. This government is wholeheartedly committed to improving palliative care services and announced $47.4 million towards palliative care in the 2019–20 budget taking expenditure over the four years to 2023 to a record $206.2 million. This is the largest investment in palliative care in the state’s history and will boost services, particularly to our regional and rural communities. I might also advise members that detailed planning is underway to implement the Department of Health 10-year “WA End-of-Life and Palliative Care Strategy 2018–2028”, which was released in 2018. The strategy will ensure a strategic state-wide policy direction for quality end-of-life and palliative care. This Voluntary Assisted Dying Bill comes to the house following a long and considered process of community consultation. Arising from the recommendations of the joint select committee, a ministerial expert panel was appointed to undertake consultation and develop legislation for voluntary assisted dying in Western Australia. The panel was chaired by Malcolm McCusker, AC, QC, former Governor of Western Australia. Panel members included senior palliative care physicians, former presidents of the Australian Medical Association WA; a former WA Chief Medical Officer and a former WA Chief Nurse; Lawyers, including a law reform commissioner; a leading disability advocate; representatives from the culturally and linguistically diverse and Indigenous communities, and a community representative with personal lived experience. The panel heard from 867 participants and organisations during the consultation process. It received 541 submissions. More than 60 organisations were consulted. The consultation process is outlined in the panel’s final report. This was an in-depth, comprehensive consultative process that respectfully heard the views, comments and suggestions of the public as well as health professionals and other subject matter experts. The panel’s comprehensive final report provided government with recommendations for the introduction of voluntary assisted dying legislation. The government carefully considered all the panel’s recommendations; however, it has chosen to adopt a cautious approach. The Western Australian community would expect nothing less than a careful and considered response from its government on this issue.

This debate is a deeply personal one and from the outset I want to acknowledge the Western Australians and members of this place who will share with us experiences about their loved ones and what they witnessed in their final days. As a society, we do not talk enough about death. While we are comfortable discussing how to lead good lives, we are less at ease talking about how we might have a good death. By opening up the conversation about death, we are also opening up the conversation about palliative care and making it easier for patients to access it. In those jurisdictions with voluntary assisted dying, they are accessing palliative care at increasing rates. Palliative Care Australia has reported that if anything, in jurisdictions where assisted dying is available, the palliative care sector has further advanced. Giving people who are at the end of their lives a choice about the timing and circumstances of their death, whilst ensuring strong protections, is the compassionate thing to do. Western Australians should be supported in making informed decisions about their medical treatment, and should be able to choose to spend their last days surrounded by loved ones, coherent and without pain, and ideally at home. This is a rational choice.

Witnesses to the joint select committee shared their experiences. Personal stories are compelling and I am sure members will be moved by these experiences as I have been. One witness, William Philip shared the story of his wife. He said —

in the next 10 days she basically drowned slowly. Her lungs continued to fill up. No matter what the doctors did, they were not able to do anything about it, nor were they able to put her out sufficiently that she was unaware of it … Her eyes were bugging out and she was throwing herself around; she was terrified and that should not have happened. The palliative care people came that day, they helped stabilise her and they were as good as they possibly could have been. I think they were there three or four times that day and she should have settled down, but from then on she just gradually quietly drowned.

Another witness described the terrible suffering their mother experienced in her final days with these words —

A nurse said: “Look, it’s her last, final hours … what’s going to happen is we’re going to give her some morphine when she starts twitching. She will settle—give it some time to kick in—and just keep calling us when she twitches. So it was four or five cycles of madness. So my mum twitches, we call the nurse, they come within five minutes, they press the button to give her more morphine… It takes her 15, 20 minutes to settle. There is peace and quiet for a little while—maybe half an hour if we are lucky—and then she

Extracted from finalised Hansard
starts twitching again, and then we call the nurse again and then they inject her again, and then we wait and then she twitches and then we inject and then we wait and then she twitches and then they inject and then we wait! It was absolutely pointless. Then mum was pronounced dead at 8.20am.

Yesterday with the Premier, and with other members present, I greeted Belinda Teh on the steps of Parliament House. Belinda walked three and a half thousand kilometres from Melbourne to Perth in honour of her mother, who endured a painful and agonising death. An advocate for voluntary assisted dying laws in Western Australia, Belinda acknowledged her mother received the best possible palliative care anyone could wish for—here in Western Australia. But it simply was not enough. Belinda said, “My mother died in a way that will haunt me for the rest of my life. There are some things we cannot change and there are some things we can.” I would like to acknowledge Belinda in the gallery today.

The current laws are outdated and put patients and health practitioners at risk. Some doctors have acknowledged that people are being assisted to die right now. But this practice is hidden, unregulated and potentially unsafe. This bill provides a legal framework ensuring protections for the person and for health practitioners. No health practitioner who follows the requirements of the bill should be worried about being prosecuted. The coroner tells us that in Western Australia around 10 per cent of suicides are linked to chronic disease or terminal illness. These include deaths from plastic bag asphyxiation, hanging and gunshot. These are the wrongful deaths we should be concerned about. This is where our compassion is lacking. We can do better than condemn people to suicide. There is also an unknown cost—the consequences of unsuccessful suicides. That people are left so desperate is shocking, the distress for their families unimaginable. The joint select committee reported that there are currently several lawful options available to those with harrowing suffering due to terminal or life-limiting illness. Commonly, individuals choose comfort care and refuse further medical treatment in place of continued invasive treatments that incur distressing side effects. Less commonly, individuals with extreme suffering elect to refuse food and water—deliberately striving to hasten their death. These deaths can be painful and distressing. As a civilised and compassionate society we should not accept this situation.

I would like to emphasise that this bill has nothing to do with euthanasia. This is about providing assistance to someone who is already dying. It is not euthanasia and it is not suicide. It would be wrong to confuse voluntary assisted dying with suicide. The bill specifically provides that voluntary assisted death is not suicide. Suicide involves the tragic loss of life of a person who is otherwise not dying. Voluntary assisted dying involves a person’s choice about the manner of their death when faced with inevitable and imminent death as a result of an incurable disease, illness or medical condition. I might also say that voluntary assisted dying does not detract from this government’s determination to reduce the incidence of suicide in our community.

While the Joint Select Committee on End of Life Choices was conducting its inquiry in this state, the Victorian Parliament passed the Voluntary Assisted Dying Act 2017. The Victorian legislation presented Western Australia with the opportunity to examine the approach taken in Victoria. However, during the development of the bill, the circumstances and needs of Western Australia have been kept in mind. Western Australia has different clinical models than Victoria due to its geographical size and location. WA is the most culturally diverse state in Australia, with Aboriginal people, migrants and refugees accounting for nearly 30 per cent of its population. Where possible, consistency with the Victorian legislation has been maintained; however, this bill reflects what is suitable for the needs of Western Australians.

Before I move on to provide a more detailed explanation of the bill, I would like to bring members’ attention to some key elements of the eligibility requirements. At all stages, this is a voluntary process for people and health practitioners. The person must be 18 years of age, an Australian citizen or permanent resident and ordinarily resident in WA for the past 12 months. The person must be diagnosed with a disease, illness or medical condition that is advanced and progressive and will cause death. The condition will, on the balance of probabilities, cause death within six months, or 12 months in the case of a neurodegenerative illness, and the person is experiencing suffering that cannot be relieved in a manner that the patient considers tolerable. Eligibility will be assessed independently by two doctors who must have completed mandatory training to understand the legislation, assess decision-making capacity, detect coercion, communicate with patients at end of life, and understand the patient’s palliative care options.

The government carefully considered the question of coercion. Under the bill, it will be a crime to induce or coerce another person to participate in voluntary assisted dying. There have been numerous inquiries, both internationally and in Australia, that have considered the issue of coercion. These inquiries concluded that there is no evidence the vulnerable are being coerced into accessing voluntary assisted dying. Patients already make a range of life and death medical decisions; for example, decisions to undergo or withdraw from chemotherapy, to remove assisted ventilation, to commence or cease medical hydration and nutrition, or to commence or cease renal dialysis. Such decisions, routinely made by patients in collaboration with their doctors, do not have the legislative safeguards proposed for voluntary assisted dying. If, when assessing eligibility, a doctor is unable to determine whether the decision is voluntary and free from coercion, the doctor must refer to a suitably qualified and experienced person for further assessment. As an additional safeguard, the CEO of the Department of Health and police have powers to investigate the process, including powers of entry, search and seizure regarding any concerns with conduct under this law.
The government takes the risk of coercion seriously. The bill provides robust and rigorous safeguards to ensure access to voluntary assisted dying will be only for those people who are assessed to be eligible. The government will also provide an implementation phase for the law. It is anticipated that it will take 18 months to complete. It will enable the development of policies and protocols, and the establishment of a Voluntary Assisted Dying Board to ensure compliance with the law.

There are 102 safeguards within the bill, and I will provide a document to outline these for members. The government has worked hard to find the right balance between the safeguards necessary to ensure the integrity of the model and to ensure that those who are eligible and who genuinely wish to access voluntary assisted dying are not prevented from doing so.

Pursuant to standing order 126(1), I advise that this bill is not a uniform legislation bill. It does not ratify or give effect to an intergovernmental or multilateral agreement to which the government of the state is a party; nor does this bill, by reason of its subject matter, introduce a uniform scheme or uniform laws throughout the commonwealth.

I now turn to a more detailed explanation of the bill. The bill proposes a systematic process through which a person may access voluntary assisted dying. From requesting access to voluntary assisted dying to the prescription, dispensing, administering and disposing of a voluntary assisted dying substance, the bill includes a number of safeguards that reflect the needs of the Western Australian community. Part 1 of the bill sets out the principles and the key themes for voluntary assisted dying in Western Australia. The principles will serve as a guide in interpreting and applying the bill. They reflect the importance of giving people genuine choice and autonomy over their decision-making, while also recognising the need to protect individuals who may be vulnerable to undue influence. Notably, the bill enshrines the right of registered health practitioners to refuse to participate in the voluntary assisted dying process. A health practitioner may be a conscientious objector or they may object for other reasons, such as not meeting essential qualifications or being unable or unwilling to perform the training and duties required by the bill.

The bill reflects the position that participation in the voluntary assisted dying process is completely voluntary and there is no obligation for anyone to participate. Health practitioners must still provide general information about voluntary assisted dying to the person who has requested access to voluntary assisted dying. After all, this person is still a patient to whom a duty is owed under the Western Australian healthcare system. A fundamental safeguard to the proposed model for voluntary assisted dying in Western Australia is that the person’s decision is well informed throughout the process. Standardised information regarding the voluntary assisted dying process will be developed during the implementation phase and will be made available to all health practitioners for provision to patients who make a request or require information. A registered health practitioner will be able to begin a discussion about voluntary assisted dying with a patient to whom they are providing health or professional care services. There should not be an attempt to censor the conversations that health practitioners have with their patients and they should be able to raise and discuss voluntary assisted dying in the same way as other serious health or medical decisions at end of life.

The bill also makes clear that a person who seeks to access voluntary assisted dying may decide not to proceed with the process at any time. This provision reflects the voluntary nature of voluntary assisted dying. In order for the process to continue, the person’s choice to participate is paramount. The entire process must be driven by the person. Their decision to participate must be enduring. The person is not obliged at any stage of the process to take any further action.

Part 2 of the bill sets out the requirements for access to voluntary assisted dying, including the eligibility criteria against which a patient is assessed. The government acknowledges that the criteria will prevent some from gaining access. However, the criteria are necessary safeguards for ensuring that people can be appropriately assessed and that only those at end of life have access.

The first criterion is that a patient seeking to access voluntary assisted dying must be at least 18 years of age. It is the position of this government that only adults should be eligible to make this choice about their death. The second criterion is that the patient must be an Australian citizen or permanent resident and, at the time of making the request for voluntary assisted dying, have been resident in Western Australia for a minimum of 12 months.

The third criterion is that the patient must be diagnosed with a disease, illness or medical condition that has certain characteristics—namely, that it must be advanced, progressive and will cause death. It must also, on the balance of probabilities, cause death within six months or in the case of a disease, illness or medical condition that is neurodegenerative, within 12 months. These factors will be determined on a clinical basis by the medical practitioner based on an individual’s particular circumstances, including their overall condition and their comorbidities. The disease, illness or medical condition must also cause suffering to the patient that cannot be relieved in a manner that the patient considers tolerable. This is a subjective element to be determined by the patient and is consistent with the person-centred approach of the bill to voluntary assisted dying.

The government carefully considered the recommendation of the ministerial expert panel regarding the time line until death. A time line of six months—or 12 months in the case of neurodegenerative illness—reflects that to be eligible, a person must truly be at the end stage of their life. This is consistent with the Victorian act.
The fourth criterion that must be satisfied by the person is that they must have decision-making capacity in relation to voluntary assisted dying. A person’s decision-making capacity is assessed at several stages throughout the voluntary assisted dying process. This staged approach, as set out in the bill, reflects that a person’s capacity to make decisions about voluntary assisted dying may fluctuate, and that in order to access it, there must be enduring decision-making capacity.

The assessment process reflects current clinical practice in Western Australia and endorses the position of the Royal Australian and New Zealand College of Psychiatrists that referral for specialist assessment occur only where there is doubt about decision-making capacity. Concerns were raised during the public consultation that the system should include a mandatory psychiatric review. The Royal Australian and New Zealand College of Psychiatrists’ submission to the joint select committee indicated that referral should be mandatory only where there is doubt about decision-making capacity. Doctors assess decision-making capacity every day as part of ordinary clinical practice. Doctors have to determine whether a person has capacity to decide to undergo chemotherapy or life-saving surgery. They have to decide whether a person has capacity to refuse life-sustaining treatment, such as dialysis. This is part of routine clinical practice. Notwithstanding this, the bill requires that a doctor must refer the person to a psychiatrist or other appropriate health practitioner if they are unable to determine capacity. In addition, further training to assess decision-making capacity and to identify signs of coercion will be an important part of the mandatory training for participating health practitioners.

In deciding whether a person has decision-making capacity, the assessor must be satisfied of five things in relation to the voluntary assisted dying—that the person has the capacity to understand any information or advice about the decision that is required under the act to be provided to the person; understand the matters involved in the decision; understand the effect of the decision; weigh up these factors for the purpose of making the decision; and communicate the decision in some way. For example, the patient has to have the capacity to understand that he or she will die if they self-administer or are administered a voluntary assisted dying substance. In addition, the State Administrative Tribunal may review any determination about decision-making capacity. This review process can be commenced by the person, their agent or any person whom the tribunal is satisfied has a special interest in the medical care and treatment of the person.

The fifth criterion is that the person must be acting voluntarily and without coercion. Participation in the voluntary assisted dying process will always be completely voluntary. Furthermore, it is fundamental that a person is not being coerced or unduly influenced to request or access voluntary assisted dying. The sixth criterion is that the person’s request for access to voluntary assisted dying must be enduring. This enshrines the position that in order for the voluntary assisted dying process to continue, the person’s continuing decision to participate is paramount.

Part 3 of the bill sets out the request and assessment process for voluntary assisted dying. This is a robust process that ensures that an accurate assessment of the person’s eligibility criteria can be made. Rigorous criteria and safeguards throughout the process actively prevent a person from being coerced or manipulated into engaging in the voluntary assisted dying process. Request and assessment requires three requests by the person—two verbal requests, with a written declaration in between that must be witnessed by two independent people who will not benefit financially in any way from the death of the person. Assessments must be conducted by two independent registered medical practitioners. Both medical practitioners must independently come to the view that the patient satisfies all the eligibility criteria. In accordance with best clinical practice, both medical practitioners are also able to refer any part of the assessment to a suitably qualified professional with specialised skills and training. Where a doctor is unable to determine the diagnosis, the prognosis, the decision-making capacity or whether the person is acting voluntarily and without coercion, the bill requires that the doctor must refer to a registered health practitioner or another person who has the skills and training to make a determination. This may include a psychiatrist, neurologist, clinical psychologist or other health professional. In the case of coercion, it may also include referral to a social worker, a police officer or other suitable experienced and qualified person for investigation. Following these assessments, there is also a final review to ensure that all the proper steps have been followed. The bill balances the need for a thorough assessment of eligibility whilst ensuring the process is not too cumbersome for the person seeking to access voluntary assisted dying.

The bill sets out the minimum experience requirements that a medical practitioner must have before they may carry out specific roles under the bill. Only qualified and suitably experienced and trained medical practitioners may assess a person’s eligibility. The minimum requirements are supported by advice from the Western Australian branch of the Medical Board of Australia and are consistent with recommendations by the ministerial expert panel. The doctor must be either a specialist with at least one year’s experience as a specialist; a generalist doctor with at least 10 years’ experience as a doctor; or an overseas-trained specialist who meets the requirements set down by the chief executive officer. In all cases, each medical practitioner must have also successfully completed the approved voluntary assisted dying training. The training will ensure that the medical practitioners are aware of their legal obligations under the act; understand the eligibility criteria that must be met; and are able to assess the person against the eligibility criteria.

Training will be developed during the implementation period of the bill. The Royal Australian College of General Practitioners has indicated that the college is prepared to assist in the development of appropriate training and to provide accreditation for health practitioners. A person who meets all the eligibility criteria is not automatically...
able to access voluntary assisted dying. Each medical practitioner, having assessed that a person meets the eligibility criteria, must inform the person about a number of matters related to the voluntary assisted dying process, and the person’s specific circumstances and options under the process. Only where both the medical practitioners are also satisfied that the person understands the information provided will they be able to conclude that the patient is eligible for access to voluntary assisted dying.

Part 4 of the bill provides that a person may progress to the next stage of the voluntary assisted dying process only if the request and assessment process has been properly completed. The patient may then make an administration decision about either self-administration or practitioner administration of the voluntary assisted dying substance. This administration decision must be made in consultation with, and on the advice of, the person’s coordinating practitioner. It must be a decision that both the coordinating practitioner and the person discuss, and to which the person consents and the coordinating practitioner agrees. This position has been strongly supported throughout the public consultation process.

It is clear that practitioner administration should not be limited only to people who are physically incapable of self-administration. For example, a physically capable person may still have an inability to self-administer due to concerns about being able to ingest or absorb the medication. In certain circumstances, the bill provides that a qualified nurse practitioner who has also undergone the training may be able to administer the voluntary assisted dying substance to the patient. Practitioner administration requires an independent witness to be present.

If a person makes a decision to self-administer the voluntary assisted dying substance, the coordinating practitioner will prescribe a voluntary assisted dying substance only if the person has appointed a contact person. The contact person’s role is to ensure that once supplied, a voluntary assisted dying substance can be monitored and safely disposed of if unused. This ensures that a patient is supported in the management of the voluntary assisted dying substance. Clearly identifying who will be responsible for returning any unused substance to the authorised disposer is another safeguard in the process of accessing voluntary assisted dying in this state.

Part 4 of the bill also sets out the requirements for prescribing, dispensing, administering and disposing of a voluntary assisted dying substance, consistent with the Medicines and Poisons Act 2014 and the safeguards afforded by that act. The bill authorises the coordinating practitioner to prescribe the voluntary assisted dying substance from an approved list. Regardless of whether a self-administration or practitioner administration decision is made, the coordinating practitioner will send the prescription directly to the authorised supplier, who will supply the prescribed substance to the patient or their agent when required. This is another safeguard built into the legislation, as it negates the ability for another person to copy the patient’s prescription or for the type of substance being used for voluntary assisted dying to be made public. The type of voluntary assisted dying substance prescribed will depend on the person’s illness, disease or medical condition and the ability of the person to self-administer.

The bill makes provision for authorised suppliers and authorised disposers to deal with the proper supply and disposal of substances prescribed for the purpose of voluntary assisted dying. Only registered health practitioners who are authorised to supply or dispose of schedule 4 and 8 poisons will be designated as an authorised supplier or authorised disposer.

As noted earlier, when there are any concerns around the medication process, the bill provides for WA police, or an investigator appointed by the CEO, to conduct an investigation under the Medicines and Poisons Act. They will be empowered to enter premises, search, seize items, question and use reasonable force to conduct their investigation.

The Victorian act provides for a permit system; however, this is not a further clinical review. It is an opportunity to ensure compliance with the request and assessment process. This reflects processes consistent with this state. It includes express authorisations that enable the prescription, supply, preparation, possession and disposal of the voluntary assisted dying substance. These authorisations offer protection for health practitioners performing functions under the bill and a safeguard for patients seeking to access voluntary assisted dying. The prescription must include a statement that clearly indicates that it is for a voluntary assisted dying substance and certifies that the request and assessment process has been completed in respect of the patient in accordance with the Voluntary Assisted Dying Act; that the patient has made an administration decision; and whether the decision is for self-administration or practitioner administration.

The first request, the assessments, the written declaration, the final review, the contact person, and the prescription and dispensing of medication must all be reported to the Voluntary Assisted Dying Board within two days of each step taking place. The supplier of the substance is prohibited from supplying the substance unless they have confirmed the authenticity of the prescription, the identity of the person who issued the prescription and the identity of the person to whom the substance is to be supplied.

There are also specific labelling requirements for a prescribed substance. These requirements are in addition to any labelling requirements under the Medicines and Poisons Act 2014.

Part 5 of the bill establishes the review jurisdiction of the State Administrative Tribunal, whereby an eligible applicant may apply to the tribunal for a review of particular decisions that the medical practitioner makes under the bill—namely, whether the patient has or has not been ordinarily resident in Western Australia for 12 months.

Extracted from finalised Hansard
at the time of making the first request; or has or does not have decision-making capacity in relation to voluntary assisted dying; or is or is not acting voluntarily and without coercion. An applicant who is eligible to apply to the tribunal will include the patient or their agent and any other person the tribunal is satisfied has a special interest in the medical care and treatment. The requirement of a “special interest” excludes people who simply oppose voluntary assisted dying—they cannot interfere with the autonomous decision of the person. Merely being a member of the person’s family or their primary caregiver is not, on its own, intended to be sufficient to constitute having a special interest. A special interest will be determined on a case-by-case basis by the tribunal.

Part 6 of the bill creates a number of indictable offences for breaches of conduct that could occur as a result of the legalisation of voluntary assisted dying. Existing criminal laws will still apply. The bill makes it a crime for a person to administer a prescribed substance to another person other than as authorised under the bill. The penalty attributed to this offence is life imprisonment. This reflects the seriousness of anyone administering a voluntary assisted dying substance outside the process allowed under the bill. Administration of the substance may occur only via practitioner administration to the person or via self-administration—by the person to themselves. This offence provision is a clear warning to all that there are strong repercussions for anyone who intentionally contravenes the fundamental requirements of the voluntary assisted dying process under the bill.

The bill also creates a number of other offences, including those related to inducement, making or giving false or misleading statements or information, and failure to return a prescribed substance to an authorised disposer. The penalties attributed to each offence reflect the severity of particular conduct and breaches of the provisions of the bill. They are also consistent with the penalties in Western Australia for similar offences. WA police, the Department of Justice and the Director of Public Prosecutions provided feedback on the offence provisions.

Part 7 of the bill allows for contraventions of the Voluntary Assisted Dying Act to be investigated and the provisions of the act to be enforced.

Part 8 of the bill creates a number of express protections from liability that may arise due to the voluntary assisted dying process. These protections are important, as it would be unfair and unreasonable for a person to be found liable for doing, or not doing, something that is complementary to the process being enabled under this bill. These protections do not exempt a person who acts contrary to their obligations, or contrary to what is enabled, under the bill.

Part 9 of the bill establishes a statutory board to ensure proper adherence to the bill and to recommend safety and quality improvements.

The Voluntary Assisted Dying Board will primarily have a monitoring and advisory role on matters related to voluntary assisted dying—collecting and maintaining data, reporting to the houses of Parliament on the operation of voluntary assisted dying in Western Australia, and making recommendations on best practice or areas needing improvement. The bill sets out comprehensive reporting requirements that enable the board to check that each stage of the voluntary assisted dying process is being correctly followed. Each step must be recorded in an approved form and provided to the board. The board will have a holistic view of the process and will maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

The bill also enables the board to make essential notifications or refer suspected contraventions of the bill to bodies such as the Western Australia Police Force, the Coroner’s Court and the Australian Health Practitioner Regulation Agency. This is a critical safeguard, as it enables the appropriate authorities to investigate potential criminal conduct, professional misconduct or any other wrongdoing.

This is not a slippery slope. Parliamentary processes, such as those in Victoria, Canada, Oregon and other American states, have demonstrated that considered, evidence-based reform, sought by the community, can be appropriately legislated by parliaments. There is no reason why we cannot do the same in Western Australia for our community, for us to meet the test of what it means to show genuine compassion for those in our community who are enduring a level of suffering most of us would be unable to imagine. In other jurisdictions, introducing a legal framework for assisted dying reduced the incidence of unlawful activity. Australian and international inquiries demonstrate that the vulnerable can be protected.

The government recognises the importance of all end-of-life care. The bill does not create a lower standard of care for people who are coming to the end of their lives. We are not replacing palliative care. We are providing another option for those who are dying. What emerged from the joint select committee and the ministerial expert panel is that the current legal framework and medical interventions surrounding end of life care do not adequately meet the needs of a small but significant group of people. This bill is an answer to those who are at the end of life and who so often lack the health, strength or voice to be heard. People want their loved ones around them as they die; they want to be able to say goodbye properly. It does not seem to be too much to ask. Today we say to those Western Australians: “We hear you. We want you to have a choice at the end of your life, when the end is inevitable. We want you to be able to make your own decision.” The bill includes safeguards embedded at each step to ensure that only those persons who meet the eligibility criteria and who make an informed, voluntary and enduring decision, are able to partake in the process.
There have been six attempts to pass similar legislation through the Western Australian Parliament. The time has come for us to provide safe and compassionate legislation to end the most severe suffering of those Western Australians who are currently dying without dignity, who are dying without those they love being present, and who are often dying in the presence of their families in such terrible circumstances. It is my hope that members acknowledge community concerns and the calls for compassion to support people at the end of their lives, to provide dignity, and to provide choice, because Western Australians are ready for voluntary assisted dying. Voluntary assisted dying enjoys huge public support. Newspoll, Vote Compass and other surveys over the last 10 years consistently show 80–88 per cent support. This includes support of around 70 per cent from people who identified as members of major religions. Finally, this is a deeply personal matter. The public has asked us to grapple with this issue and we should do so. In doing so we must ensure that we meet the standards the community expects of its leaders. I again ask members to ensure our debate is respectful, compassionate and dignified. I now table documents outlining the proposed process, and the comprehensive safeguards built into the process, and I commend the bill to the house.

[See papers 2634 and 2635.]

Debate adjourned, on motion by Mrs A.K. Hayden.

Legislative Assembly
Tuesday, 27 August 2019

VOLUNTARY ASSISTED DYING BILL 2019
Appropriations

Message from the Governor received and read recommending appropriations for the bill.

Legislative Assembly
Wednesday, 28 August 2019

VOLUNTARY ASSISTED DYING BILL 2019
Second Reading

Resumed from 7 August.

MR M. McGOWAN (Rockingham — Premier) [12.21 pm]: I begin by thanking the people in the gallery today, in particular Belinda Teh, Mr Malcolm McCusker and Mr Marshall Perron, who has come from the Northern Territory to be here for this debate.

Today marks the start of a parliamentary debate that has been a long time coming, something that has been eagerly anticipated in the community for many months now. But for campaigners and those who have experienced their loved ones going through hardship, this has been years in the making. We should recognise that many have not made it to see this legislation be debated. It has been encouraging to see the manner in which this debate has been conducted so far, for the most part. I have said before that this is a debate of which convictions are sincerely held and reasonable people can completely disagree. It has been heartening thus far that in 2019 such a difficult issue can be debated civilly. I would like to see that continue and this legislation come to a vote without it being unduly delayed. This is an issue of great public interest with overwhelming public support at a time when many in the community have concerns about the capacity of institutions to operate effectively and in the public interest: banks, regulator and Parliaments. I believe it is important that we demonstrate that as legislators in the Western Australian Parliament we can do our jobs and tackle an issue that, although difficult and thorny, the public want to see addressed. That is our job here not just over the next weeks and months, but always. This issue needs to be resolved one way or another. It needs to come to a vote.

Life is full of choices. MPs will have a choice here. For mine, the choice is straightforward: do we wish to give the terminally ill who are in pain the opportunity to have the choice to end their suffering or not? It is often said that this legislation is important because it is a matter of life and death. As the chair of the Ministerial Expert Panel on Voluntary Assisted Dying, Malcolm McCusker, AC, QC, said, that is not the case at all. Under the regime we have developed, it will be open to only those who are terminally ill, and those for whom death will occur within six months, or 12 months in the case of neurodegenerative illness, and those who are experiencing suffering that cannot be relieved. It is not a choice between life and death; it is a choice about the manner in which death will occur.

Extracted from finalised Hansard
The choice before us as legislators and members of Parliament is: do we want the status quo to prevail, of needless pain and suffering for Western Australians; of families, helpless to witness that suffering; of medical professionals forced into legal and ethical grey areas; and of gruesome suicides that take place when people are forced to take matters into their own hands? Or do we want to set up a regime, that is safe and compassionate and that lets people have the freedom to choose an end that is dignified? That is the issue of conscience that we will be voting on.

Since 2012, when I became the Leader of the Opposition, I have made my personal position on this matter clear: I support a regime for voluntary assisted dying with the appropriate safeguards. I have never really had the chance to explain fully why I support such laws. Today is a rare chance to go into it. Many people here will have deeply personal stories of loved ones dying, and I am sure that by the end of this debate we will have heard some heart-wrenching stories by members of Parliament about their family members and friends. I know people who have had difficult and painful deaths, but I do not have the intimate personal experience that many people do.

There are three main reasons I support voluntary assisted dying. Firstly, for the person who is dying, I believe that they deserve a means to not have to endure unnecessary pain and suffering. Secondly, for the families, I believe that the status quo does not serve them, and they will bear witness, horrible witness, to their loved ones needlessly suffering, or they will be forced to endure finding them after they have taken their own life. Finally, I believe it is an issue of logic and a freedom of choice. It is a freedom of choice for individuals to make their own decisions about their own lives and to not have decisions made for them. I would like to take a moment to expand on each of these reasons.

Firstly, I believe that voluntary assisted dying should be legal, for the benefit of the terminally ill who suffer. As I mentioned earlier, the regime that we have set up is for the terminally ill. If a painful death is a certainty, I believe that those who are dying should be given the choice of the means of their death. If they do not wish to go through needless suffering, they should not have to. It is not beyond us to provide them the means to do so. I believe that reducing suffering of Western Australians is entirely inside our remit as parliamentarians. The stories contained within the Joint Select Committee on End of Life Choices “My Life, My Choice” report are often harrowing, with people living ending under circumstances that are undignified and difficult to hear, let alone difficult to experience.

One such story is Melanie’s, a bright young lawyer who suffered from motor neurone disease. Melanie was shuffled between hospitals, hospices and a nursing home, where she alleged she was sexually abused, and experienced great suffering and distress. She elected to end her life rather than return to a nursing home. She was told that her only option was terminal dehydration—the refusal of all nutrition and liquids. This is a means of passing—of dying—that can take up to 14 days. This is not how any of us would wish to end our lives. It is not a dignified death; it is a painful and horrible death. It is a grim irony that it took the incredible compassion of medical professionals to facilitate the kind of uncompassionate death allowed under our legal system. It is a further grim irony that Melanie was considered lucky, as she had private health cover.

There is also the story of Belinda Teh’s mother, Mareia, who had terminal breast cancer, a reminder that palliative care—an important part of end-of-life choices for Western Australians—cannot alleviate all suffering. Despite excellent palliative care, dedicated doctors and medical staff for whom Belinda has the utmost respect, the end of Mareia’s life could not be described as a “good death”. The final two months of her life were spent in pure agony every time she moved; her breast cancer had metastasised through her bone marrow and fractured her spine. Beyond that, she was vomiting, had lost control of her bowels and in her final hours, despite terminal sedation, she would wake up gasping for air, twitching uncontrollably. It was heartbreakingly for her daughter Belinda to witness. But how must Belinda have felt when she made her brave journey across Australia and found her mother’s story was all too common across this country? There is a great groundswell of Western Australians who do not want that kind of an end, and, frankly, I do not blame them.

Belinda’s story shows that this is an issue that goes beyond the individual; it affects their families, their loved ones and their friends, and it spills outward, not just from watching someone waste away, which is of course horrible, but in the consequences of what happens when people in this situation take matters into their own hands. It has been said that Western Australians have the ability to take their own lives if they so choose. This cold truism does not consider two things. Firstly, it is not physically an option to many who would choose such a thing. Secondly, and most compellingly, many people already do. It is a further grim irony that it took the incredible compassion of medical professionals to facilitate the kind of uncompassionate death allowed under our legal system. It is a further
In this context, I am reminded of the very sad story of Clive Deverall. Clive was a very prominent Western Australian. He was the former head of the Cancer Council; an incredible fundraiser and public health advocate; a palliative care campaigner; and president of Palliative Care Western Australia. For two decades he suffered from a rare form of non-Hodgkin’s lymphoma. One of his friends, Terry Slevin, described him as “an extraordinarily energetic, fun but dedicated soul.” He said —

“Clive had passions, Clive had beliefs and he never stepped back from those. For the last years of his life, Clive had been a passionate advocate for voluntary assisted dying. Clive, as president of Palliative Care WA, knew that palliative care was not a cure-all. In October 2016, he told the ABC —

“Certainly I still embrace what palliative care stands for, but even with their clinical guidelines, they avoid the elephant in the room which is the very end stage patients where symptoms cannot be controlled …”

Clive, not seeing options or progress from politicians, and not feeling relief from his pain, decided to end his life himself. He told his wife that he was in a world of pain. The next day, on Saturday, 11 March 2017, he went to a public park and killed himself. That was the day of the state election. I think that is incredibly tragic, not just because a man who saw no options took his own life, which is inherently tragic, but also as a campaigner, he wanted his death to send a message. Although his death received some solemn coverage from the ABC and The Australian, and the member for South Perth raised his story in a written op-ed, ultimately he did not get the attention or the impact that I think Clive wanted. To me, that was devastating for him. Clive Deverall deserved better than that. I hope he would be encouraged by the progress we are now making, and that his story has made it to this place, to this second reading debate.

Even if this Parliament is too late for Clive, we do not have to be too late for others. I think this shows that inaction has consequences. Staying with the status quo has a cost. How many more Western Australians need to witness their loved ones suffer without relief? How many more family members need to come home to discover the person they love and are caring for has ended their own life horribly and painfully? How many police officers need to come off shift with a traumatic memory they cannot shake, especially when there is a model for something better, safer, less traumatic and more compassionate? It is well documented that some people, with the help of medical professionals, help their family members die when they are terminally ill. The vast majority of us would say that that is fair, humane and compassionate. However, I want to make one point on this: it is compassionate, except someone else is making the decision. The ultimate decision, one of the most important decisions affecting a person’s life, is made by someone else. Does it not strike people as strange that it is accepted that a family member can make a decision for someone to die, but when they are in pain and terminal, the law blocks them from making that decision to have a humane and dignified death? I once attended a meeting where a prominent man said he opposed voluntary assisted dying, but he also said that he had taken steps to ensure that his mother died with the assistance of medical practitioners when she was terminally ill. He made the choice for her, but she was not allowed to make the choice for herself.

[Member’s time extended.]

Mr M. McGOWAN: For me, I primarily see it through a lens of logic and freedom. It is my life. If the end is not only inevitable but also imminent, and if the forecast for my remaining days is for suffering and dramatic deterioration—in other words, a good death is not an option for me—I would like to decide the terms on which I die. I would like to be given the option of a calm and painless death with my affairs in order, supported by loved ones. I think that is far preferable. I do not know whether I would personally use it because I have never been in that situation. But if I were, I would be comforted by the knowledge that I had a choice. It is an option. After all, this is “voluntary” assisted dying. The government does not force it on you. If someone believes that life is sacred and it should never be ended before fate decides it, that is their choice. But for those who would choose such a thing, must everyone else be bound by your world view? I think that is the key point. People have very deeply held beliefs on this issue. That is something that I understand. But should those beliefs ultimately restrict the freedom of others—freedom from suffering at the end of our life and to choose the manner of one’s end? After all, one of the restrictions in the legislation is on soundness of mind. The person must have decision-making capacity and be assessed to be free of coercion. For those in this chamber who approach politics through the paradigm of freedom and rights, and who follow the work of John Stuart Mill and others, is this not an incredibly simple issue to decide? This is the ultimate act of personal choice, of freedom, of individual rights.

For the past two years, a lot of hard work has been undertaken to get to this point. I thank the select committee, the ministerial expert panel, the Minister for Health and his department, the Attorney General, the member for Morley and the drafters for their work. I thank all of them and everyone else. There have been a lot of people and I cannot name them all. There has been extensive consultation with the community. This has been the largest public and community consultation ever undertaken by Western Australian Health. The ministerial panel heard from 867 participants and organisations during the consultation process. It received 541 submissions. More than 60 organisations were consulted. The select committee also received around 700 submissions and held 81 public hearings. I know members on all sides have been holding forums with their electorates or issuing surveys or

Extracted from finalised Hansard
consulting in whatever manner they have seen fit. This has been a very public discussion, well canvassed in the media, both print and television. As we have gone along, as people have seen what is happening in Victoria, and as more detail of our legislation has been released, we have seen an already high level of public support further increase. That is because we have developed a safe and compassionate regime for voluntary assisted dying.

In order to access voluntary assisted dying, a person would need to be aged over 18, be an Australian citizen or permanent resident and have been resident in Western Australia for at least a year. They would need to have a disease, illness or medical condition that is advanced, progressive and will on the balance of probabilities cause death within six months, or 12 months if it is a neurodegenerative condition. The condition would also need to be causing suffering to the person that cannot be relieved in a manner that the person considers tolerable. The request and assessment process requires three requests by the patient—two verbal, with a written declaration in between, and witnessed by two independent people. There must be a minimum of two independent medical assessments by two doctors and a final review by the coordinating doctor. Palliative care and treatment options available to the patient and the likely outcomes of that care and treatment are among a list of rigorous assessment measures and information included in the medical assessment phase. Each step in the voluntary assisted dying process, from the first request to the registration of death, must be recorded in an approved form and provided to the Voluntary Assisted Dying Board. The statutory board will ensure proper adherence to the bill and will have a monitoring and advisory role on matters related to voluntary assisted dying. This bill contains 102 safeguards. It is strict and it is conservative, but I believe that that was appropriate to achieve the broad support that it has.

This is an intrinsically hard debate to have as not only politicians, but also humans. We find it hard to talk about death. It is true that we find it very hard to talk about; I do not like talking about it. It is inevitable for every one of us. It will happen one day to each of us. We do not want to imagine a time without our loved ones and they do not want to imagine a time without us. I do not mind telling members that my parents had a conversation with me a couple of months ago about arrangements that they want for the end of their lives—funerals, notices and that sort of thing. It was hard, I have to say. I tried to change the subject, but they were very insistent on the conversation. As Premier, I am used to having difficult conversations, but although it is natural not to want to talk frankly about death, in this debate we need to put that to one side. We need to stare it in the face and have an honest conversation about the kinds of deaths available to Western Australians. Too many are suffering needlessly. I believe that we need to give them the option of a compassionate end, with the safeguards required so that the system cannot be abused.

It is a tough conversation for everyone, but it is on us to be careful but kind, and to understand that as a society we make rules and laws about all sorts of matters every single day, yet we have never had the courage to deal with one of the most important issues we all face—the death of ourselves and our loved ones. But we can do this and we can create a system that works for those who want it. Members, it is time to do the right thing morally and ethically, to be brave and to be kind. We can and should make this the law in Western Australia. Thank you.

MR Z.R.F. KIRKUP (Dawesville) [12.47 pm]: I stand today to speak on the Voluntary Assisted Dying Bill. As this bill was introduced by the Minister for Health and as I am the shadow Minister for Health, I take the responsive lead on it. This is the first piece of legislation that I have had such a privilege to deal with, so it is great to start with quite a challenge.

Looking back at the history of this Parliament, I am conscious that over the coming weeks we will be undertaking one of the most significant legislative considerations in decades. Regardless of the perspective any of us might have on this issue, the significance of this bill cannot be overstated. Truth be told, I initially was quite hesitant about this legislation because of not only the issue, but also the significant undertaking that may result in Western Australia being only the second state in the federation to implement assisted dying as an option of end of life for the terminally ill. However, from the process that I have gone through and after speaking to thousands of people and going over this legislation a number of times independently, I am no longer hesitant or apprehensive. I am emboldened that can I play a small part in contributing to what will undoubtedly be one of the most consequential legislative processes in the near future. I am proud to participate in the public discourse, this parliamentary debate and the overall process, because I know that when generations look back on this moment, I am confident they will see the best in all of us here as members of the Legislative Assembly. I am sure that they will see members who came together, regardless of our political allegiances, to discuss a concept that is momentous in its legislative capacity and, if the bill is passed, will substantially alter the futures of us all.

I am conscious that in considering this legislation, I do so from the perspective of having borne witness to very little death and dying myself. As the youngest member of this place, representing the oldest district in this state, I have felt a somewhat heavy burden arriving at my decision here today, given that I have had only a fleeting relationship with death. I have lost only a grandfather some 20 years ago, at an age when I remember less about the brain cancer that took his life and much more about the nostalgic feelings of warmth and love that he gave me as I was growing up. In my consideration of this bill I know that death awaits us all. The reality is that this legislation seeks to ensure that there is a control over that process that has been deprived of many in this state over the course of history. The question that has been asked is whether this is something that any of us should have any control over. Should we allow suffering to overcome us or should we try to shorten that process and have ultimate control.
ourselves? For those who subscribe to God’s plan, should we allow the intervention of humanity? Is this a concept that one considers that a controlled death is the ultimate mark of a dignified society or an intervention beyond acceptance?

As I stand here today, marking something like my ninth draft of this speech, this was not a decision that I arrived at easily. If we assume that the majority of people who wish to access this legislation will ultimately be the older cohort of our population, I stand here today as one who is the least likely, the furthest away—although it is by no means a guarantee—from needing to access voluntary assisted dying as an option if it becomes legislated.

Mrs L.M. Harvey: I certainly hope so.

Mr Z.R.F. Kirkup: I do hope so. With this lack of proximity to death, I did not have an immediately firm position on voluntary assisted dying. To establish my decision here today, I did a lot of searching. Initially, I somehow hoped that I might be lucky enough to land at an immediate and enlightened position on how I might treat this bill. Some of that searching was a reflection of my own personal values, but most of the searching was to establish a reliance on the opinions and beliefs of the electorate that dispatched me to this place in March 2017. I resolved that no matter what, the perspective of my district, the district that I represent, should matter more to me and how I represent their views in this place, and that my views should take second place. I have always believed that, first and foremost, the role of a parliamentarian is to reflect the views of those we have the privilege of serving. With this in mind, I set about trying to establish how my district feels about this issue and the legislation itself. As members will see, it has been a somewhat exhausting process. Before I outline the work we did in detail, I would like to thank Amanda Burton and Gaynar Sanders from my office, and the volunteers who assisted me with the legislation—Olivia Fortune, Jenny Green, Jill Millman, Joanne Stillaway and John Robertson—for their assistance in what we have achieved together.

As elected representatives we operate these days in a world in which we are not well liked and, at times, not well respected, and there is an overwhelming view that sometimes we are disconnected from the citizens who send us to this place. If the process of this legislation has taught me anything, it is that people more than ever want their representatives to connect with them, to listen to them, to respect them and, ultimately, to act on behalf of them. At every point in the consultation I undertook, I found differences of opinion on this issue. In my district, those views were often shared publicly at town hall or community group meetings, and although there were differences of perspective, there was no lack of respect among participants. In the experience across my district, people listened to each other, they respected each other, they spoke with high emotion, they spoke through tears, they spoke with conviction and they spoke with resolve on their perspective on this legislation and, ultimately, the end of life. However, at no point did this get the better of them. Instead, they understood opposing views and resolved to treat each other with dignity. I have found this process of direct, democratic engagement one of the most enriching opportunities I have had thus far in my parliamentary career and it only further reinforced the deep sense of pride I have in serving the district of Dawesville and the people of Mandurah more broadly. I am thankful to the thousands to whom I have spoken and I am grateful that by and large we are able to have these difficult conversations in peace, without violence or intimidation.

The process that I went through to consult with and establish the views of my district was divided into six elements. First, I created a dedicated page and resource on my website from the moment that the report of the Joint Select Committee on End of Life Choices was released. I wanted this to become the central depository for people in my community and a reference point for those who wanted more information. The Joint Select Committee on End of Life Choices report, the minority report, the Ministerial Expert Panel on Voluntary Assisted Dying report and the bill itself can still be found there, together with a form that people could fill out to provide me with their direct feedback. In the past month alone, more than 460 individuals have accessed that page and participated.

The second part of consultation reveals a bit of a trade secret. I am fortunate that after much community engagement, I have worked to secure the email addresses of over 6540 households in my district. As the second part of this consultation process, I emailed every one of them asking for their views on this issue and this legislation. A significant level of engagement came to me via email—sometimes one line; sometimes an essay from the citizen’s perspective. As with every email I get, I read through the emails and understood and absorbed their views, and I responded accordingly.

Thirdly, we called every single household in my district where there was a resident aged 65 or over. This resulted in more than 3040 households being called and asked specifically how they felt about voluntary assisted dying. As with all the language I have used throughout this debate, it was a very straightforward conversation. I was conscious that I did not want people to feel uncomfortable letting me know their views and that they did not feel influenced by the manner in which I might question them to understand how they felt about this matter.

Fourthly, we contacted every person who wrote to the Mandurah Mail or the Mandurah Coastal Times, even if they did not live in my district, to ask them whether they wanted to meet or discuss this issue over the phone. In total, 23 such meetings were held. Some of those meetings were the most confronting I have experienced. All of us in this place know that there is no training or handbook for much of what we do as members of Parliament. I assure you, Mr Speaker, that little can prepare you for when you have an elderly gentleman, who is otherwise quite composed, breaking down in your office when talking about the loss of his partner. As a young member of this place, and

Extracted from finalised Hansard
a palliative care nurse. She echoed my sentiments that in the regions, in particular, there is a lack of investment in funding for the provision of high-quality palliative care across Western Australia. When the Parliamentary Liberal Party had the opportunity to spend our winter conference in the Kalgoorlie district, I had the chance to meet with a representative, I will not be at odds with the views of my community and absolutely intend to support the legislation. As a freshman elected in only 2017, conversations like that left an indelible mark on me. Perhaps it is because we are reminded that our lives are too short and that we, too, will face death that these meetings I had with constituents were both emotionally crushing and yet full of hope for the opportunity that I might have to help relieve their situation.

The fifth part of consultation revolved around two town hall meetings that were conducted last week, one on Wednesday and one on Saturday, with a total of 139 people attending. At those town halls, I spent one and a half hours briefing residents on my summary of the legislation as best I could. Nothing can really test your knowledge of a bill quite like conducting your own briefing and then taking questions from those who attend. It was a miniature consideration in detail process from my own perspective, with people asking me questions such as why I did not include certain elements in the bill. I had to remind them that I was not the author.

Once again, as members would expect, there was a significant diversity of opinion. People such as Bill McWhirter from Halls Head told me that the legislation was too complex and that I needed to simplify it, referring to the “keep it simple, stupid” principle, and then ended, rather affectionately, by calling me stupid for not doing so. Others such as Emily Pinell remain concerned about the emotional impact that this legislation might have on practitioners.

I conducted sentiment analysis polling prior to my briefings at the town halls, and then once again after my briefings, to get the views of each participant on the specific elements of the legislation. Participants were asked to provide a score indicating their level of support for this issue prior to the briefing and then subsequent to it. The final step in the process was to engage with community groups in my district on this issue. In total, we engaged with more than 30 community groups. In some instances, I presented to them about VAD; in some instances, they provided me with direct feedback. In all, we contacted more than 9,580 households of the 18,765 households in my district. To put it another way, we contacted approximately over 51 per cent of those in my district. The youngest person who offered their view was 19; the oldest was 92. With these numbers in mind, I can report with confidence to this place that the sentiment in my district is as follows: 7.7 per cent of people remain unsure about voluntary assisted dying and this legislation; 8.5 per cent of people were against it; and 83.7 per cent of people in my district remain in favour of voluntary assisted dying and this legislation. Although this sits a few points below the research published in The West Australian, it is still quite obvious that the overwhelming majority of people in my community support voluntary assisted dying.

For what it is worth, I began this process with a hypothesis that perhaps the soft vote on this issue was quite high and that after individuals were challenged, there would be an erosion of support. In the sentiment analysis that we conducted during the town hall meetings, in which every person offered a score on how strongly they supported or did not support the issue prior and post my briefing, people overwhelmingly remained steadfast in their views. A small percentage of people were unsure of the legislation prior to the briefings, but in equal measure split to be supportive or unsupportive after the briefings. It is clear to me that this matter crosses many cultural, political and social divides. I know people in my community who did not support same-sex marriage, but who stood in favour of voluntary assisted dying, for example. I know, too, when I discussed this issue with members of all three of my local Liberal branches, there was an overwhelming view, even from the most conservative of my members, that they wanted to see voluntary assisted dying introduced. Given this opportunity and experience, I strongly reject any notion that there is a high soft vote on this issue, and that somehow when people are challenged to think critically about this issue, they reverse their position in droves, and it results in a 50–50 split or the like. This is not what I have seen. The reality is that in my district, and I suspect perhaps across the state, people have made up their minds on this issue. As a parliamentarian, it is now my turn. It is clear to me that my district wants me to support voluntary assisted dying in Western Australia, and I intend to do so.

Having gone through this legislation three times and made in excess of 450 mark-ups on the bill, I still have concerns and believe elements of the legislation need to be explored through the consideration in detail process. As a representative, I will not be at odds with the views of my community and absolutely intend to support the legislation. As a legislator, I consider it my moral responsibility to ensure that this bill is deeply scrutinised and that we explore any, and all, issues that may be associated with its design and implementation. I am encouraged that the minister has come to this with an open mind and has demonstrated a willingness to work in good faith with all members of this place to ensure that the legislation passes through this house in good shape. Very few landmark pieces of legislation go through both houses without some deep investigation. I believe we all have an obligation to ensure that the Voluntary Assisted Dying Bill passes in a state of immense fitness and accountability to the people of Western Australia.

There are three areas of immediate consideration associated with voluntary assisted dying that I would like to explore briefly: specifically, the provision of palliative care services in Western Australia, the delivery of VAD and end-of-life choices to Aboriginal communities in WA and, finally, the logistics surrounding the substance that may be used to access voluntary assisted dying.

Although palliative care is not dealt with exclusively in this bill, I remain quite concerned about the lack of guaranteed funding for the provision of high-quality palliative care across Western Australia. When the Parliamentary Liberal Party had the opportunity to spend our winter conference in the Kalgoorlie district, I had the chance to meet with a palliative care nurse. She echoed my sentiments that in the regions, in particular, there is a lack of investment in
high-quality palliative care. I note that the bill suggests in the principles in part 1 that all end-of-life choices should be considered and specifically singles out that there should be access to high-quality palliative care, which simply does not occur in the regions.

I think it is important that while the minister seeks to pass this legislation through this place, we should ensure that guaranteed funding for palliative care is in the forward estimates. I sincerely wish that during this debate and during the consideration in detail stage, we get an understanding from the minister on what that funding will look like over the forward estimates, and are assured that the government intends to focus on regional areas. Kalgoorlie is not that far away when compared with Broome, Esperance or Newman, but all people in Western Australia deserve equality of access to palliative care without being disadvantaged due to the tyranny of distance from our capital. I note that there are only 15 palliative care specialists in Western Australia, and that presently in places such as Royal Perth Hospital, palliative care is delivered on a nine-to-five basis from Monday to Friday.

I have made mention of the fact that Mandurah has the oldest population. With this in mind, it is my experience that there needs to be a significant investment in specialist palliative care in our city—a regional city that is just over an hour away from Perth. We know that further away from Perth, the inequality in accessing palliative care services grows. Our state deserves better than that. When I talked in my town hall meetings about the distance to palliative care services, concerns about distance and isolation came up time and again. When it comes to possibly accessing voluntary assisted dying, many residents felt they could not access practitioners in Mandurah, let alone what that might translate to in Kalgoorlie, where the waitlist for a general practitioner is over two and a half months. Many people in my district felt the bill does not properly consider how those who live some distance from Perth, in a regional city like Mandurah, or who may be mobility impaired, may access a coordinating practitioner, let alone a consulting practitioner. I pointed out to people that although there are provisions for teleconferences and the like, it is likely that this option will be removed from the legislation due to overriding commonwealth legislation. Distance from Perth is an obvious concern for government in the provision of all services. However, as our minds turn to the end-of-life choices legislation, I think it is important that more effort is put into establishing guaranteed minimums, perhaps an overarching state palliative care plan led by the Department of Health, and a better understanding of how voluntary assisted dying might be accessed by those who do not live in the western suburbs. We must strive to ensure that citizens are not disadvantaged because of their cultural background or their socioeconomic status or simply because they have chosen to live outside our capital.

In a not dissimilar theme, I would like to discuss the delivery of end-of-life choices for Aboriginal people, in particular those who reside in remote or regional communities. All of us in this place know that Aboriginal people are negatively overrepresented in nearly every key indicator for health, wellbeing and development. Detrimental health outcomes haunt Aboriginal Western Australians from the very beginning of their life. In WA, the infant mortality rate for an Aboriginal child stands 2.7 times higher than for non-Aboriginal children. Western Australian Aboriginal children are 10 times more likely to have a mother who consumed alcohol during pregnancy, resulting in 89 per cent of Aboriginal children accounting for all foetal alcohol spectrum disorder diagnoses. As we have seen with coronial inquest after coronial inquest, Aboriginal people are 2.7 times more likely to suffer psychological distress compared with their non-Aboriginal counterparts, and are highly overrepresented in our state’s suicide rate. When it comes to chronic disease, it is upsetting to consider that Aboriginal people are 3.5 times more likely to suffer from diabetes and 70 per cent more likely to die of cardiovascular disease. Ultimately, Aboriginal Western Australians die 13.4 years earlier than any other Western Australians, which is a larger mortality gap than in any other state in our Federation.

When one considers the desperate situation that our Aboriginal communities face, we must resolve to do better in the delivery of culturally appropriate and local palliative care options. We know that palliative care is not being delivered with a sense of equality in Perth and in regional areas, but the situation is far worse when we consider this in the context of Aboriginal communities, particularly those in remote settings. It strikes me as deeply unfair and deeply unreasonable that our Aboriginal Western Australians, who die 13 years sooner than everyone else, do so in an environment where they cannot access palliative care treatment—and, more than that, are now being offered the option of voluntary assisted dying. We must do better. I worry that without guaranteed investment and a plan to deliver culturally appropriate and local palliative care options to Aboriginal communities, wherever they may be, opening another avenue to death may further exacerbate the vulnerabilities that Aboriginal people face. With this in mind, I know that this government, this minister and indeed all in this place care deeply about the circumstances confronting Aboriginal people that I have described. I do not raise this issue to be controversial, but because it is a depressing reality and we must acknowledge it and resolve to work together to improve the health of our First Nations people. If we legislate to provide access to voluntary assisted dying, it is only fair and reasonable similarly to resolve to invest in better health outcomes to help extend the lives of Aboriginal Western Australians and to close the gap, so that when the end of a person’s life arrives, we can provide the option of better culturally appropriate palliative care treatment, preferably on country, or voluntary assisted dying. We can and must do better.

The final concern that I would like to raise before I finish my contribution is about the logistics around the substance that ultimately will be provided in order to bring about a patient’s death. When we consider remote or regional communities, it is imperative that we look at this legislation not only through the lens of application in
MR J.E. McGRATH (South Perth) [1.13 pm]: I rise to contribute to the second reading debate on the Voluntary Assisted Dying Bill 2019. At the outset, I would like to inform the house that I will be supporting the legislation that we have before us today. I am supporting it because I think it is the right thing to do. I am supporting voluntary assisted dying because of the people who have stopped me in the street—some of them total strangers—who have expressed their support for this legislation. I am supporting it for all the people who showed the courage to come before the Joint Select Committee on End of Life Choices and give evidence on the traumatic experiences of their loved ones at the end of their lives. I am supporting voluntary assisted dying for those doctors and clinicians who I know believe it is the right thing to do; and for Emeritus Professor Max Kamien, who, as ABC reported today, has split with the Australian Medical Association on this issue. I am supporting it because of the great number of doctors surveyed by the AMA in 2016 who believe that voluntary assisted dying should be provided in some circumstances. I am supporting it for the people who have a neurodegenerative disease and are wondering what their end-of-life experience will be like. I am supporting voluntary assisted dying for the nurse practitioner who recently came to my office and gave me a graphic description of the visceral nature of the dying and deaths
of the cancer patients she has tended to, and for the 80 per cent of Western Australian nurses surveyed who also support it. I am supporting voluntary assisted dying for the 84 per cent of people who came out in support when recently surveyed by the Council on the Ageing Western Australia. But, above all else, I am supporting voluntary assisted dying for the 88 per cent of Western Australians who, as reported in *The West Australia* on Monday, are asking legislators to grant them the choice to not suffer unnecessarily at the end of life’s journey.

When I entered Parliament in 2005, I said that my political ideology was quite simple. I said that politics should never get in the way of an initiative that would really benefit our state, and that I would never stand in the way of anything that would benefit my electorate, South Perth—very similar to the member for Dawesville. I believe that legislating for voluntary assisted dying will benefit not only my electorate, but also Western Australians around the state, and I believe very firmly that politics should not get in the way. Some of my colleagues might wonder at the strong stance I have taken on the issue, given that my portfolio and main areas of interest have been around sport and recreation, and racing and gaming. But to my mind, although we all bring our particular experiences and expertise to our roles as members of Parliament, we are here to represent our constituents on a broad range of subjects. If there is one thing I have learnt on the topic of voluntary assisted dying, it is that, at the end of the day, we legislators are all in this together.

I know that in this place, opposing opinions on voluntary assisted dying are genuine, and that every member of Parliament is considering the issue very carefully. On this occasion, we are entitled to vote in accordance with our conscience. Above all else, I simply urge MPs to consult their constituents, as has been demonstrated by the member for Dawesville—an amazing performance to consult so many constituents.

My views on end-of-life choices have been profoundly shaped by my work on the joint select committee. For that reason, I am grateful to the many hundreds who shared their experiences, expertise, views and concerns, and particularly those who exposed their grief, pain and suffering to the committee, often in full view of the public. I would like to specifically acknowledge the late Mr Clive Deverall, who was mentioned by the Premier in his speech. Clive Deverall was a constituent of mine. Clive’s tragic death prompted me to nominate myself as one of the two Liberal Party members on the committee. As the Premier said, Clive was the former head of the state’s Cancer Council and Palliative Care WA, as well as being a board member of Palliative Care Australia. On 11 March 2017, the day of the last state election, Clive ended his life in a public toilet close to the polling booth in my electorate, only a few hundred metres from my home. I later found out that Clive had chosen that polling day to send a message to us as politicians. Clive’s wife, Mrs Noreen Fynn, was one of many who gave evidence to the committee. Noreen, who went on to become a member of the ministerial expert panel, spoke powerfully of Clive’s life and death. Noreen said that although Clive took his own life, he did not choose between life and death. Instead, his actions were about the relief of suffering, choice and control when there was no prospect of a cure nor recovery, and no hope. Clive intended that his final act on election day 2017 would support the introduction of legislation in Western Australia to allow for assisted dying. He left a note: “Suicide is legal; euthanasia is not.”

Other witnesses also had a profound effect on me. I have spoken before in this place about the evidence of Mr Bill Spanbroek and his daughter, Mrs Katherine McBarron. Bill and Katherine have seen a great deal of suffering and death in their lives largely associated with the ravages of the genetic and neurodegenerative Huntington’s disease, including Katherine’s biological father who had Huntington’s disease and gassed himself in a car across the road from her home when she was just six years of age. Her brother Michael also died suffering terribly without effective pain relief at just 29 years of age and weighing less than 30 kilograms. I found Katherine’s evidence to be most compelling. When she appeared before the committee, Katherine was a young, vibrant 39-year-old woman. Her bravery in coming forward really had an impact on me. Katherine told us that she was 25 years of age when she was diagnosed as being gene positive to Huntington’s. She now lives knowing that Huntington’s could strike at any time. Despite that, Katherine told us that she lives a pretty happy existence that is full of life. But her greatest fear is that if the worst happens, she will have the same limited choices that her family members did when they were dying. It is important to note that Katherine told us that she was speaking for not only herself, but also others who might be in a similar position. I would like to read to the house part of Katherine’s evidence to the committee. Katherine said —

… my brother did not have a quality of life for five weeks in hospital, but they made him sit there because it is the law … I got to witness the intensity of Huntington’s. It was quite aggressive, the type of suffering he was going through and the changes he was going through. It was just horrible to watch. I just know that when it gets to be point where I do not have a quality of life and I am struggling, I will not be able to tie my shoelaces or be able to feed myself, I will be falling over and hitting my head, all of that sort of stuff … I do not want to get to the point of my father or my two half-brothers. I want to be with family and do it on my terms and celebrate my life and do it the right way and say, “See you, guys. My time is up; I have done enough.”

When I cross the chamber and vote in favour of this legislation, I will be thinking of Katherine.

By the end of a year of going through the committee process, I had come to the conclusion that legislating for voluntary assisted dying was the right thing to do, but I am convinced that parliamentarians must not only act to

*Extracted from finalised Hansard*
address the suffering of so many at the end of their lives. Assisted dying must be the choice of only the dying person, no-one else, and that point has been made by the previous two speakers. Assisted dying must be truly voluntary. That means that a dying person must not only have capacity to make a decision on assisted dying, but also not be under any compulsion or coercion to do so and, instead, have real choices. That is why the committee recommended that significant safeguards be in place in the proposed legislation for voluntary assisted dying. It is also why the committee strongly supported palliative care. I, too, am a great supporter of palliative care. I remember the day I was permitted as a committee member to accompany a Silver Chain nurse called Lyndsay on her rounds. We visited a cancer patient, a lovely gentleman, who agreed for me to come into his home with Lyndsay. I chatted with the gentleman about footy—he was an Eagles supporter and he loved watching the game on television—while Lyndsay dispensed medicine and discussed his progress with him and his wife. As we drove away, I thought to myself that if I ever get into that position, I would certainly look forward to a visit from someone like that. I often wonder whether the gentleman is still with us. I wanted to contact Lyndsay and ask about his progress but felt that might be too intrusive, so I still do not know.

As part of the committee process, members also visited hospitals and palliative care facilities around the state. I particularly want to record my appreciation of the commendable work being done by Dr Anil Tandon and his colleagues at Sir Charles Gairdner Hospital. I also acknowledge those patients of Dr Tandon who kindly gave their permission for committee members to visit them. The end of life can bring great sadness, but by being allowed to share a small part of it with those who were dying and those who cared for them, I got to witness how remarkable people can be, even in the most difficult of circumstances. It was a privilege to meet those patients and to see the work of Dr Tandon and it left me in no doubt about the value of palliative care.

These experiences explain why the committee recommended, among other things, the establishment of a hospice in the northern suburbs of Perth; that community palliative care providers, such as Silver Chain, be adequately funded to provide for growing demand; and that the government determines the unmet need for palliative care and ensures that regional palliative care is adequately funded to meet demand. I was pleased that the government, as part of its response to the committee’s recommendations, allocated substantial additional funding for palliative care throughout the state. I am sure that this will be an ongoing matter for the government that will be raised again during this debate.

Now I would like to briefly address some of the more technical aspects of the proposed legislation. The Western Australian bill is largely modelled on the Victorian Voluntary Assisted Dying Act 2017, which came into effect on 19 June this year. The Victorian act is largely drawn from the model enacted in Oregon more than two decades ago. Dr David Grube is a retired Oregon physician with more than 35 years’ experience in caring for patients at all stages of life, including those who have requested and utilised medical aid in dying. During a recent visit to Perth, he stated that there are some important differences between Oregon and Australia. He said that Oregon does not have universal health cover or what he described as the wonderful palliative care and hospice programs that we have here in Australia. Dr Grube also pointed out that the laws in Oregon are not defined as specifically as the proposed legislation in WA, yet he says that in Oregon that has not been a problem. Oregon’s Death with Dignity Act, which has served that state for 22 years with only one very recent amendment, is just 12 pages long. The WA bill consists of 119 pages.

Safeguards in the WA bill require that coordinating, consulting and, when relevant, administering practitioners consider and certify that the patient is acting voluntarily and without coercion. Their assessment needs to be reported to the review board that will be established under this legislation and, in doing so, they risk not only their professional accreditation, but also facing fines and imprisonment if it is false or misleading. Some may argue that this safeguard is not enough. However, those same people appear unconcerned that there is nothing at all like this in place for existing end-of-life choices such as refusing life-sustaining medical treatment. Others argue that irrespective of how many safeguards there are, it still will not be enough and that the only proper course is to simply prohibit that choice and that voluntary assisted dying should never be legislated for. I cannot understand that. Why? Because it would deny everyone, including vulnerable people, the dignity to make their own choices.

Apart from Oregon, there are now another eight states in the United States where medical aid in dying—MAID—has been legislated for or is lawful, and another is expected to join them next month. All the legislation is similar to Oregon’s MAID and is available to terminally ill, competent adults who have six months or less until expected death and have requested access twice orally and once in writing. Mr Acting Speaker, did you know that by mid-September, one in five Americans will live in a state where this option is available? Long-term data from Oregon and Washington shows an increase in the number of patients using medical aid in dying over time, but that these remain fewer than 0.4 per cent of all deaths per annum. A quarter of those who are prescribed the medication do not even use it. The data also shows that concerns that MAID would unintentionally target socially disadvantaged patients have not materialised.

We know that voluntary assisted dying is not limited to the United States. It is also lawful, in various forms, in Canada, Colombia and a number of European countries. But where voluntary assisted dying is recognised within a human rights framework, such as in the Netherlands and Belgium, it has never been limited to only people with a terminal illness. Voluntary assisted dying legislation in those countries is different from that in Oregon and the
other US states and Victoria and what we have proposed here in WA. Voluntary assisted dying in these jurisdictions more resembles the existing medical practices that provide for the means to alleviate suffering at end of life. I do not think it is based on a right to not suffer. It is far more limiting because it requires the person to have a predicted death from a terminal disease. Therefore, to use what is happening in the Netherlands and Belgium to argue against what is proposed here is simply confused. I support the broad thrust of the Voluntary Assisted Dying Bill 2019, which comes from the Victorian and Oregon models. But I am pleased that it varies from the Victorian legislation in a number of ways. I will return to this during consideration in detail.

I support the following. First, although participating practitioners will need to complete approved training, there is no requirement in the WA bill for a doctor to obtain a voluntary assisted dying permit from the government for each patient. Second, the Victorian prohibition against practitioners raising voluntary assisted dying with a patient has not been adopted. Third, under the WA bill, although a practitioner will still have the important right to decline to participate in the process, they will be required to immediately inform a patient who is asking for voluntary assisted dying about their conscientious objection. They must also give the patient standardised information, presumably about how to find a doctor who may be willing to assist. Fourth, in WA, key discussions relating to requesting and assessing eligibility for voluntary assisted dying can take place using audiovisual communication.

Mr J.E. McGRATH: Nurse practitioners can administer the lethal medication if self-administration is not appropriate. This is basically so that dying people in remote locations will be able to access voluntary assisted dying. Victoria did not include these options, but it is a small state compared with the vast and remote country areas of WA. The Nationals WA and the member for Dawesville referred to issues to do with audiovisual communication, and I look forward to the government’s response during consideration in detail. Fifth, the WA bill provides for practitioner administration of the lethal medication in wider circumstances. The panel cited limited evidence of complications in 4.9 per cent of cases in which a patient self-ingested the lethal dose, mostly involving regurgitation. It recommended extending the exception beyond just physical incapacity to include a clinical determination that self-administration is not suitable, and this has been adopted in the bill. This avoids discriminating against people with certain disabilities or illnesses who would otherwise be denied access to voluntary assisted dying.

Despite favouring so much of the bill, I am disappointed that it adopts the estimated time frame to death from the Victorian legislation—that is, six months, except for neurological conditions when an estimated 12 months to death will apply. The committee’s recommendation that death from the condition needed to be reasonably foreseeable was based on the impassioned evidence we received that severe and intractable symptoms may be experienced for months—even years—and that an expected time until death is not always clinically justified. Time to death is notoriously difficult to estimate. Brightwater care group has disability share houses across Perth, including some that specialise in supporting people with Huntington’s disease. In Brightwater’s submission to the panel, it did not support imposing a time frame until death because it said that time frames are far less predictable for people who have a neurodegenerative disorder. In fact, Brightwater had experience of people dying from issues related to their neurological disease who had accessed palliative care only the day before they died due to the difficulty in correctly estimating a person’s life span with those conditions.

The WA expert panel was told by Dr Grube that in Oregon, where there is a criterion of a six-month time frame to expected death, about 50 per cent of people who commenced the voluntary assisted dying process died of their disease prior to the completion of the process. I am concerned that in adopting the six-month criterion with only limited exception, the legislation before us will unnecessarily exclude dying people from accessing voluntary assisted dying. Despite my disappointment, as I said, I support this bill. I would now like to deal with some of the recent arguments that have been raised against it.

Some people argue that if only a small cohort of people are going to access voluntary assisted dying, why is the Parliament even considering this legislation? I am at a loss to understand how someone could put forward that argument. Why do people who are dying not matter? Others claim that if a person requesting voluntary assisted dying is not assessed as eligible, the bill will allow for doctor shopping. Dr Grube pointed out on 720 ABC that this does not happen. According to my notes, he said —

These are people that are really sick. They can’t “shop” around. They’re in bed at home ... they have to find two different doctors like you would in WA, you have a waiting period, you have all these processes that you have to go through. Shopping around is folly. It doesn’t happen.

Another argument is that despite the fairly detailed requirements for transporting and storing the lethal medication, these are not good enough because it is a poison that would be dangerous if it got in the wrong hands. As if this lethal medication would be the only poison available to the community. Perhaps they should take a look in their garden shed or medicine cabinet? Similarly, some argue that dying people should not be allowed to stay at home but should go to a health facility to have the medication administered under supervision. Requiring a dying person to leave their sick bed and travel to some unfamiliar facility to be assisted to die strikes me as heartless. It is precisely the opposite of what voluntary assisted dying is meant to achieve. It neither respects a dying person’s choices nor provides for the option to die at home even though that is what the vast majority of us hope for.

Extracted from finalised Hansard
I have come to the conclusion that the options in place now are not good enough. I think we can and should do more. Although existing choices allow a person to eventually end their suffering, many would find cold comfort in the option of slowly starving themselves to death, being sedated into—hopefully—oblivion until they pass away or leaving it to their families to grapple with once they lose their capacity. For all of the importance of palliative care, it has to be said that it is not the complete answer claimed by opponents of voluntary assisted dying. Data from specialist palliative care services shows that a total of 13.9 per cent of patients in their care die in severe distress from various physical symptoms. Clive Deverall at his last public appearance spoke about palliative care nightmares. He did not want to be among them and took his own life. Evidence provided to the committee by the State Coroner and other witnesses, as was mentioned earlier, demonstrated how brutal and lonely suicide is as a preferred option for those who have been diagnosed with a terminal or debilitating physical condition. Of course, as Clive noted, suicide is legal. But his and similar deaths give no reason to be complacent about existing choices, not least because of the impact suicide has on so many others.

I repeat: I am supporting voluntary assisted dying to give dying people more choice at the end of life so that they will at least discuss their situation with health professionals and be made aware of the alternatives, so that they can choose not to end their life alone by attempting to take or taking their own life. As Royal Perth Hospital chaplain Reverend Ken Devereux said this week —

It is a terribly lonely thing to do and causes great distress to family, friends and first responders like paramedics.

As Katherine said, we need a system in which dying people can, at the end of their life, be with family, celebrate their life, die on their own terms and do it the right way. Similarly to the Premier, I have no idea what course of action I would take if I came to that stage of life. I do not think any of us know. But this legislation will give people a choice. At present, there is no choice. People I speak to say that they do not think they would do it, but that it would be good to have the choice. That is what this legislation is all about—choice. Nothing will be forced on anyone.

In closing, I am supporting voluntary assisted dying. I am supporting it especially for Katherine, who has asked us to give her that choice. I am also supporting it for Clive, who did not have that option. I commend the bill to the house.

[Applause.]

MR R.R. WHITBY (Baldvis—Parliamentary Secretary) [1.40 pm]: This is the most important decision any of us will ever make on legislation before this house. It is a decision with the potential to have a direct and intimate impact on Western Australians—on those facing their final days and on the ones who love them. For me, this is not a political issue. This is not a philosophical issue. This is not even an issue of faith. When we cut through all the debate, this is about humanity, compassion and love. Ultimately, it is about the right of all of us to choose. It is the right to seek voluntary assisted dying and the right not to seek it.

Under the Voluntary Assisted Dying Bill 2019, no choice is right or wrong. If someone has a strongly held faith-based conviction to oppose voluntary assisted dying, their rights are protected. The legislation does not allow force or compulsion by others. It is not about making anyone endure something against their wishes. That would be wrong. That prompts me to ask: why should someone who does seek the option of voluntary assisted dying be denied that option by others? Why should they be forced to endure against their wishes? All members of this place innately know that no-one should have the right to interfere with the fundamental and personal choices of others. When it comes to such a choice at the end of life, this should be especially so. Why would those of us who trumpet the rights of individual freedom abandon that principle when it is needed most?

I served alongside Labor, Liberal, Nationals and Greens colleagues as a member of the Joint Select Committee on End of Life Choices, which investigated voluntary assisted dying, palliative care and advance health directives. We were diligent, conscientious and respectful in our work. Apart from a strikingly divergent minority report written by one member, the final majority report represented strong agreement across party lines. Since our report, there has been exhaustive community consultation and advice sought from a range of respected professionals. The result is one of the most carefully crafted, sensitive, respectful and detailed pieces of legislation for voluntary assisted dying ever put before lawmakers on the planet. We, in this place, have had the benefit of the experience of legislation in other jurisdictions in Europe and North America that goes back decades. We have carefully and
honestly looked at this evidence and we have crafted a moderate and conservative bill to suit Western Australia. It is a bill heavy in safeguards, with a clear and careful process to ensure that those with capacity at the end of life are able to choose to end intolerable suffering.

Opponents of this bill have claimed that it represents a devaluing of human life. Nothing could be further from the truth. This is about valuing what really encapsulates life and its inherent values—the joy of life and dignity. Life is not about intolerable pain and suffering to the point at which one’s will is to die instead of to live. We debate this bill today in agreement that no-one wants to die. No-one of sound and healthy mind wants their life to end. The Western Australians who may choose to use this legislation will be those who are dying and close to death. The question is not if they are going to die, but how: alone, in stress and pain, or surrounded by the love of family? When so many options are no longer available, this is an option some may want to embrace.

This legislation touches the hearts of many Western Australians. One of them is a courageous woman named Kirsten Whitby. Kirsten met my cousin Darren when she was 14. She lived over the back fence in Rossmoyne. They were childhood sweethearts and went to Rossmoyne Senior High School. Darren later served in the Navy before they eventually settled in Busselton. Darren loved to surf, he loved his dog Darcy and he loved Kirsten. He passed away at 50, just months after being diagnosed with motor neurone disease. It was a shockingly rapid decline. Darren’s parents, Brian and Jan, his brother, Mark, and sister, Karyn, were there for him, along with Kirsten and her parents, John and Robin McDonal. I acknowledge John and Robin McDonald, who are in the gallery today. John and Robin had known Darren since he was 17. He was as much a son to them as he was to Brian and Jan.

Not everyone is able to voice their views in this Parliament, but I am going to give Kirsten her voice here and now. These are Kirsten’s words —

“The disease often leaves the diagnosed with no sense of control over their own life. Medical and other services take over, the worry about family and loved ones being left behind, the legal necessities to be dealt with, just trying to live and deal with the day to day physical and mental issues arising from the illness. It is a roller coaster nightmare of emotion and physical and mental exhaustion already without the terrifying knowledge of what sort of death the illness may give you.

The power to control this, that you can dictate your own destiny rather than the disease would be a strength to those people, and often enough to allow them to cope with it through its natural course. But they should not have to do so.

There are religious leaders and members of our community strongly opposing this legislation. That is their belief. That is their right. That is their choice. Their religion, choice and beliefs should not dictate laws for the rest and I would suggest the majority of the community.

If voluntary assisted dying becomes law, they do not have to choose it. They can choose to follow their beliefs and allow the disease its natural progression. No one will be forced to choose assisted dying. It is illogical and immoral to deny the right to choose assisted dying to the majority of the community because of the views of a minority.

I’m not religious but I pray that our politicians see common sense and the will of their constituents and pass the legislation. There can never be a one size fits all that works perfectly for everybody, exactly as we see in palliative care. But this will give hope and help so many to live the best way they can for as long as they can, their loved ones to have them for as long as they can, and if we can achieve this by passing the proposed legislation into law and help to reduce suffering, surely we must.”

Those were Kirsten’s words.

Opponents say we do not need these laws because palliative care can deal with any terminal illness, or at least the vast majority of them. But dying Western Australians can and do take the brutal step of ending their own lives, often violently and often alone. They do so while they are still physically able to, unnecessarily shortening their lives and time with loved ones. But opponents say we do not need these laws. Dying Western Australians shoot themselves, hang themselves, leap from buildings or jump in front of traffic to avoid an intolerable death. But opponents say we do not need these laws. Dying Western Australians refuse medical treatment, food and water, and die of starvation and thirst. But opponents say we do not need these laws. Doctors in Western Australia drug patients into comas by upping the dosage of pain killers with the result that patients endure a lingering, unconscious death. But opponents say we do not need these laws.

We know that even the best palliative care in the world is not enough for some patients. This is not to say that we should not improve palliative care in this state; we absolutely should. It is simply saying that palliative care does not meet the needs of all patients. The great majority of Western Australians want these laws, and they believe in giving terminally ill patients the simple freedom to choose their end of life. We have heard from doctors, nurses and a range of medical professionals who support voluntary assisted dying, but the most moving and convincing arguments often come from those who have lived through the experience of seeing a loved one suffer. As our committee witnessed, these are experiences that still bring tears sometimes decades later.

Extracted from finalised Hansard
I have been stopped in Baldivis shopping centres, at local school fairs and even here in the corridors of this Parliament by my constituents who seem to share a sense of urgent pleading. Their shared experience was watching the suffering of partners, parents, brothers, sisters and friends, and feeling utterly helpless, unable to relieve their agony and distress. One of those constituents was a woman from Baldivis on a tour of Parliament. She had watched her husband suffer. She grabbed me firmly by the arm and, with tears welling in her eyes, made me promise to vote for this bill. For her, I am sure it is about love—life-affirming love; love enough to say goodbye.

I commend this bill to the house.

MR D.J. KELLY (Bassendean — Minister for Water) [1.51 pm]: I rise to express my support for the Voluntary Assisted Dying Bill 2019. I support this bill because I support people having the right to end their suffering and to die with dignity. I see no purpose in requiring people to prolong their suffering in a way that is intolerable to them and their families. Primarily for me, this bill is about allowing people to end that suffering. This bill also provides suitable mechanisms to allow that to happen and to happen in a way that families are also properly regarded.

I believe the bill has numerous safeguards in it to reassure fears that somehow this choice will be abused. I believe the safeguards that this legislation will put in place will ensure that that does not happen. The bill is very limited in its scope. Patients have to be within six months of their likely death. Patients need to make at least three requests before they can access this process. Two independent doctors have to sign off before a patient can access assisted voluntarily dying. The sign-off from two independent doctors, I believe, is a very strong safeguard. I am surprised that some people say that this bill will allow doctor shopping. I am confident that medical practitioners will take their responsibilities under this bill very seriously. Those are just some of the safeguards that are in place. The six-month limitation is very conservative. I should say that there is a 12-month option for patients suffering from neurodegenerative conditions. Therefore, this bill is very conservative in its approach. I commend the work that has been done by the Minister for Health and the other MPs on both sides of this Parliament who have really worked hard to make sure that this bill has all the necessary safeguards to ensure that this process is compassionate, responsible and safe.

This legislation is about ending the suffering of patients, it is about ending the suffering of families, and it is also about avoiding the terrible experiences of first responders. In my life prior to Parliament, I represented union members employed in the ambulance service. Post-traumatic stress disorder is experienced by ambulance officers and police officers in greater numbers than in the general public. They experience PTSD because of some of the terrible things they have to witness and experience every day just doing their job. Dealing with people who have chosen to end their own lives rather than suffer a painful, undignified death is an all too common experience for ambulance officers, police officers and, of course, members of the family. This legislation will give people an opportunity to have a death at a time of their own choosing, with family. This legislation will take away the need for people to take their own lives and avoid all those unnecessary experiences currently endured by ambulance officers, police officers and members of the family.

I am also of the view that palliative care cannot always deal with this issue in a suitable way. Some people would like to present this debate as a choice between voluntary assisted dying and palliative care. I do not accept that. I have the greatest respect for people who work in palliative care. Again, prior to coming into Parliament, I represented staff who worked in palliative care. I also represented staff who worked in aged care. They do a tremendous job, often in trying circumstances for very limited pay. They do an incredible job. But the experts and the life experience of many tells us that palliative care cannot always deal with the suffering patients experience at the end of their lives. That is why I do not believe that this is a debate between voluntary assisted dying and palliative care. I am very pleased that the Minister for Health, under this government, will fund palliative care to the tune of over $200 million over the next four years. Record levels of spending on palliative care by this government over the next four years is an absolutely outstanding commitment by this government at a time when we all know that funds are always short. Therefore, I support palliative care, but, clearly, on the advice of experts and patients, it is not an alternative to voluntary assisted dying.

Surveys tell us that more than 80 per cent of Western Australians support this legislation. In some sense, this debate has already been had in the community, and I think that is true. The public has been talking about this issue for years, if not decades. The people of Western Australia have made up their mind. They want this legislation to be put in place; it is only this Parliament that is really behind the times. I urge all members in this house and the Legislative Council to listen to the views of the community. It is time that the Western Australian Parliament caught up with the rest of the community. To those in the community who still oppose voluntary assisted dying, I respect their views. To those who have religious views that cause them to oppose this legislation, I respect their views. However, I am saying to them: do not impose your views or your religious views on others. No-one has the right to impose their views in this regard on anyone else. This is about allowing people to die with dignity. That is all it is about.

Debate interrupted, pursuant to standing orders.

Extracted from finalised Hansard
the Legislative Council to inquire into and report on the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end-of-life choices. On 23 August 2017, the Parliament established a joint select committee of the Legislative Assembly and the Legislative Council to inquire into and report on the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end-of-life choices. The Joint Select Committee on End of Life Choices was formed and its terms of reference included —

- assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care;
- review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian States and Territories and overseas jurisdictions;

I support it and I urge others to do the same.

MRS R.M.J. CLARKE (Murray–Wellington) [3.58 pm]: I rise today in support of this very important legislation, the Voluntary Assisted Dying Bill 2019, but more importantly to pay my respects to the lives of terminally ill patients who have passed in immeasurable pain and suffering, leaving their families traumatised, and to those who may in the future want the choice of medically assisted dying. I have had an open-door policy with constituents in my electorate of Murray–Wellington from the day I was elected. I have been approached about many issues in our community, their needs, arising issues and ways we can improve our community to become more resilient and innovative for our region’s future. Voluntary assisted dying is an important subject, filled with high emotions and perspectives, stories of suffering and those of morality, and views of a vocal minority contrary to wishes of patients to have a dignified end to a great adventure. The emotionality of this subject, however, does not deter the conversation from occurring, nor should it. Many members of my community have questioned why we need a conscience vote on this legislation or a law to represent this topic. The reality is that without the right to choose, with careful and cautious safeguards in place, there is no protection and no relief for sufferers, health professionals and family members.

Hearing and learning about people’s harrowing experiences around end-of-life choices has been a choice for representatives in Parliament. I have attended as many forums and briefings as were available. Throughout this process, it has become clear to me that terminal illnesses do not discriminate, and every person who suffers from these illnesses deserves the right to decide from what is available to them on their treatment and care. These choices and this right should be respected. I believe everyone has the right to a dignified end to his or her life.

On 23 August 2017, the Parliament established a joint select committee to inquire into and report on the need for laws in Western Australia to allow citizens to make informed decisions regarding their end-of-life choices. The Joint Select Committee on End of Life Choices was formed and its terms of reference included —

- assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care;

Debate interrupted, pursuant to standing orders.

[page 6048]
I thank the members and who conducted the inquiry and I thank the staff members.

In August 2018, the report of the Joint Select Committee on End of Life Choices was tabled. Ms Amber-Jade Sanderson, chair of the joint select committee, states starkly in her foreword —

**Unnecessary suffering at end of life, and broad community agreement regarding individual autonomy, form the basis for the Committee’s recommendation that the Western Australian Government draft and introduce a Bill for Voluntary Assisted Dying.**

The committee received hundreds of submissions highlighting that the public conversation about this issue has changed over the years. The committee recommended that a bill be drafted with extensive consultation from an expert panel, including health and legal professionals, as well as health consumers. The Ministerial Expert Panel on Voluntary Assisted Dying was formed and it tabled a report in Parliament on 27 June 2019. The panel was chaired by Malcolm McCusker, AC, QC, and included clinicians, along with experts in law and palliative care. I thank the expert panel members for their contribution and I welcome that report.

As part of its consultations, the ministerial expert panel received a total of 541 submissions from individuals and organisations. It is clear that this subject evokes strong emotions. Sharing stories of painful and often traumatic memories is not an easy thing to do, and I would like to thank everyone who shared their experiences in the hope that this Voluntary Assisted Dying Bill would be passed. The report was the result of an extensive consultation process, with sessions and forums held throughout Western Australia attracting hundreds of participants. The panel’s final report includes recommendations to help inform the upcoming voluntary assisted dying legislation through its introduction to state Parliament. The report was extensive, both in process and detail.

Unnecessary suffering at the end of life, and broad community agreement for individual autonomy, formed the basis for the committee’s recommendation that the Western Australian government draft and introduce a bill for voluntary assisted dying. The WA government considered its response to the committee’s report and instructed the Department of Health and the Department of Justice to implement the committee’s recommendations on voluntary assisted dying, including developing legislation. Recommendations surrounded advance care planning, end-of-life palliative care and voluntary assisted dying. Of interest is the leading quality of palliative and end-of-life care that our health services deliver across our state. A palliative approach is used by health professionals to improve quality of life for individuals with a life-limiting illness, their caregivers and family.

Palliative care is a holistic approach to care that incorporates the needs of patients and caregivers. This is reflected in the assessment and treatment of pain, and in the provision of physical, psychological, social and spiritual care. Palliative care options are introduced at early indication of life-limiting illness, instead focusing on active, comfort-focused care and a positive approach to reducing suffering and promoting understanding of loss and bereavement.

I had the privilege of attending an information session with Oregon-based doctor David R. Grube, MD, who kindly visited Parliament in Perth to talk about the voluntary assisted dying laws that have operated in Oregon for more than 22 years. Dr Grube served on the then Oregon Board of Medical Practitioners for seven years and was chair from 2006–2007. He was awarded Oregon Doctor–Citizen of the Year in 2009 and is currently the National Medical Director of Compassion and Choices. Dr Grube confirms that in the 22 years of operation of the voluntary assisted dying laws in Oregon, there has been no evidence of abuse or misuse; no groups at risk, including disabled, minorities or the poor; no evidence of doctor shopping; and no adverse unintended consequences. Dr Grube also believes that meticulous record keeping, training, analysis and a genuine concern for sufferers of terminal illness ensure that legislation around end-of-life choices continues to develop. In Dr Grube’s words, “It relieves suffering. It is compassionate.”

I have attended many other information events to assist me in my understanding of the process, the outcomes and the protective mechanisms within the Voluntary Assisted Dying Bill 2019. What I saw when I attended these events is the community’s need to have this conversation transparently, without fear of conviction. I would like to tell you about a young, wonderful, inspirational woman who has honoured her mother Mareia. Belinda Teh witnessed her beloved mother suffer in uncontrollable pain for several weeks. These are memories that will be with her forevermore. I will read some excerpts from Belinda’s experience with her mother, Mareia’s, illness, care and passing. Mareia Teh was just 63 years old when diagnosed with metastatic breast cancer, which was so advanced that chemotherapy only hastened her demise. She died 11 weeks later. As a devout Catholic and nurse for 39 years—much of her nursing career spent in aged care—Mareia was well informed about the moral and medical considerations at the end of one’s own life.

Her faith was everything to her. But when the writing was on the wall, and she understood the suffering that was coming to her, she asked for help to pass quicker from life on earth. It took great courage for Mareia to ask for

Extracted from finalised Hansard
something that did not sit with the teachings of the Catholic Church—a change in her, born of humility and her
firsthand experience of unrelenting suffering. She twice requested help to die on her own terms but was refused.
Her request was denied because this kind of medical assistance is illegal in Western Australia. She went on to die in
a way that she did not want to—devoid of dignity. It was a horrific death that even the best of modern medicine and
caring specialists could not save her from. She did not want her suffering to be in vain. Belinda spent many months
planning a way to do just that—to not allow her mother’s suffering to be in vain. She walked from Melbourne to
Perth, inspiring people in Western Australia to take action and show that there is widespread community support
for the introduction of legislation to Parliament around end-of-life choices. Through her perseverance, grace and
will to make a difference to others, Belinda has shown that terminally ill Western Australians want access to safe
and workable voluntary assisted dying laws. Thank you, Belinda. You have made us all proud. You are inspirational,
exceptional and courageous.

I and my fellow members of Parliament have the privilege to listen to and represent our communities to the best
of our abilities. We have heard over and again that our communities want this choice. The physical suffering
experienced by dying patients can be enormous, and is not always manageable. The length of expected suffering
differs with diagnosis and condition. In addition to pain and disability from terminal illness, nausea, loss of bodily
functions and medication side-effects are common.

As with all good medical practice, end-of-life care should be patient-centred and transparent and provide safeguards.
Compassion, dignity, respect and participation in decision-making are important to the delivery of high-quality
palliative and end-of-life care, something our highly qualified expert medical community is well known for. To
facilitate a patient-centred approach, there should be open and informed discussions between GPs and their
patients, the families, carers and those people nominated to make treatment decisions when applicable. This should
be an ongoing conversation, covering topics such as symptom-control measures, goals and direction of care,
advanced needs care planning, diagnosis and prognosis.

Immeasurable suffering can cause the patient and their loved ones to be left feeling completely hopeless. Many
have told me of their feelings of indignity, saying that the loss of independence has left them believing their
meaningful life has ended. For some patients, a sense of control over the manner and timing of death can bring the
kind of comfort that palliative care cannot provide. Widening the choice of and access to end-of-life options is, at
a minimum, an opportunity for our loved ones, friends, family and neighbours to not only live with dignity, but
also die with dignity. For me, there is a high priority that thorough safeguards are included in legislation to protect
those most vulnerable.

Requests for voluntary assisted dying must be patient-initiated, voluntary and free of coercion from family
members, health practitioners and others. Although requests for voluntary assisted dying are few in number, people
who express these wishes must be supported in a way that allows time for full exploration of their concerns and
options. A great amount of effort and consideration has gone into ensuring that safeguards are in place and will
remain in place.

Eligibility criteria for access to voluntary assisted dying should be clear to provide certainty and clarity to the
community and health practitioners, and patient-centred to allow patients themselves to judge whether the suffering
and experience cannot be relieved in a manner they deem tolerable. In the process, I have enquired extensively
about palliative care options. WA is leading the world in palliative care.

We are profoundly responsible for honouring our fellow human beings. We are called on to carry burdens and
responsibilities, to exercise duties and to support those who are in need, who are ill, who are elderly and who are
helpless and those of the next generation to value life with passion, respect and responsibility. What is of certainty
is my role in the process. I am representing my electorate—an electorate that has contacted my office, had in-depth
conversations and participated in community forums on this subject. The overwhelming majority of not just my
electorate, but the entire state, supports this bill. They support allowing people to make a choice. They support the
option of stopping their loved ones from suffering in ways that we cannot imagine, and that is why I am voting to
support this legislation.

Today would have been my father’s ninety-sixth birthday. In January 1999, I watched a great man suffer
immeasurably over a six-week period. He had the very best of palliative care, but in his case, and I am sure in so
many more, this was not always enough. He was begging to be put out of his misery. The sounds of my father’s
screams and watching him throwing himself around in his bed from the pain haunt me every day. We should not
have our loved ones end a life of fullness in a manner of such extreme pain.

Today I stand in this chamber and honour my father’s last wishes and support voluntary assisted dying so that
people like my father have the choice to leave this earth on their terms with their family, friends and whoever they
want to say their last goodbyes to be with them and allow them to go in a dignified manner.

I commend this bill to the house and hope for a positive outcome of passage through both houses.

Happy birthday, dad; this is for you.
MR M.P. MURRAY (Collie–Preston — Minister for Seniors and Ageing) [8.15 pm]: During this debate on the Voluntary Assisted Dying Bill 2019, there will probably be a lot of repetition but everyone in this house has a right to speak and they should be able to put their position. I have been a member of this place for about 18 years. A similar bill was discussed about 10 years ago. At that time, I carried out an extensive poll of my electorate. About 60 per cent of my constituents supported assisted dying; it was called something different at that time. The results of that poll were presented to Parliament, and different people had a look at those results but the bill did not go any further. I think it was foreshadowed at that time. It started me thinking about what would happen in the future. Ten years or so later, society’s views have changed tremendously. Society itself has changed. After looking at all my research, the work that has been carried out and the views of lobbyists, it is a positive move for our society. I have a great deal of respect for people who have emailed me in the positive or negative. I do not have as much respect for some of the straight-out lobbyists, who were probably more on the professional side and had a different view of the world compared with the people who emailed me, stopped me in the street, talked to me at the pub or at the footy and told me which way they would vote.

It was interesting to hear the previous speaker talk about people with a Christian view, which is opposite to what the bill says. Some of those people have said to me on the side that they are glad they do not have to vote on this bill but they hope we vote the right way, meaning they hope we vote in favour of the bill. Their views may be that of their faith; others hold values for people’s health at the end of their time. It has certainly put a lot of pressure on politicians in this place, especially some of the newer members who have not been here as long, given some of the quite emotional views expressed. It is very difficult to stand and vote against your electorate or against your beliefs. As one of the more senior people in here, I say to them: stick with your beliefs but at the same time listen to what your electorate is saying to you.

It is very much on my mind that the bill will provide a safe and compassionate option for people with a terminal illness. In some cases I think the bill is a little overdone, with 102 safeguards. The red tape will probably turn some people away and they will not be able to get the care or to finish their lives in the way they would like. Having 102 different safeguards is a little over the top. Again, I will not be making any noise about that because, as we go along, I do not want any disruption. I hope that when the bill gets to the upper house, it is viewed in the same way and that it goes straight through. People will have different views from me. I am a bit of a fatalist. There is an old saying—perhaps I cannot say it in here!—things happen. There is not always a reason they happen, but that is on the way through. When I get to the end of my life, I want a choice, and I want others to have a choice. It is not compulsory; the choice will be well and truly your own. With 102 checks and safeguards, it will be quite an onerous process for some of those people. As we move into this debate, I will respect everyone’s view and certainly will not be making any interjections on anyone in this area.

The bill will enable compassion. It will give people some hope that they do not have to go through a very awful end of life. It will give families some comfort that if mum or dad, a brother or sister or another relation wants to go that way, they can, and that it will not be against the law. There is always a personal story. The way I look at it, everyone is a little bit different. In my house, there was certainly a difference of opinion at the end of my father’s days. My sister had one view and I had another, but for Christ’s sake, dad did not leave anything there because there was no way he could tell us which way he wanted to go. In the end, it was probably a different way that it ended—the morphine was turned up, he went into a coma and drifted out. That was not what he wanted. He said, “I’ve had enough.” To me, that was quite simple, but my sister was saying a different thing. We were out in the passageway, and my way of life was turned up, he went into a coma and drifted out. That was not what he wanted. He said, “I’ve had enough.” To me, that was quite simple, but my sister was saying a different thing. We were out in the passageway talking to a doctor who said, “I can do this and this, but I’ve got legal responsibilities.” It will be quite possible now with the way that the bill is set out. My father had cancer for some years. He kept going after a complete blood transfusion, which he called his oil change, and was able to go on a little bit longer, with a reasonable quality of life. When it got to the end and he said that he had had enough, there was no way he could go and do what he wanted to do and move on. There may be family disagreements. There was no law that we were able to use to say, “Dad, it’s your opinion” or, in my case, my opinion or my right to do what I want to do to finish my life, if I am in that sort of condition.

I am not going to go on for too long other than to say to the people who rang in, emailed me or contacted me in many different ways, to be quite honest, thank you for your guidance. For me today, it is a very simple process for me to say that I commend the bill to the house.

MS R. SAFFIOTI (West Swan — Minister for Transport) [8.24 pm]: These types of bills do not come along very often. When they come along, I think we all personally take a lot of time to reflect on what we should do, how we should vote and what will be the impact of our decisions. This is a bill that I have given a lot of thought to. In my spare time, I have been thinking about how I should vote and also, of course, the implications of this bill in the community. We all bring different personal circumstances and experiences to this place. It is important to note that everyone’s experience or perspective is important. Although some people may think their experience or perspective is more important than others, this conscience vote allows all members to bring in their perspectives and views, and of course the views of their electorates. All views need to be respected and listened to.

I say at the outset that I really commend and congratulate all those involved in the community consultation and in bringing this bill to the house. I thank in particular the parliamentary committee and the member for Morley for
their work in driving this legislation, the expert panel, the stewardship of the Minister for Health, and the Department of Health. This is one of those times when you are listening to the briefings and you are really impressed by the thoroughness of the work, all the issues that they have looked at, and you can really understand that this was something that was very well considered. They looked at what happened in Victoria and then built the WA case. I thank everyone involved in having to do what would have been very difficult, and directly listening to all those personal examples that were given.

From my electorate perspective, it is something that the community has raised. One very good friend of mine, who is opposed to it, sat down with me to talk about it for a long time. He told me his views and concerns. As we have seen in all community surveys and polls, it is something that has overwhelming community support. The key for me, which the Premier outlined today, is that this bill does not determine life or death—this is really determining how you die. The circumstances and the criteria laid out in the legislation are that a person must be diagnosed with a disease, illness or medical condition that is advanced and progressive and will cause death and that will, on the balance of probabilities, cause death within a period of six months, or 12 months in the case of a neurodegenerative illness; and that the person is experiencing suffering that cannot be relieved in a manner that the person considers tolerable. The criteria are laid out. They have learnt from some of the potential legislative issues in the other state and really made sure that the criteria can be applied effectively in WA.

My other concern is whether there will be enough safeguards. As the member for Collie–Preston outlined, there are 102 safeguards. Going through them, it is clear that the process has been well laid out. People really want to be in a position to make a choice. I believe that the safeguards, the criteria and the whole process have been laid out for the community. I support this bill. I had an open mind about this issue initially. When I first looked at the bill, I was not really informed about all the scenarios. It sometimes causes a little bit of fear and angst, but once it is understood what we are doing here, this will basically allow people who are suffering and dying the ability to determine the way that they die. From a patient perspective, it may not be something that I would choose to do, but people knowing they have that option would give them peace of mind if and when they find themselves in that situation. It is also about the family. I will explain my personal circumstance if I can manage to talk about it in the chamber. One of the things I realise is that many people at that stage actually want to go because they know the impact their suffering is having on their family and they are ready to accept the next stage. In most instances it is harder for the family to accept than the person directly involved. People put judgement on how they could let that happen, but it is that person’s choice. This bill will make sure that a person has the ability to make that choice and give consent, and I think that is another significant safeguard.

My story is more recent and I will try to get through it without too many tears. My father passed last year. My father, at 92 years old, was fighting fit. Unlike some other older members of my family, he was a person who did not talk about death or dying. He never accepted old age and he never accepted the concept of death. He was 92 years old and fighting fit, picking fruit, you name it. He probably had only a couple of nights in hospital in his entire life. At 92 years old, he broke his hip in November 2017. Six weeks later he was back to picking fruit and going to the market. He was an incredible person. He ate well. He knew to eat well and to be physically active, and his mind was absolutely incredible. In February 2018, he was diagnosed with non-Hodgkin’s lymphoma, together with my mother, and in May 2018, he broke his other hip. This basically led to a significant deterioration. He went to hospital. We talk a lot about palliative care and I want to make a point. This is not a criticism of everyone who was involved in my father’s treatment, but I think sometimes when people see a 92-year-old come into the hospital, they treat the age and not the person. They did not realise that a week earlier he was picking fruit, very active and very, very fit. The comments made to him were that he would never walk again. His deterioration started from there. I noticed when I went to visit him after his second fall that he had changed completely from the man who would fight death to the extreme. He was looking like he was accepting it. I asked whether he had had a stroke, because his mind seemed to have changed so much. He told me his sister a few months later, “I am ready to die; you have to accept that, Connie.” Again, she could not accept it and I still cannot accept it, but it was an acceptance by him that his time was coming to an end. He did not drink and he did not eat very well. In a sense, even though I am a member of Parliament and should have known better, my sister and I were a bit naive about what was happening to my father. I kept assuming that he would get up one day and say, “I’m picking the avocados; I’m out there.” I noticed when I went to visit him after his second fall that he had changed completely from the man who would fight death to the extreme. He was looking like he was accepting it. I asked whether he had had a stroke, because his mind seemed to have changed so much. He told me his sister a few months later, “I am ready to die; you have to accept that, Connie.” Again, she could not accept it and I still cannot accept it, but it was an acceptance by him that his time was coming to an end. He did not drink and he did not eat very well. In a sense, even though I am a member of Parliament and should have known better, my sister and I were a bit naive about what was happening to my father. I kept assuming that he would get up one day and say, “I’m picking the avocados; I’m out of here”, but it never happened. He died in his sleep at home. It was his way—how he wanted to go. When I look back, he did not eat and refused to take much water. In a sense, he was making that decision for us. But, God willing, he had the opportunity to do that. Yes, I would like him to be here today—I would love him to be here today—but then I think of the other option of him being bedridden, probably in a lot of pain and just so frustrated. When I talk to other people, they say he went in a good way, but of course I do not accept that, because he was my father. We do not think any death is appropriate when it comes to a family member. If he was still bedridden and suffering in pain, I do not think he would have appreciated it or that the family would have been able to accept it. As I said, in many instances people in that situation are more willing to accept their fate than the family around them. In making these decisions, it is about the person; it is about the individual. This is a very, very important bill. We have heard in the stories given by my colleagues and through the reports and other examples some of the excruciating ways that people pass. It is awful. To sit there and watch a loved one go through that serious pain would be the absolute worst experience.

Extracted from finalised Hansard
I support this bill. As I said, it is not one that I take lightly. I think it is a mature response to a very complex issue. Of all the things that we need to fight against, this is not one of them. This shows that we are a mature society. The process is backed by the medical practitioners. It is a process that has so many safeguards. I would not want to be sitting there next to a family member who is in pain and suffering and just having to accept it. There were examples of what people would have chosen to do with their own lives if they had had the ability. That is not something we should accept. These types of options should be far more available to the community. This issue has morally challenged me, but the model that has been put forward is very, very good. I read the story of the first Victorian person who accessed that state’s legislation just about a month ago. I read it and I cried. It was an incredibly touching story. The family’s view of how they got to see their mother exit the world was incredibly touching. Not having to watch your parents or loved ones suffer is a very, very important thing for me. As I said, I do not accept death yet. Accepting mortality and that we are basically visitors on this earth and not permanent is very hard. I still do not really accept it and my dad did not accept it. When he did accept it, it shocked me, because I thought, “Hang on, you’ve been resisting growing old for 92 years; how are you accepting it now?” The fact that even he accepted death shows that we all one day will need to accept it, and I think this bill is a compassionate, sound and very ethical process that will allow that to happen.

**MS J.M. FREEMAN (Mirrabooka)** [8.37 pm]: I want to answer yes to the question put by the Premier. Do we wish the terminally ill who are in pain to have the choice to end their suffering? I emphasise for the community of Mirrabooka that it is a choice on how death will occur, not a choice between life or death. It is a personal decision of each individual, and that person is also provided with access to good quality palliative care. The Voluntary Assisted Dying Bill 2019 will provide safe and compassionate access to voluntary assisted dying to a very small group of eligible Western Australians. The bill protects people’s rights to prevent coercion through rigorous and inflexible measures around assessment of the patient’s decision-making capacity. It is not euthanasia; it is not suicide. There will be 102 safeguards and the establishment of a board to ensure that the law is followed. The safeguards include that the choice will be available only to permanent WA residents over the age of 18 years and only for those with a disease, illness or a medical condition that is advanced, progressive and will, on the balance of probabilities, cause death within six months, or within 12 months in the case of a neurodegenerative condition.

I commend the work done by the Joint Select Committee on End of Life Choices, the expert panel, the Minister for Health, the member for Morley and the Department of Health. The two major reports tabled in the Parliament were extensively researched and consulted on to give us the appropriate path to deliver legislation that 88 per cent of Western Australians want us to adopt. I have made myself available to the Mirrabooka community to discuss the legislation through doorknocking, telephoning and stalls at local festivals, and by speaking to community leaders. I have attended many of the presentations made available to us as parliamentarians.

I want to talk about culturally diverse communities. As people know, Mirrabooka is predominantly a community of people who were born overseas and have English as a second language. I am satisfied that the appointment to the ministerial expert panel of Ms Maria Osman, with her extensive background and understanding of substantive equity and cultural context, and her policy experience as a former executive director of the Western Australian Office of Multicultural Interests, ensured that these considerations were given the emphasis they deserved. The contribution of the ministerial advisory group and the Ethnic Communities Council of WA to the framing and implementation of this bill will ensure that information and training on voluntary assisted dying will be culturally appropriate and that translators will be used to ensure that patients understand their choice. It is vital to recognise the importance of that because people from some cultures may not tell family members of terminal illnesses such as cancer to avoid what they consider to be unnecessary suffering. This is an issue for people with English as a second language, as they can be taken to doctors who tell family, in English, that the aged person is ill, but that person does not understand the diagnosis because of language difficulties. Indeed, that is the premise of a movie that is currently showing in Perth, *The Farewell*, which is set in Hong Kong and deals with not telling an aged relative of a terminal illness.

The collective nature of important life decisions in many culturally diverse communities, in comparison with the individualism of modern Western society, should be a foundational consideration in the delivery of this legislation. This will require access to translators and material to ensure correct representation of the information and terms, with which people in many communities may be unfamiliar. Many may be unfamiliar with the term “voluntary assisted dying”. Good translation and information dissemination will ensure that safe access will be afforded and that all of the safeguards will be understood.

I have had arms-length exposure to terminal illness—thankfully—but I have witnessed its ravaging effects. My university housemate, Bruce, died far too young of motor neurone disease. He developed it long after we had stopped sharing a house and he had gone on with his career and had had a child. My friend and legend Tony Cooke had a cancer that stole his ongoing contribution from this world. The former commissioner Jennifer Harrison lived her life well and also passed away from cancer. I cannot say that they or the few others I have known who have died through illness would have used the tools of this legislation and I cannot ask them that, but I knew them well enough to know that they would have wanted the choice. However, I had the privilege, along with many others in my family, of being with my maternal grandmother when she died. It was a sad but loving experience. Although she did not suffer from a terminal illness, she had become increasingly frail and fell at her home.

Extracted from finalised Hansard
Consequently, she suffered from renal failure. Her daughters—one of them my mother—were consulted by the medical practitioners as to treatment. They did not treat her to prolong her life. They withdrew certain treatments, which enabled her to die with family members who had arrived from all parts of the country and surrounded her with love and care as she passed from this world. As she was a good Catholic, I have always thought of her up there keeping an eye on me. Given that experience, I understand why people with a terminal illness would want their family members to be with them as they die. I cannot imagine that they would want to be alone, as many have been when they took their own lives to alleviate their suffering. Many would not have wanted to have their loved ones watch on as they suffered without the capacity to assist. Being with my grandmother was a very important experience.

I understand that the counterargument to this is palliative care. I congratulate the government for committing to improving the quality of palliative care at the same time as the choice for voluntary assisted dying is offered. I congratulate the government on its investment of $41 million this year to palliative care services, which will make up part of a four-year $206 million package. I know that the government will meet its aim to support people of all ages with life-limiting or terminal illnesses to live their lives as fully and as comfortably as possible.

Due to my history as a workers’ compensation advocate, I know that people want efficacy in decision-making for medical treatment. I know how important it is for people to feel like they have control when they have an illness or other injury. That, after all, is what we all want. Research has shown that if a person has control and choice in their medical care, their wellbeing will increase. Wellbeing is at the heart of our dreams for our lives and the lives of our family members. We all want dignity in our lives, and we all wish for dignity in death. In Being Mortal, Atul Gawande, the American surgeon, public health researcher and author wrote —

All we ask is to be allowed to remain the writers of our own story.

This legislation will give terminally ill people and their families that capacity and choice.

MR J.N. CAREY (Perth — Parliamentary Secretary) [8.45 pm]: From the outset, I have sought to have an open, genuine and respectful discussion with my local community about the Voluntary Assisted Dying Bill 2019. I deeply respect that many people have strongly held views, including those based on faith or their own personal experiences. Given that, I have sought to engage the community in an honest and meaningful way. I advertised and promoted a community forum across the whole Perth electorate, where people could ask questions of committee members about the legislation. Over 200 people contacted my office and more than 140 people attended on the evening. The forum provided a real opportunity for a thoughtful and insightful discussion. In addition, I promoted an online survey, which, again, asked for people’s views. Throughout this process, I have tried to personally respond to every constituent who has contacted me and speak to them directly about their wishes or concerns. On reflection, I was surprised by the response; a strong, clear and overwhelming view was generated from the community as part of the consultation. That view was in favour of voluntary assisted dying.

I will not attempt to address all parts of this legislation, but rather, I will discuss one key principle. For me, there is one consideration and one simple truth; that is, no matter how excellent or well-funded palliative care can be, there are terminal diseases that cause human beings suffering that is so intolerable and insurmountable that not even the best of care will provide relief. I believe that in this context of human suffering, individuals ultimately must have the right to decide whether they wish to continue and that we should provide safe conditions for the choice to be made so that they may die with dignity. I do not subscribe to the belief, as some people have put to me, that human suffering is inevitable, redemptive or part of God’s will. I cannot believe that any god would be so cruel. I have borne witness to that suffering firsthand, and I recognise that my decision is guided by my personal experience. Some may see that as a failing, but I do not. It has given me, like others in this Parliament, a critical insight.

For the public record and for the understanding of my local community, I will detail some of this personal experience. Our community often struggles to talk about death. I know it is difficult. They say that until you have lost someone very close, it is often challenging to really understand and talk about death, loss or grief. I lost three members of my immediate family in seven years. My father died from complications due to old age, but both my mother and sister died due to cancer. I want to share my mother’s story, Delys Carey. My mother was my best friend; I loved her dearly. She was a brilliant mum, incredibly creative and smart, a people person who would light up the room. She always supported me and made me feel accepted and loved, even sometimes when I found it hard to accept myself. The early signs of mum’s illness were there, in hindsight, but fleeting and easily overlooked at the time. She would repeat the same story and forget things; she had balance problems and had fallen over in the street. That view was in favour of voluntary assisted dying.

From that point, everything changed rapidly. In a huge shock, within 48 hours of the onset of the headaches, my mother was diagnosed with brain cancer in March 2006—a glioblastoma grade 4 brain tumour. GBM 4 is one of the most aggressive forms of brain tumour, with an average survival rate of 10 to 12 months. Only five per cent of patients survive more than four years. It grows quickly and has finger-like projections into normal brain tissue that are near impossible to remove with surgery. My mum would have her first brain surgery within two days of that diagnosis. She followed the typical pattern of treatment: twice having debulking brain surgery to remove as much of the tumour as possible, and then radiation to kill any cancer cells that were left behind after surgery and chemotherapy.

Extracted from finalised Hansard
With my elderly father, my sister and I took responsibility for supporting her and being her carers. I have to say this: it was the greatest honour in my life to look after her during this time. I witnessed a woman who was incredibly courageous. She had a depth of courage that I do not think I could ever personally find. She fought and fought against a shocking and terminal disease that can strip a person of everything they know and treasure. I was working full time, but cut down to four days a week. I visited her every night and stayed over to care for her three nights per week. Every night we had the same ritual: I would massage her feet and hands and stay with her to keep her company. She fought desperately for her life, and we nearly lost her after the second surgery. This was high-risk surgery with potentially severe consequences, including brain damage and death. She survived, but then, just before Christmas in December 2006, my mum fell over again, this time breaking her hip and requiring hip surgery. From this point on, my mother would never speak again.

In January she went into a hospice, but after five excruciating weeks, she was released to go back home. I remember one distinct moment during this time in the hospice. I was sitting in her room—no noise, everything quiet. She could not speak; she did not even show a facial expression. But, in a moment I will never forget, I turned to her to see tears streaming down her face.

My mother’s last three months were not a fit or dignified way to die, her body and mind wasting away. To cope with the swelling in her brain, her level of steroids increased, but with that came significant side effects—blurred vision, massive mood and personality changes, body swelling, muscle weakness and insomnia. She suffered severe neurological deficits, with confusion, bouts of distressing delirium, significant intracranial pressure, seizures, and fluctuating levels of consciousness. She became bedridden and incontinent. She would not eat for a few weeks, and she slowly starved to death.

My mother died in February 2007.

The end stages that my mum experienced are, unfortunately, not uncommon for those with grade 4 brain tumours. Following my mother’s death, I founded the Brain Tumour Association of WA, a support network for patients and their families, because I found that there was no support network for this community. During that time, I witnessed another 30 members lose their battle against this disease.

This experience has crystallised my views on this legislation. My mum, Delys, should have had a choice, and every other individual facing a terminal disease now should have that choice—a choice to fight; a choice to determine their own treatments; a choice to endure; or a choice to end their suffering, in dignified conditions, on their own terms. That is why we need these laws now.

I want to congratulate the Joint Select Committee on End of Life Choices and the ministerial expert panel for the way in which this issue has been considered and examined. A significant body of work has been undertaken with key experts in the field to develop this legislation, and I believe it strikes the right balance with considered and necessary safeguards. It cannot be described as a rushed process. The Ministerial Expert Panel on Voluntary Assisted Dying consulted widely, considered, and delivered, with its significant experience and expertise, recommendations for resulting legislation in its final report. Neither the select committee nor the ministerial expert panel were reluctant to tackle the key concerns. The panel’s key guiding principles showed a responsive and considered regard for this issue, and I wish to highlight one. It gave consideration to the proposal that people who may be vulnerable to coercion and abuse in relation to end-of-life choices and decisions should be protected.

Opponents of VAD argue that particularly vulnerable groups of people will be subject to greater pressure or undue influence. Given human nature, it is right and proper to consider protections and safeguards for those who may be unduly influenced, but research from other jurisdictions indicates that coercion is very rare and, when it does exist, is more likely to be in terms of not accessing VAD and continuing treatment. For example, I refer to the report, “Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe”. The report found that in no jurisdiction was there evidence that vulnerable patients had received euthanasia or physician-assisted suicide at rates higher than those in the general population. In fact, it found that the demographic profile of patients in the United States who received these interventions was white, well educated and well insured. A further study into data collected in Oregon and the Netherlands found —

“Rates of assisted dying in Oregon and the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured … people with low educational status, the poor, the physically disabled or chronically ill … people with psychiatric illnesses including depression, or racial ethnic minorities, compared with background populations.”

A similar line of argument is put that these laws will enable family members to coerce their mother, father, sisters, brothers or any other loved ones to end their own life. With regard to this argument, firstly, I would argue that these laws have the necessary checks and balances in place, through a thorough request and assessment process. Secondly, I would argue that there is often considerable and incredible pressure on an individual to go on, because their loved ones want them to. I wanted so desperately for my mother to live and fight. I researched everything I could find—alternative treatments, anything and absolutely everything—to prolong her life. I suspect that after the second debulking surgery, my mother was finished; she was done. But I simply did not want to admit that.

Extracted from finalised Hansard
In conclusion, I want to sincerely thank every one of my constituents who contacted me regarding voluntary assisted dying. I know some of you will be disappointed in the way I am voting, but I want you to know that I thoughtfully considered the issues you raised with me, and truly valued your input in my consideration of this bill. I want to acknowledge that many of my constituents, both for and against this legislation, shared their own deeply personal and traumatic experiences of watching someone they love die. I do understand that pain, and I want to say that I am deeply honoured to hold and understand your experience. I want to end on this: I hope we see a decision in the upper house. I hope we do not see a filibuster or any attempt to deliberately delay, or ultimately stop, a vote from being taken. This would be an abuse of our democracy. It would block the will of people. Ultimately, it would rob us all of the choice to have a dignified death.

MR B.S. WYATT (Victoria Park — Treasurer) [8.59 pm]: In speaking on the Voluntary Assisted Dying Bill 2019, I want to begin—as have many members this afternoon and tonight—by acknowledging the people of my electorate. The nature of these debates—which are rare—is that we are required to engage with our electorate more than we would do ordinarily on the legislation that comes through this place on a daily basis. We have a conscience vote on this issue. I listened intently to the Premier’s speech today. At some point, we all have to face our own death, or the death of people we love and are close to us. That is inherently difficult. We are all, of course, creatures of our own experiences. The member for Perth, who spoke before me, outlined his experiences wonderfully well. All members have outlined their own experiences incredibly well over the course of this debate. Of course, our approach to this issue is overlayed by our religious background, religious convictions and faith, and how we approach death.

I say from the beginning that I will be supporting the passage of this legislation. I want to spend some time outlining why I believe this legislation is appropriate for me to support. There has been a long debate around the issue that I guess is generally described as euthanasia. I look to the Minister for Health, knowing full well that that is not what we are dealing with in this legislation, but that is how it has colloquially become known in the broader debate. In fact, back in 2006, not long after I was elected, this issue was raised with me from time to time, and of course closer to today’s debate it has been raised with me much more frequently. To be fair, it has been raised generally by my older constituents—people who are approaching the end of their lives, and who have had family and friends who have died badly, as other members have talked about in describing their experiences. I have not had that experience with my close relatives. My father passed away after a very good experience with palliative care. Palliative care saw my father out very well.

It is clear in my electorate that there is overwhelming support for people to be given a choice about how they want to end their life, in a very narrow and specific circumstance. I want to emphasise that. I know that the debate that will continue in my electorate with my constituents is that people will be disappointed about how narrow this legislation actually is. I will give an example. My mother is a very healthy woman. I hope she has many years of life to go. However, due to the experience of her mother, she is worried about dementia. That is her great fear. This legislation will not apply to her. I think a lot of Western Australians would like the opportunity to counter the onset of dementia. This legislation will not apply to that situation, because the key word is “voluntary”. I will come to that in just a minute.

Clearly, there is overwhelming support for this legislation. Western Australia is generally considered around the country as a conservative state. We are having this debate today after an incredibly productive period, with hearings by a joint select committee of this Parliament, and an expert panel, and also, as the Minister for Health has outlined, after the most significant consultation period ever undertaken by the Department of Health. The fact that we do not have a protest at the front of Parliament about this legislation highlights that Western Australia is a very different state from what some of our colleagues on the east coast think we are. I am very thankful about that.

The point has been made by many members that the key issue is choice. However, the point has also been made that we need to ensure that that choice is legitimate. Some colleagues have raised the issue of people who live in regional and remote parts of Western Australia. I have had those conversations with the Minister for Health, and during consideration in detail we will flesh out how we can provide the opportunity for people who do not live in the city to access palliative care and/or the voluntary assisted dying regime that is embedded in this legislation, assuming it passes this Parliament. That is fundamental. I think all human beings, regardless of who we are and where we are from, have an innate desire to fight for life. That is what we do. None of us wants to pass away. All of us will pass away, but none of us wants to do that. I think about my family and friends, particularly those who live in regional Western Australia. I think about Aboriginal people in particular. Aboriginal people have been referenced by a range of speakers tonight. The great desire of Aboriginal people is to be given the opportunity to go home and die on country. That is something that we need to ensure. I know that the Minister for Health is attuned to ensuring that people are given the opportunity to go back home to pass away, whether that be through palliative care or voluntary assisted dying. Assuming this bill makes its way through the Parliament, fundamentally Aboriginal people in particular desire that return. I find time and again that even though Aboriginal people may have spent the majority of their lives in Perth or other cities, their home country is in another part of Western Australia. The Minister for Health has spent some time on that, and that will be fleshed out during consideration in detail.

Extracted from finalised Hansard
My reading of my electorate of Victoria Park is that there is strong support for this legislation. It is not surprising that in a progressive electorate like mine, the overwhelming response has been in support. However, that has not been one way—absolutely not. As I have said, we are all creatures of our own experience. We are also creatures of our religion. I am a Catholic. I came up through the Catholic system. I will not say I am a particularly wonderful Catholic, but I am a Catholic. I remember that when the now Premier was the Leader of the Opposition, he flagged that he wanted to have this debate in the event that the Labor Party won government and he became Premier. This issue had been around for a long time. I will be honest with my colleagues and say that when the Premier first raised this issue, I was inherently suspicious of this debate. This issue does not come easy to any of us. However, I believe this bill has struck a balance between providing safeguards, and, as the Premier articulated wonderfully well today, handing to us all the freedom to make the final decision of our lives, should we choose to take it. That is what this legislation seeks to do. It provides safeguards that will protect us all from the things that we worry about. The member for Perth outlined that research suggests that when it comes to, I guess, undue pressure, that tends to come, unsurprisingly, from family members who want to keep a family member going for longer and longer. I found that with my father’s passing. The Minister for Transport touched on this issue. We all struggle with the passing of our own parents, to the point at which—I think back to the passing of my own father—I think that he had made the decision well before me. It was done, and he was keen to go. As I said, though, the palliative care process was very good to my father. I cannot fault that at all.

I have not had as much correspondence as I would have expected. I have had a reasonable amount from all over Western Australia, and in fact from all over Australia. I have had correspondence from Tasmania, Queensland and other states, and a reasonable amount from my own electorate, but I think it has been mainly through mobile offices, where I have had the conversations with my own constituents. I want to read in two emails from my constituents. They are for and against. The first one reads —

Dear Ben

I am writing regarding the proposed euthanasia laws being introduced in W.A. By way of an aside, I make the point that, colloquially, it has become the euthanasia laws, but it does not actually deal with euthanasia. I will finish off this email —

I realise my one voice is no more important than any other but feel strongly enough to write to you and express my opposition to any form of euthanasia. As background, I am a 64 year old parent of 4 children (who went through Ursula Frayne) —

That is where my own children are going, so I know a bit about that school —

and have lived in the area my whole life. I usually vote liberal but may vote independent at the next federal election.

This goes back to March —

The only times I voted Labor was for Geoff Gallop and yourself who both do a great job for our local community and are both very decent blokes.

That is very good of him —

I am not sucking up, rather just giving you my background. I am also a catholic (though don’t believe in all the man made type laws that churches have). I do think however that going to a church on Sundays does help keep life in perspective, and gives time to reflect.

I say, by way of aside, that I agree —

I have been struggling with euthanasia for quite a while but after listening to arguments from both sides, and having been involved (as others have) in the deaths of people who have waited quite a while in a bad state, I am now satisfied that my beliefs have been right and am firmly against it. I feel it will harm irreparably the people involved in having to provide the service and everyone involved in the preparation. The process of death does have many lessons for the people involved and it is those learnings that shape the values of our future. Any attempt to end life would be destructive to our development.

Anyway I can only ask that you vote against this legislation and encourage others to do the same.

This is from a constituent in Gallipoli Street, in Lathlain. It highlights the point that I think Western Australians have been very considered in the way that they have gone through their own debate in households and community groups around Western Australia, as highlighted by the fact that many of us have had local conversations about it with our electorate. Before I make some comments about both of them, I want to read in another email from a constituent. It reads —

Dear Benjamin Wyatt MP,

I am writing this to ask you to please vote for Voluntary Assisted Dying Laws.

I watched my husband suffer with cancer and cared for him until he passed away. It’s not easy believe me. It’s an extremely painful slow death.

Extracted from finalised Hansard
I have since had experience with Palliative Care when I sat with my dying best friend and I can tell you now that it doesn’t work. I watched her suffer dreadfully with terminal secondary bone cancer, in a private hospital here in Perth for weeks. It was heartbreaking listening to her pleading with God to take her as she had suffered enough. She certainly didn’t deserve to die like that.

It is beyond me as to why we are having to fight for this, after all we are continually told that we seniors, who built this country I might add, are now being told we are a burden on society. How sad. By way of an aside, I do not think any of us, hopefully, regard any of our seniors as a burden on society, and that is not something we want. The email continues —

Clearly we are obsolete now.

People like me, on a seniors pension, and can’t afford private health cover can languish for years on the back-burner waiting for hospital appointments and surgery.

Yet you won’t allow us to chose the time of our death.

I am only 67 years old but sadly already I feel like I am an inconvenience.

I live alone, my son has MS and a family of 4 children, so if I should become terminal with cancer at any stage in my life, I will not be an extra burden on my family, I can assure you I will not go through what my husband and my friend went through.

Don’t make me and people like me, have to take our own lives, we deserve more than that.

We should have the right to make our own decisions, whether we are terminal or not, after all no-one really cares about us now, yet the minute we say we want to die, everybody wants to save us!

I am not religious so the Churches have no right to make decisions on my behalf, do what they want with their churchgoers but leave the rest of us to make our own decisions.

I fully support Voluntary Euthanasia.

My life, my choice, my decision.

This is from a constituent who lives around the corner from where I live, in Heirisson Way in Victoria Park. I want to make a couple of points about these emails. These are two people with obviously very different views. I think the second email, from my constituent in Heirisson Way, makes the point, as stated in the final sentence, that we should have the right to make our own decisions. Although I suspect that, for her, this legislation actually is not as broad as she would like it to be, we are giving her, I think, the comfort of the knowledge that what happened to her husband will not happen to her. She will be given the opportunity to make that decision about how her life concludes, should those narrow circumstances apply to her. As she said—I think this is ultimately the key issue for my religious friends in particular, and I pay particular attention to what they say because I value their views—the choice is there to be made for people based on their own value judgements and their own choices that they want to make about how they end their lives. I think, ultimately, that is the key. The principles listed early in the legislation and how we effectively define decision-making indicate that we are being particularly careful—some may say overly careful—about how we go about defining how people get the opportunity to make a decision in that regard.

[Member’s time extended.]

Mr B.S. WYATT: The other point made by my constituent in Heirisson Way in Victoria Park—this was made by the Premier very well in his speech today—is that there are regular instances of people who find themselves forced, through their own experiences, to take their own lives. People who do that—I think we all know this—find themselves in a scenario that is a violent and often unsuccessful attempt to end their own suffering. This legislation provides us with a better, more compassionate opportunity for people beyond something that I do not want to see. I do not think any of us want to see people who have to take their life into their own hands to end the suffering that they endure. I think this legislation does that.

As I said at the beginning, back when the debate started, I was still in opposition and I was inherently suspicious of this debate, because it was always going to be difficult to have. How do we have these conversations about how we end our lives? I do not know whether in the distant future I may have to take advantage of this legislation should it make its way through the Parliament, but that will be my choice, as it will be for all of us. The point has been made by many that we all want to provide palliative options, and, as I said, my experience with my father in palliative care was very good, but I want to ensure, as other members have raised, that people who do not live in inner-city Perth, as I do, also have those opportunities. I know that the Minister for Health is very aware of that, and the budget has attempted to deal with that early. No doubt there will be further conversations around that.

Extracted from finalised Hansard
Finally, I want to thank the Joint Select Committee on End of Life Choices. I think it did a wonderful job in taking the leadership of the conversation around this into the communities early and then to the expert panel. Member for Morley, I think a great job has been done in fleshing out the conversation. As I said, the emails I have received—many from my electorate but from all over Western Australia—highlight that I think Western Australians have given this great thought. I think people are really sophisticated in their understanding of this issue. I fully respect members of my family, those who are perhaps more reliable Catholics than I am, who will not support this legislation, but I hope they understand the position I take in supporting it.

I want to conclude I guess, with final points about my mum. Growing up with my parents, my mum was a much better Catholic in the family than my father, to be honest. She was the one who insisted we all go to church and do the sorts of things that we had to do. However, ultimately, it is my mother who has been a big part of my decision-making around this. She wants to ensure that she has the opportunity, even though I suspect for her it is a long way to go yet—it may or may not be an opportunity for her—she wants to know that in the rare circumstances that this legislation contemplates, she has an opportunity to make that choice rather than having to either suffer or take matters into her own hands, which I doubt she would in any event.

I support this legislation. I think it strikes the balance of security, of compassion and in giving people what they want. The people of Victoria Park have clearly articulated to me what they want: choice over a point in life that is so fundamentally personal to them that they should have the right to make that decision.

DR D.J. HONEY (Cottesloe) [9.21 pm]: There has not been a more important bill come before Parliament since I came into this place. I suspect that could also be said for many members here. Members often allude to the importance of issues by highlighting that a particular decision can make the difference between life and death. This is often an overstatement. However, in the case of this Voluntary Assisted Dying Bill 2019, that is literally true. We are debating whether or not it should be legal for the state via medical practitioners and others to provide and/or administer a poison with the specific purpose of ending a human life before that would have occurred otherwise.

This is an issue that demands a collaborative and non-partisan approach. It is our responsibility as legislators to listen in good faith to those who disagree with us and consider with an open mind alternative points of view. In view of the vital importance of this bill, I have found some of the public debate disappointing and lacking proper reflection of the gravity of the matter we are deciding. Much of this discussion has focused on whether people approve of voluntary euthanasia as a general concept. We have seen the results of opinion polls on the matter given great prominence. I expect that the polls do reflect a general consensus on the ideal concept of voluntary euthanasia. However, our task is not simply to consider an idealised concept and give it our endorsement. With this bill, we are deciding on a form of words that will give legal effect to a specific process by which that general concept is actually to be put into practice in Western Australia.

It is not simply a matter of being for or against voluntary euthanasia. It is quite possible to approve of the general concept of voluntary euthanasia but to disapprove, even strongly disapprove, of this bill either as a whole or in part. So this, in fact, is the difficult and important work with which we are charged. Is this form of words adequate to ensure an appropriate manifestation of that general concept? Does the process that would be put into operation by this bill actually reflect people’s general concept of acceptable voluntary euthanasia? Do the provisions of this bill demonstrate a proper understanding and due consideration of the very many factors that must be considered when legislating to operationalise the concept of voluntary euthanasia? Are there adequate protections to ensure that vulnerable people are not preyed upon; that decisions are made freely and are properly informed and properly motivated; that the person who will die has the capacity to make that fatal decision; that untreated, preventable health decisions are not influencing the decision; that others, for their own reasons, ranging from a sense of compassion for a loved one, through to personal gain, are not influencing the person to make the decision; that family and/or societal abandonment of a person is not influencing the decision; that the lack of other adequate alternative treatments is not influencing the decision; and that people are not compelled to participate in an act or process that they find morally and/or personally offensive?

These are all complex matters and are critically important. They require rigorous analysis and careful deliberation before we consider passing this bill. Any bill dealing with this matter must be scrutinised in great detail and not rushed to meet some artificial deadline. As I stated earlier, we are not simply endorsing a concept; we are legislating to put into operation specific acts and processes that will lead to people’s lives ending by their own hand or by someone else’s. We have a duty to ensure that there is proper scrutiny of the considerable detail behind that proposal.

It is my observation that in many cases when people are dying of natural causes at an older age, it seems to be more distressing for the people observing the process than the person who is dying. I have met many older people who are reconciled with their imminent death and are satisfied that they have lived meaningful lives. They want to die at home, recognising that their final moments may be undignified and/or painful. I also understand that in some cases, the distress is equally felt by everyone. Watching someone deteriorate and gradually lose function and independence is distressing. Many people find the thought of a quick death before too much function is diminished or lost a desirable outcome. Many people express a view of “a good death” as the best way to die—that is, someone

Extracted from finalised Hansard
lying comfortably in bed, conscious until their sudden end, surrounded by loved ones. I believe that the observer’s distress drives a lot of the emotion around legislating an alternative outcome, avoiding untidy or disconcerting outcomes with a certain outcome, being able to stage a good death. It is easy to confuse our own distress at seeing a loved one incapacitated and in pain for distress on their part. The dying person may sometimes be in less distress than those who cannot bear to watch them die.

I am concerned that in some cases it may be the observer’s distress that leads to overt or unintended pressure for a dying person to access voluntary euthanasia. I am also concerned that a medical practitioner’s apprehension about observing their patient in distress could influence their estimate of an earlier predicted death than is actually the case. I am also concerned that in passing this bill, we may be seen to be accepting the premise that there is an ideal death; that a good death means a controlled death. It is normal for people to feel anxious about things that are beyond their control. There might be some comfort in the knowledge that we could control when, where and how we die. While I wholly accept that no-one should die in pain and indignity, I question the premise that seems to underline this bill—that there is an ideal version of a good death and, in particular, a good death means a controlled death. If we accept this premise, it may be inevitable that there will be pressure to expand the availability of voluntary euthanasia to give a wider class of people access to a good death. Will people with diagnoses of dementia or other terminal illnesses that would not under the provisions of this bill, if enacted, allow them to access voluntary euthanasia feel that they have been disadvantaged—that a death, albeit without pain, is not as good if it is not controlled nor does it otherwise conform to an ideal notion of a good death?

Finally, if we accept the premise that death is not dignified unless it is controlled, then almost all deaths that occur naturally are undignified. We have already heard one member in this place express concerns that this bill is too restrictive. I have also been disappointed by the overuse of phrases such as “dying with dignity” or this being “compassionate legislation”. It is personally upsetting to me that people state or imply that in order to demonstrate compassion to a person who has a terminal illness, we must provide them with a means to end their own life, and that to do otherwise is to deny a person a dignified death. There are other ways that we can ensure people with a terminal illness have a dignified death that are compassionate and caring. It is my view that these options should always be the first choice we pursue.

Some of the shortcomings and essential services have been covered by previous speakers, and I will be examining that further in the consideration in detail stage. This bill if passed, constitutes a momentous step. It is important that we do not, even through a sincere desire to ease the suffering of others, ignore or gloss over the contentious factual assumptions and value judgements implicit in it that would, by passing this bill, be imported into the law of Western Australia.

This bill presupposes that a person can be reasonably known to be dying within a certain period—in this case, six months for a disease or illness, or 12 months for a neurodegenerative condition—and that they will be enabled to ingest a poison that will simply bring forward an inevitable outcome. Members will be aware from their own experience and the several briefings we have had that there is considerable uncertainty about when a person will die when they are in the final stages of a terminal illness. People who are strong proponents of this bill are keen to point out that many practitioners are overly optimistic about the estimated likely period left to live. The scientific literature supports that view. However, there are also a large number of occasions when the prognosis is overly pessimistic. Many of us would know of instances when someone has had a prognosis of imminent death, often from cancer, and they have gone on to live for a good few years. One of the factors that causes suffering for many patients is the apparent imminence of death. It would be a dreadful unintended consequence of this bill if that distressing fact led to a person taking their own life early.

There are inadequacies in the bill around ensuring that the most informed estimate of someone’s probable remaining life span is obtained. The bill outlines training requirements, and we need to see the detail for this, I presume in the associated regulations. Experience in other jurisdictions would indicate that training can be perfunctory. I am also concerned that there is no provision in this bill to validate whether the prognosis of imminent death is actually accurate. For example, there is no requirement for coronial oversight. As I mentioned earlier, many people have concerns that intended safeguards on estimated life span will be eroded over time. I appreciate that the involvement of the coroner can cause a delay in someone’s funeral. However, given the gravity of this legislation, I believe it is prudent to have some form of substantive review and a non-identifying reporting process to ensure that the mandated safeguard around estimates of imminent death are actually correct.

On a related issue, I am concerned about the short time allowed between when a person applies for voluntary euthanasia and when they can access the process. The bill indicates that this can occur in nine days and, in fact, in certain circumstances the time can be less than this. It disturbs me that a person may not be in a fit state of mind to make such an important decision in such a short time, especially if the prognosis of imminent death has been recently delivered. It would be more reassuring if there was a strong qualification period, especially when it is in close proximity to a prognosis being delivered to a patient. One of the key elements in this bill is that the person making the decision to end their life is doing so of their own free will and is not subject to other influences. I am troubled that this bill does not go nearly far enough in resolving concern about this issue. Indeed, I am concerned that it may be beyond the capacity of this bill, however amended, to resolve this issue.
Many stories in support of this bill are about a loving family member who has been distressed by the plight of a parent or close relative. We have heard some of those stories in this chamber. These moving stories are often similar—the dying person is suffering unimaginably and the caring person is extremely distressed to see them in that condition. They believe that access to voluntary assisted dying would have been the compassionate alternative to end everyone’s distress and suffering. However, this scenario is not the case for many people. Very many people are alone and uncared for by anyone they know at the end of their life. Hon Ken Wyatt, who was the Minister for Senior Australians and Aged Care in the previous federal government, informed me earlier this year that 40 per cent of people in aged care do not have a single visitor in a year. Imagine that! You are in the final stages of your life and you have been completely abandoned by everyone you know—brothers and sisters, sons and daughters, relatives and friends. This is a very cruel and unpleasant fact. Would a person who has been completely abandoned in this way be in a fit mental state to make a decision to end their life if they also have a terminal illness?

There is a considerable body of legal cases that look at the ability of people to make free and informed decisions, mostly relating to financial matters. In many cases, they involve close relatives or friends. In the case of a person dying, there are often significant financial implications associated with disbursement of their assets. Typically, close relatives are the major beneficiaries. Although we all like to think that we would not seek to influence a person to our financial advantage in such a situation, many legal cases indicate that this happens all too often. Sometimes that influence is overt and amounts to bullying a vulnerable person. Sometimes it is unconscious influence, which can be caused, for example, when a pending recipient of an inheritance is suffering financial hardship. In these latter cases, the person responsible may be a genuinely loving relative or friend. Nevertheless, by their actions, they influence the vulnerable person to carry out an action that benefits themselves.

I find it very hard to believe that the option of hastening someone’s death through voluntary euthanasia will not become entwined with overt or covert pressure from a relative or friend who has financial issues or is greedy. Thus, this bill must include rigorous protections against this real possibility. By its nature, identifying such influence is difficult. It typically occurs in private. The dying person may be embarrassed to disclose the coercion or not want to cause problems for the relatives or friends by disclosing the coercion. Identifying such coercion requires an intimate knowledge of the dying person. It requires that that person trusts someone enough to reveal the coercion. Even more concerning than coercion is subtle manipulation and the improper use of influence. A dying person might be persuaded by someone whom they love or trust that an assisted death is best for them. This kind of coercion is extremely difficult to detect. Indeed, the dying person might not even know that their decision-making had been influenced. They would not realise that there was any abuse to report. Unfortunately, we know that coercion and undue influence of vulnerable people is extremely common.

On its own terms, this bill is directed at people whose circumstances must render them extremely vulnerable. I do not see any adequate protections in this bill to deal with this issue. There is no requirement that the coordinating practitioner, the consulting practitioner or the administering practitioner have any relationship with or knowledge about the patient before they participate in the procedure. There may be cultural differences between the dying person and the practitioners that make the person cautious about revealing coercion. There are substantial barriers for a third party—a concerned person—to intervene and reveal fears or evidence of coercion.

The bill does include the ability for a person to apply to the State Administrative Tribunal if they believe that there has been some error or unfair influence. However, I do not believe that this provides effective protection in these instances. In a great many cases, the person who is aware or suspects the coercion will be a friend or close relative. It is reasonable to suspect that they will likely be known by the people responsible for the coercion. Going to SAT is a daunting exercise that requires a significant amount of time—time that most people do not have. There is a high likelihood that it will become known that a person has made an application to SAT, and this could have significant personal repercussions for the concerned person. There needs to be a much simpler mechanism in the bill for a person to confidentially raise concerns of coercion and specified mechanisms to ensure that these concerns are properly investigated. The bill should provide some means by which undue influence might be detected and dealt with so as to assure that the integrity of the decision to access voluntary euthanasia has not been compromised.

I believe that there is a strong argument that at least one of the practitioners should have a prior professional relationship with the dying person. There should also be some protection to ensure that cultural differences are not a barrier to open communication between the dying person and the practitioners.

[Member’s time extended.]

Dr D.J. HONEY: Many people have expressed a concern to me that a focus on assisted voluntary euthanasia may be simpler than governments dealing with more complex issues around coping with ageing and dying people. I make it clear that I believe that the current health minister is genuine in his concern for people and believes that this bill is important. I do not believe that the current health minister views this bill as an expediency. However, I believe that, over time, there is a risk that people terminating, or being assisted in terminating, their own lives will be seen as a solution to dealing with the complex issues of ageing and dying. There could be a temptation to avoid cost and complexity by encouraging people down this path. Again, this can be subtle pressure. The dying person becomes aware that they are a problem; they feel that they are a burden to others; the hospice has pressure.

Extracted from finalised Hansard
for beds and staff are overstretched. There is a danger that in the long term, the option of assisted euthanasia may diminish the government’s resolve to deal with more complex solutions. For example, what is the government doing to eliminate the cruel loneliness of so many people in aged care? Is the government doing enough to improve palliative care in our community, in particular in the remote regions of our state? What is the government doing to change the view that older people are a burden, so that, rather, they are recognised as an asset to society? What is the government doing to give older people meaningful and productive lives so that they can continue to contribute to the community in their older age?

It is very clear that the dramatic increase in life expectancy and general improvements in medicine have increased, and will continue to increase, the importance of dealing with these issues. Some of the issues are the immediate responsibility of government and some are issues that require a whole-of-community response and change of attitude. It is certain that government has a key leadership role in all these areas. I would much prefer to see a stronger focus by government on dealing with these issues before it devotes so much focus to this bill.

Palliative care is a key area for concern, particularly because one of the very common justifications for this bill is the great difficulty or impossibility of preventing extreme pain for some people who are dying. Arguments about the impossibility of managing the pain of a dying person figured very prominently in the public debate leading up to the introduction of this bill. I have attended many briefings on this bill, including several from leading experts in palliative care. In the greater part, I was satisfied that these people have considerable expertise in palliative care and also extensive experience with people who are dying. It was the common and unequivocal view of these experts that the inevitability of untreatable pain is untrue. In their experience and expert knowledge, there was never a clinical reason for a person to experience unacceptable pain when ill or dying. Their concern was that there is an appallingly small number of palliative care specialists in Western Australia and that many general practitioners did not have adequate knowledge of effective pain relief.

They also expressed great concern about access to proper palliative care in regional areas. I understand that the Minister for Health has indicated a greater focus in this area. I have not seen the evidence that this area has had anywhere near the focus that compares with the government’s focus in trying to progress this bill. In my view, even if the concept of voluntary euthanasia is accepted, it ought to be the option of last resort. Until Western Australia has acceptable access to palliative care, how can we possibly assess the need for voluntary euthanasia?

A key principle enshrined in this bill must be that a medical practitioner should never be compelled to participate in voluntary euthanasia. As with the rest of the community, medical practitioners have a range of views on this subject. From my interactions with many medical practitioners, I believe that the great majority oppose voluntary euthanasia, as reflected by the Western Australian branch of the Australian Medical Association in its formal position on this bill. Equally, it is clear that some medical practitioners are keen proponents of this bill. Many medical practitioners have a deeply held view about the sanctity of human life and that their principal objective must always be to preserve life. Medicine is most often a vocation and many medical practitioners hold this view with very strong conviction. As such, they never wish to be involved in voluntary euthanasia. They see this as a fundamental conflict with their principal objective—the preservation of life. It would be entirely wrong if this bill were to force these medical practitioners to be involved in the process of voluntary euthanasia at any level. Unfortunately, as I read this bill, it is actually the case that any medical practitioner, once asked by a person, will be compelled to be involved in at least part of the process of voluntary euthanasia. If asked about accessing voluntary euthanasia by a person, the medical practitioner will be compelled to agree or disagree to be the coordinating practitioner. If a medical practitioner has strong opposition to voluntary euthanasia and objects to any involvement in the process, they are still compelled to compile a report outlining the details of the request and their reason for declining. They will also be required to provide the requesting person with information prepared by the CEO. At this stage, we have no idea what this information is; it is not clear in the bill. However, it is reasonable to suppose that this information will direct the requesting person to other resources to assist them with voluntary euthanasia.

One of the most egregious aspects of this bill is that if the medical practitioner does not provide the CEO’s information and/or submit a report to the Voluntary Assisted Dying Board within 48 hours, they could be subject to a $10 000 fine. This is intimidatory and oppressive. If it is the minister’s intention that a medical practitioner is not going to be forced to be involved in any part of voluntary euthanasia, the bill should reflect that. I believe that compelling by force of law the submission of the report to the board and providing the information from the board CEO is inappropriate and inconsistent with the minister’s stated intention. It is morally repugnant to force a medical practitioner, under threat of penalty, to provide information to someone so as to facilitate that person’s access to voluntary euthanasia. As parliamentarians, we accept that the nature of this issue demands that we ought to be allowed to follow our consciences in performing our duty. In that case, we should not deny doctors the right to be guided by their own consciences when, in the practice of their profession, they are obliged to make a decision about the extent to which they will participate in facilitating the death of another person.

I do not support this bill as it is presented. My opposition to the bill is not based on any religious or philosophical belief or on any political allegiance. Legislating for the state to facilitate someone taking their own life or allowing someone else to assist someone taking their own life is an enormously complex matter. Any such bill must have
adequate protections to ensure that vulnerable people are not preyed upon; that decisions are made freely and are properly informed and properly motivated; that the person who will die has the capacity to make that fatal decision; that untreated, preventable health conditions are not influencing the decision; that others, for their own reasons, ranging from a sense of compassion for a loved one through to personal gain, are not influencing the person to make the decision; that family and/or societal abandonment of a person is not influencing the decision; that the lack of adequate alternative treatments is not influencing the decision; and that people are not compelled to participate in an act or process that they find personally offensive. I believe that this bill fails to achieve adequate outcomes in several of these areas.

The Minister for Health has told us that there are 102 safeguards in this bill that ensure that key concerns are resolved. However, I do not see sufficient safeguards for several of the issues I have just listed. There is insufficient time to detail all those concerns during this brief speech. However, I intend to explore those issues thoroughly when we commence the consideration in detail stage of the bill.

MR D.A. TEMPLEMAN (Mandurah — Leader of the House) [9.47 pm]: I would like to make a contribution to this very important debate on the Voluntary Assisted Dying Bill 2019. I listened to the member for Cottesloe. I am not going to be critical but when I heard some of his comments, I wondered when we would have actually considered a bill of this nature. The expert panel came to Mandurah a couple of months ago. Malcolm McCusker, the chair, and two other committee members were there. It was a good meeting; I think there were about 100 people there. The members for Dawesville and Murray–Wellington were also there. The only downside for me was that I was introduced as Hon Colin Holt! I was again mistaken for Hon Colin Holt, who of course was a member of the select committee.

Mr Z.R.F. Kirkup: They were very happy he was there!

Mr D.A. TEMPLEMAN: I had to correct His Excellency Malcolm McCusker.

I was drawn to something. I am not being critical of the member for Cottesloe, but a gentleman who was at my table during that expert panel discussion leaned across and said to me—this is true—“I’m a Liberal, always have been, but this bill would not be debated if it wasn’t you guys bringing it forward.” I think that is true. I do not mean that to be a political statement, but I think it is true. We in this place are put here for a whole range of reasons, and there comes a time when we need to address issues that have been debated, discussed and talked about for a long, long time. I am sorry, member for Cottesloe, this is not rushed; it is not. This issue has been debated for probably a couple of generations. It has been highlighted as something that people want this Parliament—want us as elected members—to consider. It is the Labor Party, and I am very proud of it, that has brought this bill to this place. I want to acknowledge the members who have already spoken this afternoon and tonight for their contributions. I do not agree with most of what the last speaker said, but he has absolutely every right to say it. I think it is a fact that had it not been a Labor government bringing forward this legislation, we would not have seen it.

Quite rightly, it is a conscience vote; quite rightly, every single member of this place will have upon their conscience, and make a decision based upon it, where they land in regard to the bill. I congratulate the Joint Select Committee on End of Life Choices and its members, and I particularly highlight and acknowledge the member for Morley and others who have been stoic advocates for bringing this bill to this place. I acknowledge the expert panel and the advisers. To the Minister for Health, congratulations. There are many people in Western Australia who are grateful that this bill is now before this place. There are many people who I am sure want their voice to be heard through the debate we are having tonight and will have going forward when we consider the bill in detail and when we conclude its passage with third reading contributions. Like a number of members, I attended, and organised along with the member for Murray–Wellington, a forum that had around 150 people turn up, which was wonderful. Last Wednesday, I also attended a forum at the Catholic parish organised by Mr Carl Brown. About 16 people attended and people at that meeting were clearly opposed to this legislation. Like many members, I have had a massive amount of feedback by email, handwritten letters, phone calls et cetera—a large cross-section. Like many members also, whenever I speak to any constituent, I always finish the conversation, if it is appropriate of course, by asking their view on the voluntary assisted dying proposal before the Parliament. I can report that the overwhelming response of people from my district, the seat of Mandurah, has been that they support voluntary assisted dying. There are varied views about how they believe it should apply, and I am going to highlight a couple of those shortly. Then, of course, there are those who, for a variety of reasons, have expressed their dissatisfaction with or non-support of the voluntary assisted dying proposal. Overwhelmingly, though, they want us to have this debate.

There has been plenty of opportunity to ensure that we landed in this place a bill that was well and truly canvassed through the expert panel, the select committee process and the extensive consultation process. The media has been conducting an ongoing debate and journal, if you like, of the issue. Indeed, I think many, many households throughout Western Australia have considered this issue. We also have had the opportunity to look at what has occurred in other states in Australia in recent times. In South Australia, a bill to provide for assisted dying failed by one vote—I think it was the casting vote of the Speaker. A similar fate occurred with a bill in New South Wales. Consideration of this issue is now before the Queensland Parliament. Of course, Victoria passed its legislation just
over 18 months ago, and the first person to take advantage of the Victorian legislation did so only a few weeks ago. I do not subscribe to the view that was put by the previous speaker that this issue is somehow rushed or should not be a priority of government. I believe it is a priority for our community. It is a priority that our community wants us to debate, and that is why I am very pleased that we now have this bill before this place.

I have always been a supporter of this issue, albeit cautious of it. Like many, I have seen loved ones who have suffered, particularly my grandmother, who died at the wonderful age of 95, but the last four months or so of her life were not quality. My nanna was a farmer, and like a lot of farming folk, their livelihood was around life and death. They were sheep and wheat farmers, and even as a boy growing into a man I would talk to her regularly about her views on matters such as this. Had she known that the last few months of her life would be seen out in the way they were, I think she would have wanted to have had a choice. I think that is what this bill comes down to. It comes down to two words for me: “voluntary” and “choice”. It is a voluntary choice made by the person themselves about the way in which their death is met. When we speak to people about this, as many of us have, they say that the fact that this is a Voluntary Assisted Dying Bill that allows a person to voluntarily choose is significant.

I want to turn to a few of the comments by people that I think sum up how I have landed with regard to this bill. Geoff wrote to me. I am just going to quote some of this correspondence. He said —

... we just wanted to write to say that we are whole heartedly in support of assisted death. Put simply, people have a right to their way of life and equally they have a right to their way of death. All this of course needs to be done within the acceptable bounds of society and there equally needs to be a strong legal framework around such things. The proposals put forward by the state government are eminently reasonable.

... We are now in the latter stages of our life and death is not some distant concept. Without wishing to sound negative or maudlin death is a reality that grows closer each day. Neither of us are ill and neither of us have any thoughts of wanting to die but we do find that our concern is not so much about dying as about the way we die.

We feel quite often that opponents talk about the sanctity of life rather than the dignity of death. As we age the inevitably is that we witness the passing of friends and relatives. Some have gone peacefully but more than half in pain and discomfort. All of these people had no hope of recovery and they acknowledged their time was up: they simply saw no point in prolonging the agony.

A gentleman from Mandurah has featured quite significantly in this debate over the last few years. He was part of the advisory group, and his name is Nigel Haines. I know that he does not mind me using his name. Nigel cared for his wife, Susie, during her time of suffering. Susie’s death was not one of dignity, and has haunted Nigel since her passing. He appeals to all members of Parliament to consider this legislation as an important means of allowing choice for those who want to choose how they leave this earth. Nigel Haines is a loving man and continues to campaign for the passing of this legislation and for all people to understand that the impact of the suffering of loved ones lasts well into their lives.

I only found out today that a dear friend of mine, Ailsa Rice, has passed, and I am so sad. Ailsa and her husband, Phil, have lived in Mandurah for a long time. She passed the other day and I found out only today. She was a great woman. She was one of the first people I met when I was first elected. She was a great volunteer with the school volunteer program, as it was called then. I am very sad to hear she has passed. She wrote to me and to the Chair of the Joint Select Committee on End of Life Choices and said —

My Husband and I have just added Advanced Care Directives to our wills. The wishes of each of us is to have as peaceful and dignified death as possible when our time to die comes. We support voluntary euthanasia or assisted dying and we hope the laws can be changed to allow us this choice if needed at the end of our wonderful lives.

I have nursed a dying husband who wanted to die only one week before he did die. One long and suffering week for him and his family. He begged me to find some way to help him go. We have sat with a friend and his family who also took four long suffering days to die. Both John and David had terminal illnesses and accepted palliative care but these wonderful men were denied at the end the compassion we show to our beloved animals.

My husband’s sister suffered a severe stroke and had not put in place an A.C.D. before this happened. The result was that despite her wishes she lingered for five long years in a nursing home fed liquid food through a tube inserted into her stomach and unable to do anything for herself. …

If for some reason a chronic condition makes life unbearable, giving us the choice of assistance from a doctor to end our lives with dignity should be the right of every individual.

Extracted from finalised Hansard
We are part of the older generation, enjoying the birth of great-grandchildren but aware that dying is getting ever closer. **We want to have as peaceful and dignified death as possible, a good death at a place of our choice with whoever wishes of our family and friends around.**

That was Ailsa Rice. Vale, Ailsa. You were a gorgeous woman.

[Member’s time extended.]

**Mr D.A. TEMPLEMAN:** As I finish I want to highlight something the Premier touched on in his contribution earlier today, as did the Minister for Health. A constituent named Reg wrote —

… there are some pointers you may wish to enlighten the meeting with.

I think he means this Parliament. Reg continues —

Most people say watching their loved ones suffer and lack of dignity which is quite correct.

What isn’t often mentioned are the drastic measures some take whilst they are able and this in itself can be horrific for all to cope with.

The Premier mentioned the number of people who take their own lives because of the suffering. The important thing about Reg is this, and I quote again —

I served as a volunteer Ambulance Officer in Mandurah for many years and during the course I attended volumes of people ending their own pain and suffering.

He talks about the impact of that on emergency services.

I certainly support …

This legislation —

… having witnessed my own parents suffer and as I say the trauma that family and friends also are forced to cope with when their loved one commits suicide.

The time is right for this legislation. This is the right time to have a dignified and respectful debate. This is the right time to reflect on the important decisions that we will be making. This is the right time to remind people that this Parliament is listening to what people have been calling for for a long time. This bill is a very good bill. It is compassionate and has the important checks and balances. It acknowledges the importance of the voluntary aspect and the choice. Many of my constituents have highlighted to me that they want the checks and balances in place, but they want that choice. I am going to support this bill. That is a reflection of how my community has asked me to consider this bill.

**MR T.J. HEALY (Southern River) [10.08 pm]:** I rise to contribute to the second reading debate on the Voluntary Assisted Dying Bill 2019. First and foremost, I support my community and its majority view that voluntary assisted dying be legal in Western Australia. The Speaker may place my vote on this bill in the aye column. I will vote yes—for voluntary assisted dying to be safe and legal. For my community of Canning Vale, I vote yes. For my community of Gosnells, I vote yes. For my community of Huntingdale, I vote yes. For my community of Southern River, I vote yes.

Everyone is entitled to an opinion on this issue. My opinion is that a person should have the right and the legal protection to make their own end-of-life choices. I believe that respect is important in this debate. I believe that safeguards are important—crucial in this legislation. I believe the bill before us balances the needs of the community and the individual well.

I am not alone in having lost friends and grandparents. Some have died relatively quickly and peacefully, and others have passed in pain, over a long time. This bill gives people an individual choice about the circumstances of their passing—not whether they will live or die; that is already confirmed. For the relatively small number of people who will be eligible under this legislation, their death will sadly be imminent. This bill will allow individuals in my electorate to control the manner of their passing and reduce their suffering.

The status quo does not serve the individual or the family. This is not euthanasia; this is about freedom of choice for individuals to make their own choices. Life is messy; everyone’s circumstances are different, and the details of every circumstance do not need to be detailed on the floor of this chamber. However, they do need to be detailed between the individual and their medical professional. We should, and will, maturely and responsibly discuss how individuals can have the choice that they are currently legally denied. Individuals should not have to starve to death or refuse to eat, to wilfully crash their cars or to take random mixes of medication to relieve their suffering. We have the opportunity to change the lives and deaths of many, and I am humbled that my electorate placed its trust in me, and I will vote yes to support its wishes.

I ran an online survey amongst other ways of consulting with my community, for my residents in Gosnells, Canning Vale, Huntingdale and Southern River, and I greatly appreciated the words and guidance that came...
from their submissions, in addition to the face-to-face conversations I had on doorsteps and in my office, as well as conversations on the phone and through emails and letters. I believe, from the data that I have collected, that 94 per cent of the constituents who interacted with me on this issue support voluntary assisted dying legislation, and a strong majority were also impressed by and supported the safeguards that we listed in the survey as being important.

I would now like to read out a few of the quotes from people who completed my survey and who speak on behalf of the community that I represent —

I am 100% in favour of making my own choice. Having seen parents & husband suffer & die, I see no advantage or need to put patients and families through this agony.

Another one stated —

I don’t believe that people should be made to suffer when they are dying. This happened to my mother and father

A further submission stated —

I have watched my grandparents all die horrendous painful deaths and all of them wanted assistance to end their suffering. I don’t want this for my parents or for myself.

And finally —

My sister is currently in the end stages of —

A disease. It continues —

She has chosen to starve herself to death as no other option is available to her. This is extremely cruel and she should be allowed to end her life peacefully.

I again thank the people who participated in that survey and shared those stories with me.

My mum and my wife live in my electorate, and it is a very tough conversation for those two very important constituents of mine. My wife and I find this very difficult. I cannot imagine ever wanting to leave my family, even for one day less, no matter the suffering; but I will not deprive the right of one of my constituents to make that choice for themselves. My mum supports voluntary assisted dying but, as the member for Victoria Park mentioned, she would like dementia to be included; she thinks the legislation does not go far enough. She fears being bedridden for years without an option, if that were to eventuate. As I believe a member has already said, some people will think that this legislation does not go far enough. I believe we have struck the right balance with this bill, but I note on behalf of my wife and my mother—two constituents who certainly struggle with parts of this bill—that, as I said, there will be many who say this legislation goes too far, or does not go far enough.

Labor party supporters tell me that they support having a choice over their own end of life; interestingly—this has been raised anecdotally in previous speeches—I have also been told by Liberal Party supporters in my electorate that they support having a choice over their own end of life. However, Liberal voters in Southern River also tell me that they are not happy about former Christian Democrats, like Hon Nick Goiran in the upper house, and Christian lobbies who may seek to filibuster and avoid a vote. That is what Liberal Party supporters tell me that they are frustrated about. Labor is not perfect, either; we have had many individuals hold us back over many years, and we must keep them from holding us back from being brave.

We have a very good Minister for Health and a very good shadow Minister for Health—a future leader of his party. If I could give any words of advice, I would say that he should shape the party into what he wants it to be now. If he is the shadow Minister for Health, he should not let nonstop filibustering deprive my community of its voice. Let this come to a vote. Let the debate take place, but do not let one individual stand in the way of relieving pain and restoring dignity to my families.

There are mums and dads, seniors and young people, who support having a choice over their own end of life. One of my Liberal predecessors in the 1990s in Southern River, Monica Holmes, supports the principle of voluntary assisted dying. Another predecessor, Paul Andrews, has sadly passed away, but I talk regularly with his wife, Gim. Gim and I agree that Paul would have argued vigorously on this bill. We do not know how he would have voted, but we both agree that he would have valued the safeguards as being of great importance in the parliamentary process.

I would now like to discuss those safeguards. I think they are key to how this legislation will operate and will ensure that the community is protected going forward. It is important that it is voluntary and without coercion. It is important that the individual must be over 18 years of age, be from WA, and have sound decision-making capacity. It should be, as it is, restricted to those who will likely die within six or 12 months. It is important that this legislation is in place for those who experience suffering that—these words are key—cannot be relieved in a manner tolerable to them. Not me or you—them.

The legislation also requires three separate, clear requests—two verbal, one written; two medical practitioners; and two witnesses who are not family and will not benefit financially from the will of the person passing. It is key.
that medication can be self-administered or practitioner-administered. People should have the right to choose the location and circumstances of their death; that is what this is about. For self-administration, it is also key to the safeguards that the full process involved is considered—what happens at every step of the process to ensure that the products and medication are safe. It is important that health practitioners can refuse to participate. There are also many offences listed in this bill, broadly, for inducing a person to access voluntary assisted dying.

I fully support palliative care services, and so does the McGowan government, with record investment in palliative care services across WA. But please let me be clear: palliative care is a valid choice; voluntary assisted dying is a valid choice. It is not palliative care versus voluntary assisted dying; it does not need to be, nor should it be described as such.

I would also like to speak about my Christian influence on this decision. My faith calls for compassion. My faith calls for dignity. My faith supports this bill. It is not easy to take direction from scripture on this; most Abrahamic and biblical texts do not address these circumstances, and the Bible is also often misquoted, as it has been for hundreds of years. It was used to justify slavery; more recently, to stop women from voting; to stop interracial marriage; and to stop two men or two women from marrying the person they love. Again, we know that none of those things come from the scripture. But it is very simple to see, I think, that Jesus relieved suffering; he cared. We are all called upon, regardless of faith or religion, to be caring and compassionate. Every faith calls for this. There are some so-called Christian leaders who say there is, in suffering, a resolution. I was raised Catholic, and there is a certain dogma within the Catholic Church that suffering is important in the process of death. I do not agree with that, but some churches emphasise the importance of not interfering with the natural process of death, and that the time before death is a profoundly spiritual time and should not be interrupted. Personally, I think that seems cruel and out of touch.

A Catholic church leader said that he observes that “the Christian faith, with its emphasis on the redemptive value of suffering, can offer answers”. I say that again: “the Christian faith, with its emphasis on the redemptive value of suffering, can offer answers”. That was said by Cardinal George Pell. His words help me, because if Cardinal George Pell had those views, it helps us know that we are in a good place in opposing them. Following that train of thought about the value of suffering—which I disagree with, by the way—any medical care, including palliative care or government-funded health care, should be declined. That is, of course, ridiculous. I think of a person caught in a flood. The waters are rising, their house is flooded, and they are trapped on the roof. They pray to be saved. A boat comes, and they say, “No, God is looking after me.” A chopper comes, and they say, “No, God is looking after me”, and they pass away. When they die, they say, “God, why didn’t you save me?”, and God says, “I sent a boat, and a chopper.” If we recognise that it is okay to provide palliative care as an option to relieve suffering, can we not recognise that voluntary assisted dying is also permissible?

I want to thank the many individuals who have brought this issue to a vote in the chamber. I thank those individuals for the thousands of hours of consultation, committee work, drafting and preparation. The Leader of the House said that this issue has been discussed for generations. That is true. I thank the members of the Joint Select Committee on End of Life Choices. I thank the members of the Ministerial Expert Panel on Voluntary Assisted Dying. I commend Premier McGowan; the Minister for Health, Roger Cook; and the tireless member for Morley and cabinet secretary, Amber-Jade Sanderson—very well done. I also thank former Governor Malcolm McCusker, Andrew Denton, and Belinda Teh. I thank Hon Stephen Dawson, who will carry this legislation in the upper house, and is still doing the work. I also thank the thousands of activists and campaigners who have pushed, petitioned and placed this issue in the public eye.

There is an obligation for government to create a safe, secure and compassionate community. This bill will assist us in reaching that goal. I again say thank you to my community of Canning Vale, Gosnells, Huntingdale and Southern River for discussing with me their views on this issue. Not everyone in my electorate will be happy with my vote in support of this bill, but I believe the majority will be happy. I hope my 30 000 friends and neighbours in my electorate will understand the reasons for my decision. Once again, I will be proudly voting yes for this bill. Thank you.

MR S.J. PRICE (Forrestfield) [10.21 pm]: I rise to speak on the Voluntary Assisted Dying Bill 2019. This is a very important and highly emotive issue. I want to start by thanking everyone in my electorate who has contacted me, had a discussion with me or shared their stories with me, both those in support of this legislation and those against it. My decision to support this bill may upset some of my constituents. However, the overwhelming support for this bill has gone a long way towards making this very important and difficult decision easier for me. I also acknowledge and respect the different views that may be held by people within this place, for whatever their personal reasons may be.

The Joint Select Committee on End of Life Choices was appointed by the Western Australian Parliament in August 2017 to inquire into end-of-life choices. In compiling its report, the committee undertook the most comprehensive consultative process ever undertaken in this state. The committee, which ran for a year, and was ably chaired by the member for Morley, Amber-Jade Sanderson, received over 700 submissions, heard from over
130 witnesses and held 81 hearings. The committee report, “My Life, My Choice”, was tabled in August 2018. I would like to acknowledge everyone who participated in the development of that report. Arising from the recommendations of the joint select committee, a Ministerial Expert Panel on Voluntary Assisted Dying was appointed to undertake consultation and develop legislation for voluntary assisted dying in Western Australia. The panel heard from 867 participants and organisations during the consultation process, and received 541 submissions. The panel’s final report provided recommendations for the introduction of voluntary assisted dying legislation. I acknowledge and thank everyone who participated in the development of the “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report”.

As members have heard, a significant amount of community and stakeholder consultation has been undertaken to bring us to the debate we are undertaking this evening. It is evident from the legislation that the concerns of as many people as possible have been taken into consideration. Like every member of this house, I have had to examine not only my own conscience but also, more importantly, that of the people in my electorate. I thank the many people in my community who have taken the time to come on this journey with me and let me know their thoughts and feelings.

My personal view on the introduction of voluntary assisted dying legislation has remained consistent over my time in this place. Even though I may be a Catholic, I fully support allowing terminally ill people to choose how they wish to die. I have heard from people who work within the health sector, people who have lost loved ones, and elderly and young people alike, and, overwhelmingly, the feedback is in support of this legislation. However, most often, that support is given with the caveat that strict guidelines should be in place, with the emphasis that this should be a voluntary act. One person I spoke with, who raised opposition to this legislation, was particularly concerned that this would be a slippery slope that would enable people to more easily end their life or that of family members. With over 100 safeguards within this bill, I feel there are enough protections to protect patients who wish to access the voluntary assisted dying process. Those safeguards include the requirement that access to voluntary assisted dying is available to a patient only if that patient has been diagnosed with a disease, illness or medical condition that has certain characteristics—namely, it must be advanced and progressive, and will cause death. It must also, on the balance of probabilities, cause death within six months; or, in the case of a disease, illness or medical condition that is neurodegenerative, within 12 months. The strict eligibility criteria that must be met include that the patient must maintain decision-making capability throughout the process. The patient is required to make three separate requests, initiated by themselves, within a particular time frame, to enable them to continue with this process. These are just two of the safeguards that are in place in this legislation. These safeguards are very important, because they highlight an important aspect of his legislation—that is, that the use of terms such as “euthanasia” and “assisted suicide” are a misrepresentation of what this legislation is about. I have satisfied myself that, as best as possible, the concerns raised by not only opponents of this legislation, such as the person I have just mentioned, but also those who support it, have been met.

In the face of overwhelming support for this bill, it would be easy to dismiss the smaller number of people who oppose voluntary assisted dying. However, it is their opposition that makes me delve further into this legislation to ensure that, as best as possible, their concerns are addressed. One issue that was raised with me centred on coercion. Section 15(e) of the bill states specifically that one of the eligibility criteria is that “the person is acting voluntarily and without coercion”. The bill is very prescriptive about how that issue must be dealt with, and that will provide an extremely safe and strong level of protection for the patient.

The stories of those who have lost loved ones resonate the most with me. Many of the people who communicated with me in support of this legislation did so having watched a loved one suffer at the end of their life. I listened to the story of a woman whose father accepted his terminal diagnosis. His only concern, through surgeries, chemotherapy and radiation, was the manner in which he was going to die. No doctor could, or would, give him a specific answer.

My community raised concerns that, in the face of vocal community support, the opinions of those opposing voluntary assisted dying were realised, as he slowly lost his ability to walk unaided, think coherently, or feed himself unassisted, until he was finally bedridden and unable to talk, eat and drink. Although his family nursed him and cherished every moment they had with him, his wishes for a pain-free and dignified end were not met. Given the option of voluntary assisted dying in this instance, this man’s family would have accepted their father and husband’s wishes, had he been given that choice. Of course, they would have likely tried to coerce him out of doing that, because, as we all know, saying goodbye is never easy, and the more time we have with a loved one, the better.

Others in my community expressed the strong opinion that death should not be used as a way out. However, they conceded that life can be cruel, and the option of dying should be available if no other options are left. Although many people, constituents and others, have been in contact with me to support this bill, having watched a loved one suffer, concerns have rightly been expressed for those who do not have strong family networks, are vulnerable or could be coerced into dying for another’s financial gain. I am confident that the process set out in the legislation for requesting access to voluntary assisted dying, followed by the assessment process, is rigorous. One member of my community raised concerns that, in the face of vocal community support, the opinions of those opposing voluntary assisted dying
assisted dying may not have been sought or considered. It is therefore reassuring to note that, as I mentioned previously, the ministerial expert panel undertook a rigorous community consultation process, receiving and considering 541 submissions, outlining the broad spectrum of views, concerns and opinions.

The words “compassion”, “dying with dignity” and “strict guidelines” run through most communications I have had from those supporting voluntary assisted dying. The overwhelming majority of people in my community have expressed a desire for our society to show compassion and allow people to have the choice to die with dignity, free of pain and suffering, should they desire. When outlining the details of the bill to my community and the safeguards that are in place to meet their desire for strict guidelines, my community seems very satisfied. The comments provided by one of the respondents to my survey quite nicely sum up the sentiments of the majority of people I have spoken to. They said —

Assisted dying should be legalised. It would be far more compassionate to let a person decide to end their own life with dignity, surrounded by their loved ones, rather than suffer in unbearable pain with no quality of life until they take their last breath. It would be wonderful to see our government pass this legislation as soon as possible.

You should be able to die with dignity if you want to. You should be able to plan your passing with your family. You should be able to choose when that time is. Having considered all the views put forward by my community, this bill, in my view, meets all their requirements. I will be voting in favour of this legislation. I commend the bill to the house.

MS L.L. BAKER (Maylands — Deputy Speaker) [10.32 pm]: This is a very complex and confronting debate and I am pleased to have an opportunity to contribute my thoughts on the Voluntary Assisted Dying Bill 2019. I was not sure that I wanted to, or that I was going to spend the time outlining my views, simply because I thought that I had made them pretty public in my constituency anyway. I had an article published in the local paper, and I have run the same sorts of consultations in my electorate that we have heard other members talk about today. I must congratulate the member for Dawesville, though, for an outstanding piece of consultation — well done. I think I have a pretty good understanding of what my community wants as a result of talking, as many of us have, to thousands of people over the past 12 months, or maybe even a bit longer. This issue is clearly not about life and death. It is not that simple or straightforward. This is about a choice that people, in my view, should be allowed to make about their death, when they are already on a journey, having been diagnosed with a disease that means they are facing imminent death.

Although the aim of this bill is to provide people suffering from a terminal illness, or approaching the end of their lives, with a choice about how to manage their journey to death, the process will be complicated and difficult to manage. When we were campaigning, and the Premier was speaking, prior to the 2017 election, in support of voluntary assisted dying, he made it very clear that it was his opinion that it would work only if it could be shown to him, and if he could believe in his heart, that the process we had come to was the best that it could be. I suppose that is why I wanted to speak tonight, because I actually believe that, although this legislation may not be perfect, it is as perfect as it can be in Western Australia at this particular time in our history as a community and a culture. It is very clear to me that this is not about euthanasia, or someone else making a decision about when a person dies; this is about an option available to a person who is over 18 years old, and is facing the end of their life within six months, or within 12 months in the case of a neurological condition such as motor neurone disease. More than 100 checks are outlined in this bill to ensure that someone seeking to end their life is not coerced, and that anyone involved in the decision is safe, including doctors, nurses, relatives and friends. There is an allowance for conscientious objectors to remove themselves from involvement in the process. I have heard that that issue is a worry to people who are concerned about the process. How does a doctor, nurse or somebody who genuinely does not believe that they can be involved in this process find a way out quickly and safely? I think this bill has identified and allowed for that in a very clear and rigorous way.

I know that, right now, if I have an incurable disease and I am suffering beyond medical help, it is legal for me to end my suffering by committing suicide. I think that is an absolutely terrifying notion. From reading the literature, and the evidence from the coroner and others, I found that many of the suicides reported in Western Australia are committed by people with terminal illnesses, and many of those people have had to resort to horrific and quite gruesome and violent means to take their life, often in the loneliest of circumstances. If I have a terminal illness, it is legal for me to refuse all medical treatment, food and water, and to die slowly of starvation and dehydration. My death could take weeks. That is not a compassionate response to an imminent death. It is also legal for my doctor to slowly drug me into a coma while I wait to die, my family watching for days or weeks, or however long it takes, for my suffering to end, and this can happen without my consent. It is illegal for me to ask for help from my doctor if I am dying and suffering beyond medical help. I do not have any legal right, at the moment, to insist that a doctor gives me more or faster pain relief. I may not be in a state to ask for this. That decision is entirely up to the doctor, and that would be a doctor whose personal beliefs about suffering and dying may not be the same as mine. We have heard evidence tonight about various high-profile medical people who have commented about exactly that issue, and also a very strong religious component who argue that issue.
I think Australia has one of the best palliative care systems in the world. But in Palliative Care Australia’s own words, even with optimal care, not all pain and suffering can be relieved. Palliative Care Australia estimates the number of people truly beyond its help at about four per cent. In the words of the father of Australian palliative care, Professor Ian Maddocks —

If compassionate and loving care towards patients and families is what palliative care is all about, then assisted dying is part of that. It is time the profession dealt with it.

I cannot find any independent evidence anywhere in the world to tell me that where voluntary assisted dying laws exist, sick people have been coerced into taking their own lives.

Australian palliative care physician Dr Linda Sheehan’s 2012 Churchill Fellowship study of how these laws work overseas concludes that the slippery slope in terms of risk to vulnerable groups has not been demonstrated by the data.

I have read the emails and messages that have come to me about this complex issue. I have talked to many people, friends and strangers, about their views. I was not surprised that many of those I have spoken to have their own personal experience to share. I think it is timely that I perhaps repeat a few of those that people have brought to me with the specific request that they wanted their thoughts understood by me before I made my choice to vote yes for this. I would like to take you through a couple of them. One is from Carol, an Inglewood resident, who writes —

Many years ago I worked as a young registered nurse in a world-class award-winning medical unit for people with terminal illnesses. Many patients suffered excruciating unremitting physical and emotional pain as they entered the last phases of life. With great courage they faced death and most (including children and adolescents) asked their care givers to cease efforts to prolong their lives because they ready to die.

Palliative care units help many people achieve a 'good death’ but not all. Neither of my parents were eligible for palliative care. Once my father (a medical practitioner) knew he was close to death he signed himself out of hospital and refused to take any more medications even though these drugs were keeping him alive. A medical colleague and friend helped him to die peacefully, painlessly and with dignity. Sadly his wife and children couldn’t be with him because of the risk we’d be charged with assisting a suicide.

My mother’s last months of life were appalling. She couldn’t talk, swallow, eat or walk and she was incontinent. She begged to be allowed to die but the nursing home and her GPs would not cease her medication because ‘nature’ must take its course. Medicine kept her alive not ‘nature’! Therefore my mother who knew what was happening was forced to wear a nappy and was fed by a tube in her stomach. The last months of her life were humiliating and emotionally painful.

Once my parents knew they suffered from terminal illnesses they signed Advanced Life Directives and documented their wishes not to be kept alive once they’d had ‘enough’. After 12 years of profound disability my father chose the time and place of his death. He died in his bed cuddling his beloved dog. My poor mum, still wearing her nappy and being tube fed took several weeks to die. She remained conscious until the last few hours of her life but was unable to tell us what she wanted.

If enacted WA’s Assisted Dying Legislation will eventually help people close to death choose to die in a time, place and accompanied by people of their choosing. They and their families will not live in fear that they may face charges of homicide should the police believe they have aided a person’s suicide.

I ask you as my elected MP to support this legislation

There is another constituent of mine whom I have had many years of discussions with. Mary is a strong animal welfare supporter and writes to me often about her thoughts on a range of subjects, but this came out of the blue today —

This is hard for me to write, but as the bill is in parliament today, I feel I have to write. My husband, Chris, died of cancer when he was 42. We found out in July 1987 and he died 28th December 1987.

…

I took the kids down to see him on Christmas day, by this time he had lost so much weight and hardly recongnized us.

Excuse me for a minute.

The ACTING SPEAKER: Please take your time.

Ms L.L. BAKER: They lived about an hour away from the hospital. She continues —

This was the last time we seen him. He died on 28th December. It was a very very painful death even in hospital. He suffered so much as did our 4 children, they can all still see in their minds that last day …
If Chris had the choice he would have taken his own life. He felt degraded not being able to look after himself he was complete bed ridden. For a man of 42 not being able to hug and kiss your family was the worst thing that could happen he could not talk he could not do anything for himself.

Mary finished by saying —

This is our life, not the Doctors, we should be the ones to our own decisions about our own lives.

... Thank you for reading I hope this gives you an insight to how it affects they families.

I have only a few more comments to make, but one of them comes from a letter that I think we all got on our desks this morning when we came in. It is from Doctors for Assisted Dying Choice. I want to put on the record a few of the comments they made in their letter. The voluntary assisted dying legislation has far more support amongst doctors than has been claimed. Their letter states in part —

... the 2016 AMA survey revealed that 51.5 per cent of responding members are in support not against assisted dying … A survey by Australian Doctor in the same year found 65% of doctors were in favour of VAD.

With increasing public acceptance (now standing at 88 per cent) support from doctors would most likely be even higher today.

... Many throughout WA have been waiting patiently for end-of-life legislation. They do not like the idea of a 5% chance, at the end of life, of having a bad deaths. Doctors will make this Bill work if it passes. Contrary to what the AMA and some individuals have asserted, assisted dying is very much a part of medicine. It will represent an overdue and welcome option in the care of dying.

On careful analysis, we believe that the Bill before the House is excellent and undoubtedly the safest of its type ever put before a legislator. It is the right Bill for WA and it deserves your support. It is compassionate and humanitarian, yet full of safeguards against abuse.

... It is stressed that under the proposed legislation VAD will be voluntary—that is, a matter of choice. This Bill is too important to too many people to allow it to fail.

This is signed by Dr Peter Beahan, Dr Richard Lugg, Dr Alida Lancee, Emeritus Professor Max Kamien, Dr Roger Paterson, Dr Johan Rosman and Dr Ian Catto.

I want to be protected, as I have said, from unnecessary and unmanageable suffering. That is particularly important to me, given I have also had my own experiences, which I will not go into in any detail. It is sufficient to say that my family and I watched my father die a slow and very painful death from cancer. No amount of palliative care or pain relief helped him. My good friend was diagnosed with an incurable disease and died six months after his diagnosis, and my best mate, Liz, cared for our mutual friend for two years while she battled with her long and agonising journey to death from leukaemia. That was just recently. I think many people here knew Mary Del Casale when she was alive. I was talking about Mary.

Unbearable suffering is the thread that binds many of us together as we watch loved ones suffer and die. I understand that others will have a very different world view or want to see their journey differently. I am convinced that having a choice about how to live and, if needs be, how to die, should be central to my existence in the place I call home—WA.

MS S.F. McGURK (Fremantle — Minister for Child Protection) [10.49 pm]: Bills like the Voluntary Assisted Dying Bill 2019 before us tonight are personal, not just for all of us as legislators in this place, but for the thousands of Western Australians who will look to the words spoken here hoping for the passage of this legislation. It is Parliament’s primary function to consider how we best support the members of our community. Every day we come into this place with the aim of improving the lives of the people we represent. Tonight we have an historic opportunity to achieve this aim for not just those confronted by death but also their loved ones, those supporting through to the end of their loved one’s life.

As I have discussed this issue in my electorate and beyond, one thing has become painstakingly clear to me: rejecting this legislation will not save a single life, but passing it will give comfort to thousands of Western Australians and their loved ones. I am proud to support this bill. I want to state from the outset my intention to vote in favour of this important legislation.

I am lucky to say that I have not witnessed painful and traumatic death. On the contrary, in supporting this bill and hearing contributions to the debate, in the lead-up to this bill I reflected on my own experiences, including the

Extracted from finalised Hansard
passing of my parents. Along with my siblings, we were at the bedside of my mother when she took her last breath. It was a great privilege. She was cared for very well at the facility in Wembley where she resided. She had good palliative care. My father had multiple sclerosis. He and his wife, who was trained as a nurse and social worker, had talked through the level of intervention he would have towards the end of his life. He had an advance healthcare directive. When at 80 years of age he had been in and out of hospital with pneumonia and various infections, his wife told us that the advance healthcare directive would be enacted and he would not go back into hospital. It was difficult to comprehend but their choice was very clear. For those who knew him—some in the chamber and the Parliament did know him—he had so much verve and in fact had so many false starts towards the end that I recited Dylan Thomas’s *Do not go gently into that good night* at his funeral. A few days before he died, I went to see him while he was frail. As he was laying on his bed, I asked how he was. “Not too good, kid”, was his reply. They were his last words to me. A few nights later, I was at an event in my electorate and I realised I needed to be at his house. I went over there and was surprised that my brothers were thinking the same. It was in August. The fire was alight in the lounge room, we had a glass of red with his wife, and dad was in the bedroom in a coma by then. We told stories and went in and out of seeing him in his room. It was then that he passed. It is how he wanted it. It was calm, warm, planned and peaceful, as much as it could be. I can only hope that if this legislation becomes law, the same passing can be offered without pain, with some grace and comfort and, perhaps like dad, with a fire, some jazz and a glass of red.

We have arrived at this point because it is clear that an injustice is occurring in our community. For some time, those who have suffered have largely been invisible amongst friends, amongst colleagues and amongst the broader attention of the public. The reason is understandable; the dead cannot talk. For a time, those left in the aftermath have found it hard to talk as well, particularly those whose experiences have been traumatic. But we are all indebted to those who have stepped forward and shared their experiences. As others have observed, our society is not very good at talking about death in the best of circumstances. Instead, we often choose to avoid the subject and place it in the too-hard basket, but this is a conversation that must be had, particularly as our ageing population is demonstrating the time for change is now and it is clear that pain cannot always be relieved for people confronting death. The pain being inflicted across the community and all around the state can no longer be avoided. People confronted by death should not have to choose between palliative care or suicide. People confronted by death should not have to choose between opiates or starving themselves. People confronted by death should not have to make family members choose between breaking the law or ignoring their final wishes. And just as equally, family members should not be forced to sit by the bedside of loved ones who, at the end of life, are in untreatable pain or have lost control. The guilt, the shame and the enduring pain that this horrific confrontation often brings can and must be addressed.

Let us be very clear: this is a law about allowing personal choice for people in our community who are dying. As Andrew Denton succinctly stated in his evidence to the parliamentary committee, this is actually about how we die, not how doctors feel about how we die. I would like to add that this law is not about what the church or any other particular institution thinks about how we die either; it is about what we as individuals think about our own death, because the confrontation that death causes is personal. Let us not be distracted by any other argument. This bill has broken shackles. It has given permission for people to come forward and talk with us about something incredibly important, and they have embraced the opportunity. They have shared their opinions and experiences. As other members have outlined for themselves, I communicated with a number of people in my electorate. Perhaps the most compelling occasion was on speaking to one of the mothers I got to know at the Fremantle Primary School P&C, Lizz Clarke. She was present at some of the demonstrations out the front of Parliament because her husband and the father of their two children, Colin, had been diagnosed with mesothelioma. He is 44. Their family story was profiled in *The Sunday Times* on the weekend. I thought I would share those circumstances. There is a video available on the Go Gentle Australia Facebook page. I am quoting from *The Sunday Times* —

… Colin Clarke has been forced to accept he will die before his children graduate high school.

What he will not accept is leaving them with an enduring memory of a shallow husk of a human being begging for the end.

…

In his own words, he is in no hurry to die. But as a doctor of more than 20 years, he knows when battling mesothelioma death is inevitable and, regardless of the best palliative care on the planet, can be excruciating. That is why, with the help of Go Gentle Australia, he has filmed a plea to all State MPs …

…

In it, Dr Clarke explains that his 14-year-old son and 10-year-old daughter will carry their experience of his death with them forever.

“We, and families like ours, already face immense suffering,” he says. “I want to be able to choose when the pain or the suffering is too much and to end my life on my terms.

*Extracted from finalised Hansard*
“For me, that ideally means at home painlessly with my family there to share last words and farewell me as I drift off into a deep sleep and stop breathing.”

While describing himself as a firm believer in palliative care, Dr Clarke said he had witnessed firsthand that it was impossible to ensure the comfort of every patient.

…

“I have always held the opinion that once death is inevitable it is not a failure if the patient dies, it is a failure if it is a bad death.”

…

He said the knowledge that voluntary-assisted dying was available as an option would provide peace of mind and the strength to keep battling against his disease, rather than contemplating taking matters into his own hands while he was still capable.

“If VAD was there then even if things were feeling too difficult I could hang on a little bit further,” Dr Clarke said.

It is evident that the community has a strong interest in this legislation. It was most noticeable last week when I hosted a public forum with the member for Bicton, Lisa O’Malley, and the member for Morley and Chair of the Joint Select Committee on End of Life Choices, Amber-Jade Sanderson. It may surprise some here to learn that at the forum, the majority of the questions from the 130-plus people in attendance were about why the bill did not go further. I understand that some people in the community will feel the bill is not bold enough, but I also firmly believe that the legislation before us strikes the correct balance between compassion, safety and protection. Members can rest assured that the process has been thorough.

I can confidently state that because of the 730 submissions, 81 hearings and evidence collected from 130 witnesses by the parliamentary committee, that over 860 participants were involved in the consultation process, and a further 541 submissions were received and considered by the ministerial expert panel. With guidance from the ministerial expert panel, which comprised 13 experts from medical, palliative care, advocacy and legal backgrounds, we now have the bill that is before us in this Parliament. At least 15 jurisdictions from interstate and around the world have implemented or are implementing legislation of a similar nature, from which we have been able to learn. In fact, Simon Towler, a former Chief Medical Officer of WA, stated last week that he did not think that any other legislation in the history of the Parliament had been scrutinised as much as this bill.

People are entitled to different values and beliefs. This is what democracy is. But these values and beliefs should never be imposed upon others when they can clearly be rebuked by evidence. When misinformation is spread with the primary objective of misleading people, we as decision-makers representing our communities must stick to the facts. It is important that we remain focused, not on who can shout the loudest or who can talk for the longest, but on what the evidence clearly demonstrates.

We know that the opposition to this legislation will be fierce. In light of this, I want to add my comments to some of the concerns that will likely cloud this debate and how the legislation addresses them. If you are concerned that palliative care will suffer, you can rest assured that this government has invested over $200 million of extra resources into palliative care. We are voting on legislation because we recognise that even the best palliative care cannot relieve all suffering. If you are concerned about vulnerable people being coerced to die, you can rest assured that over 100 safeguards in the bill will protect people’s decisions. We are voting on legislation that is designed specifically for people who are already dying. If you are concerned that people will choose to die because they feel as though they are a burden, you can rest assured that psychiatric and psychological referrals can be made to support their mental health through this process. We are voting on legislation that will require support from third party witnesses, which will encourage deeper discussion. If you are concerned that voluntary assisted dying will lead to doctor shopping, you can rest assured that all decisions will be reviewed by an independent board. We are voting on legislation that will ensure that rigour and safety are applied. If you are concerned that voluntary assisted dying breaks a doctor’s oath to do no harm, you can rest assured that doctors who do not want to take part in voluntary assisted dying can choose not to. We are voting on legislation that gives as much choice to doctors as it does to patients. If you are concerned that voluntary assisted dying laws will lead to a slippery slope, you can rest assured that the long legislative process to enact change is heavily scrutinised and requires consensus. We are voting on the legislation before us, not the possibilities of future legislation.

Finally, if you are concerned that this legislation will set a dangerous precedent, I would say that this is a principle that we as a community have already accepted. We allow cancer patients to stop treatment; we allow life support to be switched off; we allow people in palliative care to refuse food and water. In terms of the choices people are making currently in our community, there is no oversight, no review, no scrutiny, no guidelines and no accountability. However, the single fact that should weigh on people’s minds in this debate is reflected in community sentiment—that about 88 per cent of people in our community support these laws. Really, what I think the community sentiment boils down to is a debate about a fundamental human right: constituents want to be empowered to make decisions about their life and their body. They do not want legislators or other organisations trying to control that human right.

*Extracted from finalised Hansard*
As the Minister for Women’s Interests, I am acutely aware of how this issue can play out publicly. We have seen that in the abortion debate recently in New South Wales. The community is asking us to find a way to make voluntary assisted dying happen in this state, not to find a way to stop it from happening. I am proud to be a member of a party and a government that has the courage to have the difficult conversations and to take decisive action.

I would also like to place on record my thanks to the parliamentary committee and the ministerial expert panel for the countless hours of work that have been put into bringing this bill to a vote. I would also particularly like to thank the countless advocates who have joined us in this fight, including Belinda Teh, who walked from Melbourne to Western Australia in support of these laws, in honour of her mother; Andrew Denton, who founded Go Gentle Australia following the passing of his father, for his realisation that we can and should do better; and Noreen Fynn—who also knew my father and his wife—whose husband, Clive Deverall, carried out his final act on election day 2017, which should serve as a staunch reminder of the choices people in the community currently face. But last, and most certainly not least, I would like to thank all those people who have come forward to courageously share their experiences, particularly those who shared handwritten notes with my office.

We now arrive at the next step in this important process. The decision falls on us, through our voting on this legislation, as leaders of our respective communities. There is no disputing this is a significant bill. We are not starting from a blank page with this legislation. I would urge members not to delay this any longer. The time for consultation is over; the time for change is now. I urge members to consider the evidence that has been presented and to carefully weigh up what their communities want. Do not be on the wrong side of history—choose courage, maturity, compassion, safety and dignity. I know that I will, on behalf of my constituents, in the aim of strengthening our community and for those people who are suffering as they die.

MR M. HUGHES (Kalamunda) [11.07 pm]: Like my parliamentary colleagues who have spoken before me, I have carefully considered my position on the matter of voluntary assisted dying and I support the Voluntary Assisted Dying Bill 2019. Prior to the last state election, I was asked by many voters what my attitude was towards the concept of voluntary assisted dying. At that stage, I was able to say that in principle I would support legislation to that effect but that my support was qualified on the basis that I would have to be satisfied the proposed legislation would be carefully measured and contain appropriate safeguards. I have kept abreast of the issue as my community has lobbied me prior to and since the 2017 state election. I have read the select committee’s report, “My Life, My Choice”, including the minority report.

In early May, I held a community forum on the issue of voluntary assisted dying. I thank the member for Morley and Hon Alannah MacTiernan for facilitating the forum. I have carefully read the recommendations to the government from the ministerial expert panel. I have not struggled to decide to support the legislation. I acknowledge that for other members of the Legislative Assembly it has not been easy. For some members, it could never be countenanced. My constituents clearly know my support for voluntary assisted dying legislation. I have made it clear to them. I acknowledge that there are some among them who have a diametrically opposed view. However, the overwhelming majority of my constituents, in common with the broader community of Western Australia, want this legislation to be enacted. Within that majority, there are those who hold the view that the legislation does not go far enough, and I know they will be disappointed by the conservative nature of the proposed legislation, particularly that access will not be permitted through the mechanism of an advance healthcare directive. The nature of the legislation is measured, the structure of the legislation has been carefully drafted and an important principle of the legislation is that, right to the very end, the person who seeks voluntary assisted dying should be fully able not to proceed should they wish; therefore, advance healthcare directives are not an option.

Despite the claims that the Australian Medical Association is opposed to the voluntary assisted dying law reform, the fact is that the membership does not have a uniform view on this matter. I am aware that Associate Professor Brian Owler, a neurosurgeon and past president of the AMA, speaking to the National Press Club on 12 October 2017, said —

Voluntary assisted dying is not about a choice between life and death. No. Rather, it is about respect for a dying person’s choice, about the timing and manner of their death.

The need for this legislation —

He was speaking of the Victorian legislation —

is plainly evident. Many of those most determined to see this law pass have personal anecdotes of loved ones whose death has been terrible. Not only was the person’s suffering prolonged and unbearable but it left deep lingering wounds in the hearts of their family and friends.

I also note that the Australian College of General Practitioners, with a much larger membership than the AMA, has welcomed the Victorian Voluntary Assisted Dying Act, in contrast to the position of the AMA.

My constituents will be well aware that my career prior to becoming a member of Parliament was as a teacher, and that I spent 21 years between 1996 and 2017 as principal of an Anglican community school. I am amongst many Christians supporting choice for assisted dying. I believe there is nothing about voluntary assisted dying that
It would not be “anti-Christian” to ensure that terminally ill patients avoid “unbearable” pain.

... “One of the key themes of the gospels is love for our fellow human beings … Today we face a terrible paradox. In strictly observing accepted teaching about the sanctity of life, the church could actually be sanctioning anguish and pain—the very opposite of the Christian message.”

But on a much broader front than the opinions of a single eminent cleric, the 2016 Australian election study conducted by the Australian National University found that support for the statement that “terminally ill people should be able to legally end their own lives with medical assistance” was overwhelming, with 74.3 per cent of Catholics, 79.4 per cent of Anglicans and 77.8 per cent of those in the Uniting Church supporting the statement. Of those with no religion, 90.6 per cent were in favour. There is overwhelming community support for this legislation. As Hon David Templeman has said in this place, this is the time for this legislation to be enacted by this Parliament.

Providing patients with control over dying is a palliative process equal in value to the effective control of pain. The legislation before us does not seek to be a substitute for effective palliative care. Voluntary assisted dying is not, as some would have it, assisted suicide; nor is it euthanasia. It provides a means by which a competent adult, facing the inevitability of their imminent death, is able, should they choose, to take control of the process rather than it being left to others. Should the individual choose, choice—an individual and confident choice—is at the centre of this legislation.

I have two older brothers who have died in the last five years. The first died from progressive congestive heart failure. Had he had the option, he would have wanted to have access to the provisions of the proposed legislation—to go out on his own terms, as he would have said. The second died much more recently from the consequential effects of oesophageal cancer. He, I believe, would not have sought access to voluntary assisted dying, but would not have denied others access to it. I will not go into great detail on matters that are essentially personal and very private, but in May of this year, my younger sister, brother and I, in the absence of an advance healthcare directive from our older brother and his lack of capacity, were left to decide to withdraw all medical intervention—no hydration and no nutrition—for our brother, whose death was judged to be imminent. Palliation was begun. It took eight days for my brother to slowly die, with increasing levels of medication to prevent his increased anxiety during the process. Although he was not able to speak to us, he was very conscious of what was happening to him. This was, by default, a decision we took on his behalf. I would rather not have been placed in that position, but the issue of advance healthcare directives is another matter. In that regard, I digress.

The creation of legislation to give effect to access to individual choice in the manner of their death is, I believe, a community good, even though the evidence from other jurisdictions where voluntary assisted dying is available is that few people will use it. The ability to talk openly about dying with an empathetic doctor is seen as a profound benefit that this legislation provides to those who would choose to take advantage of it. When it becomes necessary, putting the means to end life peacefully into the hands of the person who is suffering and no-one else is the greatest safeguard against possible abuse. Experience elsewhere where voluntary assisted dying has been introduced tells us that a person given the opportunity will not necessarily embrace that opportunity unless there is an absolute necessity in their view to do so, and indeed some do not need to use it at all. This legislation places the dying individual human being in full control. It allows a competent adult person to use their intelligence as to how and when they will die, and respects every person’s decision, whatever it may be.

Dr Rodney Syme, awarded the Humanist of the Year at the Australian Humanist Convention in April 2017, reflected on voluntary assisted dying legislation. From his 25-year journey, talking with, not to, people with intolerable and unbearable suffering, and studying the medical and bioethical literature, he proffers six self-evident truths. The first is that dying people may experience severe suffering that may crescendo as death approaches. The second, and crucial truth, is that such suffering will end only with death. The third is the observation that doctors have a duty to relieve suffering. The fourth is that palliative care, despite the wishful arguments to the contrary, cannot relieve all pain and suffering in dying. The fifth is that some people persistently and rationally request assistance in dying. The final, and sixth one, is that doctors have a duty to respect their patient’s autonomy. For those doctors, however, who are unable to accept a role in providing a patient access to voluntary assisted dying under this legislation, there is no compulsion to do so. All they are required to do is provide opportunities for people to receive information about that process.

It has become evident during the course of the debate across the wider community that most people in Western Australia want control over the end of their lives; that is, they want, should they choose, to be given the ability to decide when, where and how they will die. Under the Western Australian legislation, voluntary assisted dying will be accessible only by those people who meet strict eligibility criteria, as detailed in the minister’s second reading speech. The Joint Select Committee on End of Life Choices found that although existing models differ, they all have in common robust legal frameworks that focus on transparency, patient-centred care and choice, and that

Extracted from finalised Hansard
there was no evidence of institutional corrosion of the primary intent of the legislation or what is often cited as the slippery slope. Of the 18 jurisdictions that have legalised voluntary assisted dying—or in some jurisdictions, voluntary euthanasia—only one jurisdiction has made an amendment to their law. All others have remained unchanged. Belgium passed changes in 2014 to permit doctor-assisted death for minors in hopeless medical situations and with their explicit consent. That is not contemplated at all by this bill.

I have had many emails and letters from persons urging my support for the legislation and very few urging my opposition. I might add that there has been a fairly comprehensive email campaign by some peak bodies that are determined that this legislation does not pass. I do not count them as my constituents. However, I do count Janet from Darlington as one of my constituents. She wrote —

I am writing to you in the hope that basic human decency and compassion will guide you in your choice to vote FOR the Voluntary Assisted Dying ... when it is scheduled in the near future.

My sister, who has always been a strong advocate for the right to choose how and when she dies, is now dying of pancreatic cancer, and without this law being in place faces an agonising death.

For the love of all that is true and good within you please remember her, and all the countless others who will suffer a similar fate, and allow them to make this choice for themselves.

Palliative care resources and availability in WA is stretched too thinly to be considered a comfortable way for her and their lives to end. Please factor this also into your decision making process.

I say to Janet from Darlington that this government understands the need to more adequately fund palliative care and has responded to this need with significant increases to the budget allocation for palliative care, as reported to this Assembly by the Minister for Health. The McGowan government has demonstrated its commitment to supporting and improving palliative care services. In the 2019–20 budget, the government announced $47.4 million towards palliative care. This takes expenditure over the next four years to 2023 to a record $206.2 million. We have heard from the Minister for Health that detailed planning has begun to implement the Department of Health’s 10-year end-of-life palliative care strategy released in 2018. This will ensure, member for Dawesville, a statewide policy direction for quality end-of-life palliative care.

Anita of Lesmurdie writes —

Please accept this email as my support for the VAD Laws.

As an individual with debilitating chronic disease ... if this legislation passes it would make my future decisions easier. It would be comforting to know, if I suffer multiple organ failure (a likely outcome as I age). I will have the choice to terminate my existence legally and without causing distress to others.

Currently I am undergoing expensive (to the Government) biologic infusion therapy as well as ... pain relief ... which entails consuming considerable quantities of strong medication. I am only able to work 15 hours a week (this is becoming unsustainable) ... if my condition deteriorates. If my future consisted of being bedridden and unable to function as I wish to, it would cause me a great deal of mental and physical suffering.

I also have seared in my memory, my much loved mother in law begging me to help her end her life. She had terminal cancer which had spread through her body and finally to her brain. Her pain was excruciating despite hospice care workers coming into the home to try and ease her pain. I of course could not help her as I am generally law abiding —

We all know what that inference is —

and had small children to raise. I wish she had been able to have someone support her in this endeavour legally and with dignity.

Mr M. HUGHES: I have read the correspondence sent to me by my constituents, the vast majority of whom want the passage of this legislation. I have responded to individual constituents seeking meetings with me and urging my support for the legislation. I also appreciate the frank exchanges of views from the few constituents who have voiced their opposition to this move. I thank everyone who has taken the time to write to and meet with me.

My support for the bill is grounded on respect for each person to make a considered decision to end their life at a time of their choosing in a way that is safe and supported, providing the option to die with dignity. Sadly, as we have heard, there are those who already choose to end their lives. It is done in circumstances that are unconscionable. The suicide statistics of terminally ill patients are disturbing, with upwards of 10 per cent of people who commit suicide being terminally ill persons. This cannot be allowed to continue. A person should not be denied the option to end their life at a time of their choosing in a safe and supported manner.

It has been argued that palliative care will be able to manage pain and provide comfort for those nearing the end of their lives, but, unfortunately, that is simply not always the case. Palliative care is a vitally important care option.

Extracted from finalised Hansard
Voluntary assisted dying is not a substitute for palliative care. However, when pain and suffering have become intolerable for the individual, individual choice should be respected and the option to voluntarily end one’s life should not be denied.

Michelle of Lesmurdie writes —

As an exnurse who worked in oncology I witnessed the incredible pain of many dying patients. There was nothing dignified or respectful about it. Often it resulted in patients being in immense fear of what was to come. In the event that a person wishes to end their life to avoid such a miserable end and doctors support their decision and prognosis then they have no right to override their final wishes. I am sure many families would be relieved by their loved ones not being put through this due to antiquated legislation."

The Voluntary Assisted Dying Bill 2019 sets out clear parameters that will allow people to access voluntary assisted dying only in very limited circumstances. In order to be eligible, a person will need to be an adult resident of Western Australia with decision-making capacity who has been diagnosed with an incurable medical condition that is, on the balance of probability, expected to cause death within six to 12 months, depending on the particular circumstance, and is causing suffering that is intolerable to the person seeking access. For the small number of people in these very limited circumstances, having personal choice to end their lives will give them some control over the timing and manner of their death. For many more people, knowing that this option is available will provide them with comfort. Some may choose to access voluntary assisted dying but ultimately not administer the drug because they feel a greater sense of control. The reality is that the vast majority of Western Australians, as borne out by the evidence from other jurisdictions where voluntary assisted dying exists, will never want or need or choose to access voluntary assisted dying.

A number of concerns have been raised with me about the protection of vulnerable people and the potential for coercion. These are concerns that I once shared, but I believe these concerns to be groundless. I am now confident that this is a measured and very carefully crafted piece of legislation. The 102 safeguards included in the bill protect the vulnerable and remove the potential for coercion. These measures include the prescriptive multistage process, with safeguards embedded throughout the request and assessment phases that, taken together, establish a comprehensive system of checking, oversight and clear accountability, as well as the limited criteria for eligibility, including the need for decision-making capacity.

Importantly, these protections exist to ensure that people are not being pressured by others to participate in the process. These protections are also entrenched through the offences included in the bill, such as the offence of inducing another person to request voluntary assisted dying; the offence of inducing self-administration of a voluntary assisted dying substance; and the offence of making a false statement—each punishable by imprisonment. I am satisfied that the safeguards address the concerns that have been raised with me about the implementation and application of the proposed framework, and as such I am supporting the bill and respect for the individual’s right to decide. Supporting voluntary assisted dying is a human rights issue—dying with dignity, and giving people the choice, under the safest and most rigorous framework possible.

For people who are nearing the end of their life, where the strict criteria in the legislation has been met and the pain and suffering is no longer tolerable, the individual should have the option to end their life at a time of their choosing and in the most dignified way possible, and this bill provides them with those mechanisms. With that, I support the bill.

MR D.T. PUNCH (Bunbury) [11.31 pm]: I support voluntary assisted dying, as expressed in the Voluntary Assisted Dying Bill 2019. I have made this decision after spending a considerable amount of time thinking about my own values, about living and dying, and about what a “good death” might mean. More importantly, though, I have listened to many people in my community whose views I respect, even though some I may not agree with. Many people I have spoken with have had very personal stories about the death of a loved one, and many still bear the pain and grief of seeing a loved one suffering. I want to especially acknowledge all those people who shared their intensely personal experiences with me over the last few months.

The fundamental reason I am supporting this legislation is that it provides people with choice. It provides people with control over the manner in which they will die, the time at which they will die, and where they will die, when they are suffering from a life-limiting disease and the suffering is intolerable. It puts the person at the centre of decision-making about their life and their death. The title of the legislation, Voluntary Assisted Dying Bill 2019, reflects the core of what the legislation is about—enabling people to seek assistance to end their lives at a time they choose, when they are faced with the likely probability of death within 12 months for neurodegenerative diseases, and six months for other conditions, and when they are experiencing suffering that is not tolerable to them.

In my view, it is assisted dying, not euthanasia, because it is a decision made by the person. There may be an arguable point in those circumstances where a third party has to physically assist with the medication, but critically, the person receiving the medication is still capable of deciding their future and exercising a choice. It is a decision of the person; it must be voluntary, and it must be enduring over time. It is a decision that can be withdrawn by

Extracted from finalised Hansard
the person, should they choose. It is an intensely personal decision that should be made in a climate of compassion and acceptance. I know that for some who are family and friends of the person at the centre of this decision, it may be very difficult for them to accept.

I support this legislation because of my belief in a person’s ability to make a decision that is the right decision for them—a decision that they are deemed legally competent to make, with full knowledge of the implications of the decision, and a decision that is not subject to coercion by a third party. This is a belief that is shared by many in my community, but not all. Tomorrow I will table a petition from more than 200 people who do not support this legislation, and I will do so respecting their views and their right to be heard in this place. Amongst other things, the petitioners are concerned about the possible extension of choice to the notion that eventually assisted dying would be a choice made by others; that it would become commonplace as an option for those who are mentally ill or the elderly; that economic decisions in relation to the cost of health care might drive expansion of the legislation in the future; and that the legislation might lead to circumstances in which the community’s trust in health professions could be diminished. The petitioners also stated their concern about the adequacy of palliative care, which is a topic I will come back to in detail.

I do not share the fear that this legislation is a slippery slope, that it will open the door to reducing safeguards or that it will lead to mistrust. There are 102 components in the legislation that are intended to safeguard the decision-making process, including oversight of each individual decision designed to ensure that the person remains at the centre and the person remains in control. I know there are many in my community who believe the legislation does not go far enough, and that the ability to request an assisted death should be included in an advance care directive, detailing the circumstances under which a person wishes their life to end. There are others who have expressed a view that next of kin should be able to request an assisted death on behalf of their loved one, if they are no longer capable of making that request.

As a parliamentarian responsible for contributing to the consideration of this bill, I thought about these limitations carefully and I have come to the firm view that a person must have the legal capacity to request an assisted death, and that this request must be enduring right to the end. Removing the requirement of legal competence at the point at which a person wishes to take the medication leaves to a third party the final decision about when a person’s life will end. Even though such a decision may be in accordance with a previous expressed wish, the person no longer has voluntary control over that decision, and that makes a difference for me.

The broader eligibility requirements of this legislation also mean that it cannot simply be extended to the mentally ill or to the elderly. It is firmly based in the notion that a person is facing a life-limiting disease and that the associated suffering, as defined by them, cannot be relieved. Aside from the other eligibility criteria, the core of this legislation is the juxtaposition between an enduring decision by a legally competent person, and limited life due to disease and intolerable suffering, as defined by the person.

The notion of choice, though, requires people to have access to full information about the options that are available to them through both palliative care and end-of-life care, and it embodies notions of what is a good death. I personally think a good death is one that is a long way off! But the reality is that we will all die, and some of us here will know that we will have a finite lifespan at some point. It is time we talked about what a good death really means, and that can be tough.

Emeritus Professor Ian Maddocks, Senior Australian of the Year 2013, observed —

“Sometimes I think it’s better to step back and say you don’t need all that procedural stuff, what you need is good care now. You are going to die. Let’s do it well.”

This concept of dying well is the common thread that ties end-of-life choices together, and I want to use the remaining time to explore that concept.

The Australian Institute of Health and Welfare describes seven features of dying well. They include being cared for and dying in a place of one’s choosing; involvement and control in decisions about care; access to high-quality care given by well-trained staff; access to the right services when needed; support for one’s physical, emotional and spiritual needs; having the right people knowing one’s wishes at the right time; and having the people who are important to the person to be supported and involved in their care. These are pretty basic principles. Dying well means that the person is at the centre of those principles. The person has control of what is happening to them, understands what is happening, and has access to information. Care is determined by the person, in partnership with healthcare practitioners, family and significant others. Assisted dying provides an expansion of the choices available to a person and complements their choices within a palliative care framework. It is not a case of one or the other. It is a case of the person being at the centre — defining their end-of-life pathway in order to define what is a good death for them, not a good death as some other person views it.

This pathway can be different for each person. The Australian Institute of Health and Welfare has described three patterns of life-limiting illness. The first is characterised by a short period during which bodily functions decline rapidly, with no sign of recovery, and a relatively short period between onset of the disease, and death. That is found in many cancer conditions. The second is characterised by long-term limitations, with intermittent

Extracted from finalised Hansard
serious episodes, and a slower decline, with intermittent sudden declines, and a longer period between onset of the disease, and death. That is found in heart and lung failures. Finally, there is a pattern of prolonged decline, with loss of bodily function over an extended period. That is found in diseases such as dementia. Each of these would result in a different pattern of care response. The latter group may well not meet the eligibility requirements for access to voluntary assisted dying. These patterns highlight that choice with regard to care implies being given access to viable options. Some of these options are determined by the nature of the disease itself.

Most people wish to die at home, surrounded by loved ones. The Productivity Commission noted in a recent inquiry that accurate data about how many people die at home is limited, because people’s wishes change over time, and these changes are not captured by the surveys. The research estimates that up to 70 per cent of Australians would prefer to die at home. However, the reality is very different. Only about 14 per cent of Australians actually die at home. The majority end up dying in a hospital setting. This is a pretty significant statistic. The majority of people end up dying in circumstances different from what they had wished for. At the beginning of the twentieth century, death and dying was very much a family and community matter. Today, with advances in medicine, the end-of-life experience has become increasingly institutionalised in hospital settings. Notwithstanding the excellent care and support that is provided in these settings, this trend is likely to increase over the next 25 years as the number of older people increases.

Community-based hospice care is a good option. However, it is limited, and in regional Western Australia is difficult to access. In addition, the costs are significant, even though research by Silver Chain shows that hospice care service recipients had, on average, eight per cent fewer emergency department admissions and spent five days less time in hospital in the last year of life, with a greater probability of death occurring at home.

I saw the challenges of dying at home firsthand with two friends, Peter and Helen. Helen had been battling cancer for a number of years and eventually went into palliative care at St John of God Bunbury Hospital. Her overwhelming wish was to die at home, with family. Helen had major problems with mobility, and needed constant nursing care in order to achieve dying at home. Towards the last few days of Helen’s life, the palliative care unit provided a loan hospital bed and equipment to enable Helen to relocate to home, and family and friends came in to support Peter, her husband. Helen achieved her wish. However, in that last few weeks, their life as a couple was dominated by negotiating palliative care pathways that were difficult, not patient-centred, and expensive, and resulted in Peter receiving a serious injury from heavy lifting, which required extended time off work. This was a family in desperate need of support, and it found it largely through family and friends. A palliative care system that embraces community networks would have done so much more to make this family’s experience of loss more bearable.

I support assisted dying legislation. However, I also support the view that we need to rethink palliative care and end-of-life care if we are to maintain genuine quality options to support people to make end-of-life choices. Quality palliative care is not simply about throwing more money at a system that is increasingly providing an institutional response to a person’s end-of-life needs. We need to rethink palliative care as a public health issue and revisit the role of primary healthcare systems, as well as acute hospital systems. We cannot see palliative care solely in the context of professional symptom management and professional nursing management. It is also about how we can mobilise social assets at a community level to ensure that supports are in place for the person and their family between periods of episodic care, and to enable people who are dying to be supported by the people who are closest to them. A recent report from Western Sydney University described the networks and relationships that surrounded people who have died at home, and the struggle around the interface between professional and non-professional networks. Groups in Western Australia, such as Solaris Cancer Care and Dot’s Place in my own community, are good examples of how community assets can be mobilised in support of people and coexist with medically based palliative care.

Two questions are behind the notion of rethinking a community-based approach to palliative care. The first is what work currently carried out by professionals could be performed within the community. The second is what solutions could professionals come up with to provide care for a person who lives remotely from a service centre. The work currently carried out by professionals could be performed within the community. The second is what solutions could professionals come up with to provide care for a person who lives remotely from a service centre. The latter group may well not meet the eligibility requirements for access to voluntary assisted dying. These patterns highlight that choice with regard to care implies being given access to viable options. Some of these options are determined by the nature of the disease itself.
One of the counterarguments to voluntary assisted dying that has been articulated is the need for adequate palliative care funding, especially in regional and remote areas, before this legislation is passed. Voluntary assisted dying should not be a trade-off for more funding. It needs to stand on its own merits, and we need to have the maturity to build an integrated and responsive approach to end-of-life care. Palliative care practitioners need to embrace the opportunity to consider how we might do things differently in the future, recognising that this government is putting in additional funding of over $41 million over the next four years, with a total commitment of $206 million, including enhanced community palliative care services.

I hope I have sketched out a sense of direction for how I think palliative care needs to evolve around a partnership between health practitioners and the community that is person-centred in order to build a responsive and better system. This concept is well supported in the recent literature examining palliative care practice. I believe the bill we are debating is based on compassion, concern and love. The bill provides choice to enable people, who are experiencing intolerable suffering and are dying, to have a different kind of death—a choice that does not resort to people taking their own lives and in so doing leave a legacy of trauma, and a choice that does not involve hazy notions of terminal sedation over a prolonged period or death by dehydration. Quality community and hospital-based palliative care sit side by side with voluntary assisted dying. It is not an either/or. It is not about one system to the detriment of another. It is about genuine choice that puts the patient first. Thank you.

MRS J.M.C. STOJKOVSKI (Kingsley) [11.48 pm]: I also wish to speak on the Voluntary Assisted Dying Bill 2019. When I heard that a joint standing committee would be convened to conduct an inquiry into end-of-life choices, and subsequently that voluntary assisted dying legislation was to be introduced into Parliament, I was concerned, and very conflicted. I value life. As someone who struggled for many years to create life, I could not understand how anyone would want to end their own life. Perhaps the teachings of my Catholic upbringing were also playing on my mind. On the other hand, I would never want anyone to suffer unnecessarily. However, I have never been in the situation of watching a loved one suffer, or die.

As members of Parliament, we have been afforded a number of briefings on this issue, and I have done a lot of research. I could stand here tonight and give many facts and figures collated by governments and organisations on both sides of this debate, but I have chosen a different approach. Despite my trepidation, I decided that the best course was to engage with my constituents, and use my position as their member of Parliament to reflect their views and tell their stories. Over many months I have been collecting opinions, views and stories from my electorate through an online survey; a hard copy of that survey; small forums at retirement villages; emails; conversations, both face-to-face and on the phone; and handwritten letters I have received in my office. As this is such an emotive issue, I also received correspondence from people and organisations outside of my electorate. However, to ensure that I am truly representing my people, I have not included these in my consideration.

I would like to thank those who contacted me, filled in the online survey or attended forums. I appreciate their time, their trusting me with their stories, and allowing me to represent their views on this very sensitive issue. All opinions and views matter, and they are valid. Of all the responses I collected, an overwhelming 84 per cent were in favour of introducing voluntary assisted dying, with less than 15 per cent against and just over one per cent unsure. I would like to first address those who were opposed to voluntary assisted dying. Many of them believe that palliative care can look after those who have a terminal prognosis. They also believe that more funding needs to be given to the palliative care sector. I agree with this—palliative care does need more funding. One respondent said—

I believe palliative care can care for patients’ needs. I have seen both my brother and my mother use palliative care with good outcomes for both.

Many also feared that the safeguards could be eroded in the future, fearing that the safeguards could be altered, offering no protection to some vulnerable people in our community. For most opponents of voluntary assisted dying, the argument was a religious and ideological one, with many of the no respondents providing comments such as—

One of the ten commandments that we should obey is that thou shalt not kill. As Christians, we cannot legalise killing.

This is what got me thinking. Yes, I am Christian, and my husband is Christian, albeit of a different denomination. We send our children to a wonderful Catholic school that teaches our children beautiful Catholic values. At our school, they are called rainbow values—inclusiveness, forgiveness, service, attentiveness, courage, loyalty and personal best. I love that my children learn these in the Catholic school setting. It is a choice that I feel privileged to have. We are lucky to live in a country where this is a choice for us. However, I would never condone making everyone attend a Catholic school, no matter how good I think it is.

I feel that we need to look at this debate in the same way. Yes, I am Catholic and I may never choose to access voluntary assisted dying, but not everybody in Australia, Western Australia or even my electorate of Kingsley is Catholic. In fact, only 23 per cent of the people in my electorate are Catholic. I was elected as the member for Kingsley, not as the Catholic member for Kingsley, so how could I in good conscience make a decision based on my religious beliefs that are not held by everyone in my electorate? I live in my community, I see community members every day, at the school, the shops and weekend sport, and I do not feel that it is my right as their elected member and voice in this Parliament to impose on them others’ religious belief that they may not share.

Extracted from finalised Hansard
I understand the conflict of those who were unsure over this issue. Some of the comments they raised resonated with me. One respondent said —

My strong Christian belief makes me want to say “NO, thou shall not kill”. This is my belief. But, the thought of people in great pain having to wait in agony to die makes me want to say “YES”.

Others wanted to ensure that the safeguards in the legislation were adequate. I, too, had concerns about this. I needed to satisfy myself that this bill would not allow for elder abuse or coercion and would also protect people from feeling that they should pursue assisted dying because they are a burden on their family. I am confident that the conservative nature of this bill is robust and it is meticulously crafted to ensure the highest level of safeguards. There are 102 safeguards built into this bill.

I hope that I am never in a situation that would make me eligible to access voluntary assisted dying. I do not know whether I would ever be able to undertake it. I think for me personally it would be very hard, but should that mean that I should prevent others from accessing it? It seems I am not alone in this thought. Another respondent said —

As a Christian I believe that God decides when we are born and when we die. BUT (despite some community comments!) Christians do not force their moral beliefs on others in the community as long as Christians are free to live according to their beliefs, so we would not deny others this choice of assisted dying.

Now to those who are in favour of voluntary assisted dying. There were so many passionate comments and stories that I will be unable to outline them all here tonight. Stories of their parents, husbands, wives, siblings and friends touched my heart. It is clear that most people want to live, and fight to live, but there comes a point when life is too painful, the suffering is too great and it is not a choice of life or death anymore. Many of my constituents echoed these sentiments —

This should be legalised as too many people are suffering in agonising pain for too long just waiting to die.

The pain for many was still so raw even if it had been many years since their loved ones had passed. One constituent wrote —

My husband had two different cancers. After two courses of chemo he had a seizure and was never the same. He spent 6 weeks in hospital and then he was discharged and was home for 4 weeks. There was no palliative care bed available, morphine did not cope with his pain. He asked me and his three children to help him die. He lost the use of his legs. He went into Hollywood Palliative Care respite for a few days. He told the nurses he wanted to die and he was put on the morphine pump (once on you cannot go back). He died two days later. I had PTSD afterwards. It was the worst months of my life.

Another wrote —

Everyone should have the right to choose how to end their lives. Nobody should be forced to suffer unnecessarily. I’ve seen what it’s like to die from cancer, and that is not an end I would wish on anyone. When the end is inevitable, what is the point in a couple of extra weeks full of pain and drugged to the eyeballs? I would rather be able to say my goodbyes and go peacefully on my own terms.

Another constituent said —

Watching someone die is a very gut wrenching experience especially if they are suffering. My mother resorted to killing herself at age 59 due to untreatable and intolerable pain from terminal cancer. She died alone in the back yard of her home.

This is not an issue that affects just the elderly; I know of a man, not much older than I, who suffered from an aggressive form of multiple sclerosis. He was a proud man, with a young family and a promising career. The mental toll and physical suffering he endured in the later years of his life were almost too much to bear. I know that he told others, “Let me die”. He just wanted to die but he was never afforded that dignity. Instead, he continued to suffer and deteriorate until he did eventually die in pain.

Should we allow his suffering just to appease our own uncomfortableness? I do not think so. There are hundreds more stories I could share here tonight but the message is the same. The ability to end suffering is a humane one. This was really brought home to me recently when I had a conversation with two people in my electorate who I know are very religious. They both hold the Catholic teachings close to their heart and they said to me, “Voluntary assisted dying is not a choice between life and death; it is a choice between a peaceful, calm death and a painful death after many weeks or months of unnecessary suffering.” I know many of you who are in favour of voluntary assisted dying feel that this bill does not go far enough, that it should enable advance health directives for those suffering from dementia. However, I do feel that this decision needs to be made by an adult with the capacity at the time.

While at the beginning of this journey I was conflicted and, clearly, it is still emotional for me, tonight I stand here confident that in voting yes for voluntary assisted dying, I am representing the majority view of my electorate.

Extracted from finalised Hansard
and allowing dignity for those who are suffering intolerably to end their life. This is the compassionate course. I hope here tonight that I have represented the views of my electorate in a compassionate and understanding way, whichever way they gave me. Thank you.

**MS S.E. WINTON (Wanneroo)** [12.01 am]: I, too, rise to contribute to the Voluntary Assisted Dying Bill 2019, which we have been debating today. I have to say at the start that it is a privilege to represent Wanneroo as we debate this historical bill. It is a deeply personal issue and, as a society, we do not like to talk much about death. It is highly uncomfortable for all of us, yet death will come to all of us. It has been quite amazing to be here in this place to listen to the many stories that my fellow members have shared with us as part of their contribution to this bill. I have to say I am very proud to be part of the fortieth Parliament as we as parliamentary colleagues grapple with this most important issue.

I want to start by quoting from the Minister for Health’s second read speech. I read this out to a couple of retirement villages I visited last week and their reaction was very strong, so I want to read it again. It states, in part —

Voluntary assisted dying is not a matter of a choice between life and death. It is a choice for those who are going to die, for whom death is inevitable and imminent, but who can exercise the autonomy which is at the heart of what it is to be human—the exercise of free will.

It is important that this not be a choice about life and death; we are talking about people who are going to die. Further on in the minister’s second reading speech he states —

I would like to emphasise that this bill has nothing to do with euthanasia. This is about providing assistance to someone who is already dying. It is not euthanasia and it is not suicide. It would be wrong to confuse voluntary assisted dying with suicide. The bill specifically provides that voluntary assisted death is not suicide. Suicide involves the tragic loss of life of a person who is otherwise not dying. Voluntary assisted dying involves a person’s choice about the manner of their death when faced with inevitable and imminent death as a result of an incurable disease, illness or medical condition.

I think the distinction the minister made at the outset of the introduction of this bill is really, really important.

I want to also take a couple of minutes to highlight and recognise the incredible amount of consultation that has gone into the preparation of this bill. It is that consultation that gives me the confidence that this bill is a safe and cautious bill for our community. Of course, in August 2017, the Parliament appointed a joint select committee to inquire into the end-of-life choices. It ran for over a year and received over 700 submissions, held 81 hearings and heard from more than 130 witnesses. After a year, it tabled its report, “My Life, My Choice”. I congratulate the chair of the Select Committee on End of Life Choices, the member for Morley, for the work that committee did. It made a number of recommendations and, of course, the most important one, or the reason we are here now, is that a bill be brought to this place around voluntary assisted dying. Another key recommendation was to establish a ministerial expert panel and, of course, that was chaired by Malcolm McCusker. That panel heard from 867 participants and organisations during its consultations. That report provided key recommendations, which assisted in the drafting of the legislation. The government carefully considered all those recommendations, but has chosen a very cautious approach. As other members have said, for some, the legislation does not go far enough and, for some, it goes too far. The point I am trying to make, and have discussed with people in a retirement village, is that there is strong support in the community but also frustration about why this is taking so long. Six previous attempts have been made in this place to pass this sort of legislation but they have all failed for a variety of reasons. I think the approach that has been taken in drafting the legislation we are debating now gives us confidence that we have got it right.

I have also undertaken my own consultation in my community, as have many other members in their community. I held a forum in March attended by the member for Morley and the member for North Metropolitan Region, which was really well attended. I have doorknocked and held surveys online and by letterbox. I am in no doubt at all that there is overwhelming support for this legislation. I have heard many stories from members in my community, and many members have shared stories from their communities. The consultation has been extensive and we have now crafted a bill that is cautious and has the best chance of succeeding.

In terms of eligibility, a person who wants to access this legislation is required to be someone who is 18 years or older; they have to be an Australian citizen or permanent resident; an ordinary resident of WA; and they have to be diagnosed with a disease, illness or medical condition that is advanced and progressive and will cause death; and the condition will, on the balance of probabilities, cause death within six months or 12 months in the case of a neurodegenerative illness. There are two more important points. The person is experiencing suffering that cannot be relieved in a manner that the patient considers tolerable. It is important to understand that language because this is all about the patient, not about what a medical practitioner or the medical profession deems tolerable. This legislation is based around the patient. Very importantly, the patient has to have decision-making capacity assessed throughout the various stages and it must be enduring.

There are many different views out there and a lot of misinformation has been around since the start of this Parliament and since we started work to get us to this place. However, the truth is that this bill is for those in our
community who are at the end of their life and who want the right to choose a death that is dignified. The truth is
that there is nothing to fear in this bill. I am absolutely confident that this bill addresses the concerns that have
been raised with me and that have been raised through the various consultation processes. The bill proposes
a systematic process through which a person may access voluntary assisted dying. There are over 102 safeguards.

I have listened to the voices of my community. I stand in this place to say yes on behalf of the overwhelming majority
of the people of Wanneroo who want us to pass this bill. I fully support this bill and its safe passage through this
chamber and the Legislative Council. We have an opportunity to create a more compassionate community in which
we respect people’s rights to choose how, when and where they die and with dignity. Thank you.

Debate adjourned, on motion by Mr D.R. Michael.

Legislative Assembly
Thursday, 29 August 2019

[page 6088]

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from 28 August.

MRS L.M. HARVEY (Scarborough — Leader of the Opposition) [9.37 am]: I rise to contribute to the debate
on the Voluntary Assisted Dying Bill 2019. At the outset, I will say that I am still undecided on whether or not
I will support this bill. I have some questions to ask during the consideration in detail stage and I need to use that
process to better understand how this system will operate. I need to understand the following: How strong are the
safeguards? How can we ensure that vulnerable people are not unfairly coerced? How will this legislation be
delivered in regional and remote Western Australia? How do we ensure that people with treatable mental health
issues are not accessing voluntary assisted dying outside the intent of this place in passing this legislation? How
will this be funded and what are the expected costs? How will the guidelines for doctors be managed?

I know that the government, which has a large majority in this place, has the numbers to pass the bill. I am not aware
how the votes will fall in the Legislative Council. Nevertheless, on a conscience vote, all members have a responsibility
to properly scrutinise the legislation and ensure that we mitigate any potential adverse consequences as a result of
this bill becoming law.

This is a difficult issue and a very confronting debate. Each individual in this place brings forward their own life
experiences and their own traumatic experience around terminal illness and loss. Indeed, the debate triggers the
grief loss for most people as we contemplate this confronting issue. Debate has been raging in the community for
a long time and the lobbying of members of Parliament has been relentless. I am also very conscious that my
position as Leader of the Parliamentary Liberal Party has put me front and centre of this debate because of my
own life experiences and the leadership position that I hold. This has caused significant pain for some of my family
members when they see comments in the media that trigger our grieving process again. Although commenting on
these difficult issues is part of my job, I can never be certain when photos, or even which photos, of my late
husband, Hal, might pop up. I cannot always be out there alerting family members to stories that might eventuate,
and, in any event, if a photo is used, it still brings the sense of loss to the fore no matter how much warning is given.
I can only ask my family for their forgiveness and thank them for their understanding of the difficulties that being
related to a member of Parliament brings and for their love and support regardless of the public nature of the job.

Should this legislation pass both houses of Parliament, I understand that we will be only the thirteenth jurisdiction in
the world to have introduced this legislation. I am not sure whether that makes us more advanced or compassionate
as a society. I have listened to many members’ contributions to this debate, both in this chamber and outside this
chamber through the media and other forums. The Liberal Party’s position has been very clear from the outset that
this would be a conscience vote for Liberal MPs. A conscience vote means that members should vote according to
their own conscience, experiences and ethics, and, importantly, in consultation with the community that elects them.
My expectation is that the conscience vote will reflect the views of the community on voluntary assisted dying. We
are a reflection of the community that we represent. Although there appears to be majority support for voluntary
assisted dying in the community, there are also those within the community who oppose it for legal, personal,
religious or ethical reasons. Every view is important and valid, and should be respected. There are no right or
wrong views on ethical decisions, and Parliament should rightly reflect the range of community sentiment on this
issue. This debate should be respectful of all points of view.

In considering this legislation, I have read the Joint Select Committee on End of Life Choices report “My Life,
My Choices” and the report from the Ministerial Expert Panel on Voluntary Assisted Dying. I have read hundreds

Extracted from finalised Hansard
of emails from many people from my constituency, from across WA and indeed Australia, and I have attended many briefings. I have canvassed the issue with friends and family, and feel very grateful to belong to a large family, with sisters, aunties, nieces and nephews who are nurses, and I am proud to say that I have a niece who is studying to be a doctor. We have a large and extended family, and many members have succumbed to difficult diseases—mesothelioma, pancreatic cancer, emphysema to name some. In that context, I will outline some of my concerns with the legislation that I will raise in the consideration in detail stage.

One concern I have with this bill is that there is no compulsion for people requesting VAD to have a proper mental health assessment. By that I do not mean waiting for months on a waiting list to see a psychologist or psychiatrist, but a sit down with their GP in a long appointment to discuss how they are feeling about their illness, their life, their families and relationships, and also how their illness is affecting those close to them. A good GP will be able to assess whether a person has depression. Indeed, many GPs have a diagnostic survey that they use to refer patients to a psychologist for Medicare-subsidised counselling services. Many patients who have terminal and chronic illness may have never sat down with an independent medical professional to discuss their feelings about their predicament, and I think it is important that this happens.

My concern about this comes from looking through the prism of my own experiences. I have, as most people know, been through the difficult, sad and traumatic experience of caring for my late husband, Hal, while he fought pancreatic cancer. By way of background, a CT scan revealed a tumour on Hal’s pancreas on 30 June 2011. He had developed jaundice, which took us to the GP who ordered the CT scan. We had the scan in the morning and I received a phone call from the GP. He said, “I need to see you both, together, after the surgery closes at 6.15 pm.” The dread of attending that appointment is still palpable. From there we had a series of tests followed by surgery on 12 August. The surgery could not successfully excise the tumour and, of course, the next question we had was how long. We were told to get our affairs in order and they would try to get us past Christmas. Our children were 11 and nine; my stepdaughter was in her early twenties and our grandson, Riley, just a toddler.

It was devastating news to receive. Hal sank into a funk. Understandably, he became depressed and did not want to go through the treatment. He wanted to take our family to Switzerland where he could access voluntary euthanasia. I made it very clear to him that I would not be going on a holiday to knowingly bring him home in a coffin, but I would find him a good clinical psychologist so that he could talk about how he was feeling. I also said that I wanted to be able to look our children in the eye and tell them that he had fought hard to stay with them. Hal went to see the psychologist, who said he was in a grieving process and that he was mildly depressed. She said it was normal for people to feel this way when they receive a terminal diagnosis. Hal had several sessions with her and thankfully decided that he would give treatment a go. Through those counselling sessions, he also learnt that the biggest issue for him was that having worked so hard all of his life he was never going to enjoy the retirement we had planned.

We commenced a gruelling treatment program of radiation therapy, and chemotherapy, week in week out, with regular tests to map the success or otherwise of the treatment. Waiting for test results was always incredibly stressful, and usually accompanied by many sleepless nights and heightened levels of anxiety. We also got started on bringing the retirement forward and used the next three years to use the breaks between chemotherapy treatments to take the family on Hal’s retirement. He took Elizabeth and Sarah to Italy, and Jack to Papua New Guinea to fish. We all went fishing together at Scott and Seringapatam Reefs, the Kimberley rivers and False Entrance. We did the Gunbarrel Highway and the Gibb River Road, to mention a few. We did all this in the three years post-diagnosis, when his life expectancy with terminal pancreatic cancer at that time was less than six months, and he had wanted to opt out within the first six months.

My fear in not having the requirement for a mental health assessment included in this legislation is that using our family as an example we would not have had those three years of memories with our children, bearing in mind that those three years are the difference between my youngest losing their father at the ages of 14 and 12, versus 11 and nine, and Hal taking his eldest daughter down the aisle at her wedding and welcoming a second grandson, our gorgeous Orlando, into our world.

Another concern I have with this legislation is about proper safeguards for vulnerable people. Once again from my own experience, the last year of Hal’s life was really difficult. Our family had the benefit of having extended support from family and friends. Hal’s mum was with us every day; his sisters and families, my parents and siblings, Sarah and Shane, and an extensive network of colleagues and friends were there to support us. We met many people along the way who had little to no family support. We shared a ward in Royal Perth Hospital with a fellow who had been chronically ill for a long time. He had no sick leave left. His wife was working double shifts to pay the mortgage. The kids were overseas and not involved. He was in hospital getting visits between his wife’s shifts at 9.00 to 9.30 pm. That was his life. How would VAD feel as an option for that family going through their worst moment unsupported? VAD should not be an option because of financial hardship and lack of emotional support. The legislation must contemplate providing support for individuals in those scenarios so that they only access VAD for their medical symptoms, not because of financial pressure and emotional neglect.

I am also concerned that the legislation must ensure that no-one can be coerced into accessing VAD. I know that whenever this is mentioned strong proponents charge in emphasising the words “It’s voluntary; it’s voluntary.”

Extracted from finalised Hansard
We must ensure that a decision to access VAD is truly voluntary, and I will explain a little about the subtlety of coercion. Towards the end of our journey, Hal was heavily medicated. He had psychosis, which I am told is fairly common. He had lost lots of weight and weighed only 52 kilograms, having dropped from over 80 kilograms when he was diagnosed. We had visitors: friends and colleagues from the fishing community and others, who would come and visit. They were understandably upset at seeing the physical state that he was in. But Hal could not understand why they were so sad. Hal would ask, “Why the doom and gloom. I feel fine. I’m going to beat this thing.” He remained so positive right until the end.

But I would be counselling friends outside his room, who would be saying, sometimes loudly enough for Hal to hear, “How can you let this keep going? I wouldn’t let my dog die like this.” I cannot tell you how heartbreaking and distressing it is as a carer to have your cherished family member fighting for their life while others, no doubt dealing with their own trauma and issues, were making comments like that. I would have to intervene and have conversations along the lines of, “So, is he happy?” And he always was. He had a big smile on his face for every visitor. Did he talk about anything other than where his next trip was going to be? Did he say he was fed up and wanted to end it? The answer was no. Despite his poor physical condition, he was not contemplating anything other than fighting the disease. Our family was only interested in supporting him through it, but for others watching, they felt he should be released from his perceived suffering.

The pressure is subtle and sometimes it is overt, but the pressure is there. I had to have these conversations not with everybody and certainly not with our devoted immediate family, but with well-meaning but ill-informed friends who could not cope with their own distress in witnessing the ravages of terminal cancer. I then had to go back into the room, draw on Hal’s amazing courage, and support him through the next day. People can be very indiscreet with conversations like that. For patients, and particularly elderly patients, they might feel it is a better option, to feel less of a burden, to access VAD. That should not be possible under any regime. I accept that the government believes that the legislation will not allow this to occur, but it is still a concern, and I will need to be convinced that the legislation will contemplate managing this scenario.

There is also the issue of elder abuse and inheritance from patients. The very sad statistic that 40 per cent of elderly people in aged care have no visitors each year is disturbing. How would I feel about that—to be stuck in an aged-care facility with no family or friends bothering to check on me and having no-one care about me except paid workers? Would VAD be an option in those circumstances? Quite possibly. Is that appropriate? One would hope that a compulsory mental health check would rule that out. Many of these elderly people are on medications for heart and blood pressure and other illnesses. Should they decide to refuse those medications, their prognosis may then fit the criteria for VAD. Would this scenario be acceptable under the legislation?

I have serious reservations regarding the access and management of VAD in regional and remote areas. As has been mentioned by others, there is inequitable access or, in many places in regional and remote Western Australia, no access, to palliative care services. The parliamentary inquiry revealed the extent of this problem. It must be tackled. I accept that the government is attempting to tackle it by starting to fund that program. While I accept that funding has been allocated, there is a gap. We have a capacity problem in that there is an insufficient number of trained individuals in this important area of health care.

[Member’s time extended.]

Mrs L.M. HARVEY: I would not like to be in the situation, for example, of someone who has lived in regional or remote Western Australia all of their lives who receives a terminal diagnosis and, in the absence of palliative treatment options other than in the city, chooses VAD in lieu, so that they can end their life at home rather than in a hospice in the city. The minister will need to explain how the telehealth option will work in the context of Commonwealth legislation. I know he is aware of that issue.

As mentioned by the member for Dawesville, the statistics around the health of our Indigenous community are of concern. Given the prevalence of chronic illness in our Indigenous population, we will need to fully understand how VAD will work in remote and regional WA for those traditional owners who wish to die on country. Who delivers their care at end of life? How does VAD work in that setting?

I have other concerns that I will raise during the committee stage of this bill. However, one aspect that has not been adequately explained is: who will provide these services and how will they be funded? There are private palliative care providers that are unlikely to want to participate. Will the GP visits to request VAD be publicly funded or will there be out-of-pocket expenses? Will the schedule 4 and schedule 8 substances that will cause the death of those accessing VAD be funded through the pharmaceutical benefits scheme or will the patient have to pay the full cost? How much will that cost? If the PBS does not subsidise the prescription, will WA taxpayers be funding the drugs? And how do we make sure that the medication is secured properly while in the custody of the patient who wishes to access it? How can we be sure that once they have taken it home, they make the choice to use it in their own time and not at the coercion of potentially impatient relatives?

To conclude, this issue is complex and confronting. I completely understand why people want voluntary assisted dying. I respect that people want to have choice and control over the way they might die due to terminal illness.

Extracted from finalised Hansard
One of my sisters, who is a nurse and who joined the rally to Parliament House to support Belinda Teh, deals with utterly dreadful ulcerative head and neck cancers. I know from talking to her that while pain can be managed in most circumstances, palliative care cannot mitigate some of the horrible aspects of disease—the sheer discomfort of advanced disease. However, we must also realise that for most people with advanced disease, pain and symptoms can be managed comfortably. The fear people have of end-stage disease and death is what drives the push for voluntary assisted dying.

I am haunted by the words of our wonderful palliative care nurse, Lou, who has worked in the palliative care sector for over 27 years. She said that in all that time, she has had three patients who wanted to have access to voluntary assisted dying. She said their circumstances were utterly dreadful—simply awful. But she said that every single day, she would have a relative or friend of one of her patients say those words: “Can’t you do something? He or she has clearly had enough. They have no dignity. This has gone too far for too long. You wouldn’t want this. This needs to end.” In passing legislation to assist those three, whose circumstances, with the best palliative care provision, were still too dreadful to continue, and have them seek an earlier death, we must be very careful to ensure that there is no pressure on the hundreds of others who are not seeking an earlier death, even though their closest relatives might be seeking an end to their real or perceived suffering.

I am eternally grateful for my family supporting my late husband through his illness and that we could afford the psychological support for Hal. He never contemplated accessing voluntary euthanasia again. All of our immediate family support network were totally focused on supporting Hal’s desire to keep fighting and beat the disease.

In closing, I would like to thank the many constituents who have contacted my office by email or phone and respectfully related their views on this issue. I can assure those both for and against that I will keep your views front of mind while we continue this debate and I determine where my vote will land.

[Applause.]

MR J.R. QUIGLEY (Butler — Attorney General) [9.57 am]: Madam Acting Speaker, I stand before you without a prepared speech. I just want to give you some of my reflections on this important legislation. When I say “without a prepared speech”, it is a subject to which I have given some years of thought, because as a practising Catholic, although a stumbling and by no means a good example of one, I am nonetheless informed by the tenets of that faith. When the party went to the election on the promise of introducing this legislation with a conscience vote, I had to start giving the matter early thought. I was conflicted during that period of time, and, might I say, I badly, but humbly, offered thoughtful prayer on this matter and where I would stand when it came before the Parliament. I do not want to keep anyone waiting: I will be voting firmly yes. It befalls me, therefore, to explain to the Parliament, and most of all to the people of Western Australia, why I will be voting yes.

This bill unfortunately has been mischaracterised by subeditors at The West Australian, not by the writers of The West Australian. I note that an article in this morning’s newspaper states that voluntary assisted dying will be available to those who will probably die, on the balance of probabilities, within six months. That is not an accurate reflection of clause 15(1)(c)(i) of the bill, which states —

is advanced, progressive and will cause death;

The first test is that that which the patient is suffering from will, not on the balance of probabilities and not even beyond reasonable doubt, but as a matter of certainty, cause death. The balance of probabilities test comes in only when “when is this death going to occur?” On the balance of probabilities, this certain death will occur within the next six months. That is a nuance, but a very important point to make by the media if they can find the time and if the subeditors can fit that into their articles.

I do not intend to now go to the provisions of the bill otherwise, because they will be debated in the consideration in detail stage. We have all been heavily lobbied in the period leading up to this debate. I want to tell members about some of the lobbying I have received as a member of a Catholic community. I went to my daughter Lily’s first Holy Communion—a significant event in the life of a young child brought up in the church. My daughter was looking angelic in her white communion gown. I had been to all of the preparatory lessons with her. All the little angels were sitting in the front three rows and the parents were in reserved seating behind those three rows. I watched with both humility and pride as my daughter Lily, who is turning 10 in two weeks—she reminds me of that faith while we continue this debate and I determine where my vote will land.

Extracted from finalised Hansard
the ABS statistics who say that they are of no religion. “No religion” now tops the pops at 31.1 per cent of the population. Catholics come in at 22.6 per cent—they are only nominal Catholics; they are not ones who are going to church every Sunday—Anglicans at 13.3 per cent and the Uniting Church at 3.7 per cent. The majority of the population as a group are those who signify no religion.

There we are at First Communion and father says, “We don’t want any of this euthanasia.” That is a big error; it is not euthanasia, Father Richard. He then goes on and says, “So we want you to contact the politicians.” It was a full congregation because it was the celebration of the First Communion. He said, “We want you to contact the local politicians to tell them that we don’t want euthanasia.” But that was not the end of it. Father Richard then pointed me out in the third row and said, in church, “There is the Attorney General, Mr Quigley, so you can all approach him and tell him you don’t want euthanasia.” I had no issue with that because that was in the Catholic church that I visit voluntarily. I could not go there or I could not listen—that is my choice. He pointed me out. At the end of mass, the first communicants were having their photos taken. Anyone here who has been to one of those services would know that families have their little kids up in front of the altar. I was one of the last families to leave. I purposely positioned myself at the back of the church just inside the door. Father Richard was outside. I have never reported back to him the results of his invocation to the community to approach me and say “no”. As he approached me and made this invitation in a public place, I am sure he would not think it discourteous in any way that I respond in a public place. Father, the result was that not one of your parishioners approached me—not one—to say, “Don’t do it, John.” Not one of them even came by, sort of embarrassed, with their thumbs down. Furthermore, my daughter attends the Catholic school up there, and we are on an email list. Not one of the parents sent me a private email saying, “Don’t do it, Johnny!”—not one of them.

Following my attendance at that mass, my wife and I had arranged a dinner. I think members would know what they are like. After First Communion, there is a celebratory dinner. It was at a big Italian restaurant with a long table, with the parents drinking red wine and eating pasta and the kids running around in their little white frocks. We tried to hold them at the table but it was impossible. All the adults at the table had been parishioners at that mass. Some of them said, “That was a bit tough the father pointing you out and saying that everyone should go and see John and say no.” I said that I went there as a voluntarily person. In a democracy, why would I take offence there? However, each of the adults at that table who were in that congregation said, “John, if there are enough safeguards, you must support that legislation. You must give the population the option.” They were all the people there who heard the sermon. They were all the people who were asked to come and tell me no.

I say this: I would disagree with the Premier on one small point, but this is a conscience vote so I am allowed to disagree with the Premier on one small point. As a Christian, if I enter a room and there is a poor person dying in pain on the bed and the person is one of the 30.1 per cent of the population who thinks that everything I believe in is hocus-pocus and a myth, a fairytale written centuries ago, and says, “John, can you pass me that glass there because I want to drink that potion”, this is where I disagree with the Premier. We are not looking death in the face here; we are looking at dying humanity in the face here. I am not looking at a dead man, Premier; I am looking at a living man who does not believe in God, Christianity or a life after, but who turns to me, a Christian, and says, “John, can you pass me that cup to drink from?” How can I, in charity, deny a non-believer and say, because of the tenets of my belief, “Suffer on, baby; suffer on”? That is not a Christian attitude.

I reflected on and was moved by the Leader of the Opposition’s speech and the journey that her late beloved husband, Hal, went upon—a journey that he chose to go upon, that may have had something to do with St John of God on Scarborough Beach Road. It may have had something to do with Catholicism. It may have had something to do with all of that, and will inevitably have something to do with the decisions I make when my time comes. But that is voluntary. I do not have to visit my views on someone who thinks that I am stupid and that I am a grown man believing in myths. I cannot force that on someone who does not believe because that is in my mind unchristian. I remind the Parliament—I do not want to be here as a bible basher—that when God sent his only son to earth, he did not send him to Rome to heavy the senators to change the laws to stop mass execution by crucifixion or to free the slaves. He just sent him to live amongst the poor to live a life of perfect love and charity and to set for all an example. He did not put upon religion to change the laws of earth. Indeed, it was Saint Augustine of Hippo, one of the great saints of Christianity, who first wrote in the late fourth and early fifth centuries of the separation of the law of state and the law of heaven, and how we on earth cannot write laws for heaven. On earth we can write laws that we can try to create that will allow for an orderly, civil, peaceful and loving community. I am sure that everyone here aims for that—a quiet, peaceful, gentle and loving community.

[Member’s time extended.]

**Mr J.R. QUIGLEY:** When I was listening to the honourable Leader of the Opposition, I was reminded of the words of Dylan Thomas in his famous poem, *Do not go gentle into that good night* in which the protagonist is leaning over his father urging him to rage, rage against the fading of the light because that is what we humans want to do; we want to rage against the fading of the light. I have witnessed that firsthand. I had cancer. I had T-cell lymphoma, which is what the former head of the Cancer Council died from. I am sorry, Premier —

**Mr M. McGowan:** Clive Deverall.

*Extracted from finalised Hansard*
Mr J.R. QUIGLEY: Yes, Clive Deverall. I had the same diagnosis. I attended every week for 15 months at the Peter MacCallum Cancer Centre in the long chemo room where the pervading noise was bip-bip-bip of the 30 or 40 chemo pumps going off. I took my position on a weekly basis with the same people. I saw people ailing and ailing but still getting the shunt—still getting hooked up because they were raging against the fading of the light. But there comes a point at which they do not give up, but at which the pain overwhelms the rage. Every time the light goes on, they are living in pain. It is only when they are unconscious that they get relief. I have witnessed it. What would I say to a person who had a potion on the bedside, “John, could you pass me that cup?” As a Christian could I say, “No, I will not.” That seems to me, after a lot of prayerful contemplation, against every tenet that I want to live by. It was Saint Paul who wrote that the gospel was written not just for Christians; it was written for everybody—but not everybody has to believe it, nor everybody has to embrace it and not everybody, thankfully, has to fall off their donkey on the way to Damascus. Not everyone has to believe it. Those who do believe it take a burden upon themselves to try and live it. I fail on a daily basis; I am sorry. What my colleague the member for Scarborough described is her beloved late husband choosing an option—surrounded by family and supported. There are some who are not in that situation. There are some whose disease is different, whose pain is so excruciating, as described by the honourable Premier yesterday, that they want to choose another option. Who am I to stand here in the Parliament of Western Australia and say, “You can’t have that option because of what I personally believe”?

Out in Butler, I gave them a veritable flogging with an 18.5 per cent swing. I got the 18.5 per cent swing on about four tenets—the dualling of Marmion Avenue, building the railway, saving Western Power and getting on with the freeway. That is what the people are concerned about. But whenever I have contact with them over this issue, I get only one response: “Do it, so long as there are enough safeguards. If I get a terrible disease and I am in excruciating pain, I want to know that the option is there for me. I might not want to use it, but I want to know that the option is there for me.” Nearly everyone in the community thinks that. What I am saying is that I got elected on secular temporal issues—on what the community wants for their families. I did not come here to say, “Vote Johnny 1 and I will stuff the Catholic catechism down your throat.” I would not do that to anyone. I did not do it because most of them would vomit. I do not make light of it. I embrace it myself. I am talking to the 30.1 per cent of our community who do not believe in God. How is it that I could come here as a legislator and say, “Because of my own personal beliefs, you’re going to suffer. Because of my personal beliefs, you’re not going to have an option. Because of my personal beliefs”—not, Premier, when I am looking death in the face, “He’s gone”, “She’s gone”—when I look at a dying person in excruciating pain who says, ‘Can you pass me the challis to sip from?’, I say, ‘No way. Suffer on, baby.’ I cannot do it.

I will be voting most firmly in favour of the voluntary assisted dying legislation because it contains 102 safeguards and that is what my community wants. Thank you, Mr Speaker.

[Applause.]

MR D.T. REDMAN (Warren–Blackwood) [10.17 am]: The Voluntary Assisted Dying Bill 2019 is one of the most challenging bills that any of us have had to deal with. Certainly, it is the most challenging bill that I have had to deal with in my 14 years in this place. It is certainly something that I do not take lightly. Before I embark on my conversation, the approach that everyone in this place has taken so far in their discussion on this issue has been fantastic. I am not sure that it will necessarily play out the same way in the other place, but certainly in the chamber that I am part of, it is great to hear the approach everyone is taking.

From the outset, I support voluntary assisted dying. I have held that view for some time. The only qualifications I put on this discussion is that we go through the consideration in detail process with the bill in front of us. Although I had a number of briefings on the bill, I certainly have not had, as a regional MP, the comprehensive level of briefings that I would have liked simply because I was not able to get to Perth. I want the benefit of others who ask questions about various aspects to ensure that all those things that have been talked about—the 102 protections that the member for Butler referred to—are real, valid and robust to the issues that they are meant to protect. That is my only qualification. This is going to be a very emotional debate, no doubt. I thought it important as a member of Parliament to outline the broad approach that I took to make my decision, as many others have done. In the past I have used the words “voluntary euthanasia”. I found it interesting that the member for Butler said that this is not euthanasia, this is voluntary assisted dying—a different thing. Some of my research included asking: What is euthanasia? What is the right terminology? I refer to page 3 of an issues paper from May 2016 titled “Euthanasia, Human Rights and the Law”, by the Australian Human Rights Commission. Under the heading “Terminology” it states — ‘Euthanasia’ is often incorrectly characterised as representing one particular kind of practice. However, it is more accurately understood as an umbrella term which covers a vast array of practices that can be described as different forms of euthanasia. These include:

- Passive voluntary euthanasia—when medical treatment is withdrawn or withheld from a patient, at the patient’s request, in order to end the patient’s life;
- Active voluntary euthanasia—when medical intervention takes place, at the patient’s request, in order to end the patient’s life;

Extracted from finalised Hansard
• Passive involuntary euthanasia—when medical treatment is withdrawn or withheld from a patient, not at the request of the patient, in order to end the patient’s life;

• Active involuntary euthanasia—when medical intervention takes place, not at the patient’s request, in order to end the patient’s life.

Of course, voluntary assisted dying fits most accurately into “active voluntary euthanasia”. I say that because on page 35 of the same document reference is made to the complexity of the decisions around this. The word “euthanasia” is used. I have referenced how that is defined and I think members will understand why I am reading it. The final commentary in the document states——

Individual support for the issue of euthanasia is, at its core, a matter of personal belief. Values based on ‘sanctity of life’ and ‘personal autonomy’ are usually grounded in deeply held moral and/or religious beliefs. Further, supporting euthanasia may not be an absolute position. People may support some forms of euthanasia, such as passive voluntary euthanasia, —

That is the dominant bit that we are talking about here —

while rejecting other, more active, forms of euthanasia.

I think that that is a really important comment to make in this debate at this time.

The other question that hit me was: why take the path of legislation? These things are happening and we could simply decriminalise it. However, I think it is important to ensure that we get past, if you like, the decision for why legislation was considered to be important in taking these proactive steps. I will quote from page 37 of the same document. The comment there is broadly about some of the slippery slope arguments that if we start down this path, we will get into a very difficult situation and it will then go beyond where the community wants to go. But members will understand why I am referring to this quote. It states——

‘Slippery slope’ arguments are primarily concerned with the risk that unsanctioned deaths would occur without specific consent and/or in non-terminal cases. The practical solution to this would be to improve the safeguards contained within any regulatory regime in order to prevent this from occurring, to the greatest extent possible.

Well drafted ‘proactive’ legislation permitting and regulating active voluntary euthanasia can deliver certainty, transparency and above all, protection to all who may be involved in these practices.

Indeed, at page 225 of the Joint Select Committee on End of Life Choices report—I compliment all parties who were involved in this inquiry; the report is a fantastic piece of work—one recommendation comes to the point I am making. In the little box headed “Voluntary assisted dying legislation framework” it states——

Rather, the legislation should reform the law with a standalone Act that permits voluntary assisted dying to eligible people in accordance with strict criteria.

I think that having very proactive legislation that puts in place a clear set of boundaries is really important as the starting point in this discussion.

How did I come to my decision? How did I come to my broad position of supporting the legislation, with the only qualifier that a bit of work needs to be done in consideration in detail? Firstly, the polling has been massively compelling. If we do not have an eye for our electorates and for the view of people, we are really missing the point about why we are here. I thought the best articulation of that was from the member for Dawesville who, I admit, did considerably more work to engage with his community than probably anyone else in this house. The position that came back was very, very compelling, and it is certainly the view that came through in the strongest sense in my electorate. In The West Australian earlier this week we saw the headline “88%”—targeted. That is a really compelling position. As the member for Dawesville said, there does not seem to be a quiet vote sitting out there that is waiting to come forward. I think the polling is extremely compelling and is certainly something that is also reflected in the “My Life, My Choice” report.

Our own experiences are, I guess, the most difficult part. I congratulate the Leader of the Opposition for her commentary. It is very difficult to stand up in this place and put a personal experience on the table, because it is close; it is family and we do not particularly like putting that out on the table. As members know, I had a bit of an emotional experience before we went into the winter break—I am talking about my brother, who had mesothelioma. That is probably the most stark example for me. Probably not many people in here have not had the same experience, and I acknowledge that others are in the same situation as I am. My recollection from my conversations with my brother over the last six months of his life was that he would have absolutely wanted to have had the choice of a voluntary assisted dying end-of-life pathway. Yesterday, knowing that my speech was coming on today, I took the time to ring my sister-in-law to confirm that those were his views. She said, “Absolutely; yes. When he was diagnosed and still well, that was his view. That did not change right throughout the process”, which only took about six months. He is one very close member of my family who would have liked to have had that

Extracted from finalised Hansard
choice. It is pretty hard to be a judge from a distance, but I am pretty certain that in his situation, he probably would have taken it up given the nature of the disease that he had. But, again, none of us knows that until we get to that point.

I only really knew three of my grandparents—one died when I was a year old. At least one grandparent clearly articulated to me before she died that she would have wanted some sort of support for what she described as voluntary euthanasia, and that a voluntary assisted dying option would have been something that she would have liked to have been a part of. She was one step short of pleading, but she certainly put a very strong view to me. My father-in-law passed away from lung cancer. He was a smoker. His death occurred in my in-laws’ home; he spent his last hours there, and it was not something you like to watch. Our kids were around because there was a view that it was a family affair, and it was very, very confronting. He was in a hell of a lot of pain in those last stages, despite all the support from palliative care staff—Silver Chain, I think—who, at the time, were not able to deal with that. Nevertheless, he had a strong Catholic background and it may not have been an option or choice for him. However, after seeing that, I understand why legislators want to give people the option.

What is also really important in this debate is knowing the views of those groups of people who have been affected by pain and the indignity of dealing with that pain. A lot of articles and books have been written about this issue and those examples will be reflected upon in here, as they will in the other house. They are extremely compelling. As the member for Butler said, people must have choice. I think that is really important. It does not mean that people will choose that path—many will not, for a range of reasons. Many will simply like to have the choice but may not choose it, but others may choose it as their path. I think that choice for those eligible participants is a really important part of this legislation.

The other choice that has not been mentioned much is the choice of health practitioners to not participate—conscientious objection. That is a really important piece to this as well. None of us wants to put a health practitioner in the situation of doing something that is against their personal views and beliefs. I think that that other choice—part of this bill—is really important. Another factor to consider is palliative care, which is massively important in regional Western Australia. Recommendation 13 on page 83 of the report refers to the importance of delivering palliative care, particularly in regional Western Australia and some of the more remote parts of WA. There are difficulties and challenges with that, but ensuring palliative care is critically important. There will probably never be enough dollars for palliative care. Part of the Nationals WA’s politics is to try to get some equity for those people who live in parts of the state that are far from the key services that the state delivers. There probably will never be enough dollars for that. If we prosecute the argument that we want a voluntary assisted dying pathway with access to doctors and medical practitioners who can deliver on that, should they choose, that is also an issue. Both palliative care and support for voluntary assisted dying, should they choose, will be resource issues in regional Western Australia. For that reason, I am not linking the two as strongly as perhaps others are. My support for voluntary assisted dying in this legislation is not premised on top-quality palliative care services in every part of the state. That cannot be done, because there will always be resource issues in regional parts of the state. Likewise, there will also be resource issues in delivering the availability of doctors for people to pursue taking part in a voluntary assisted dying pathway.

I do not support what one other particular minority political party has said—that is, the trade-off of not supporting the bill unless we have a certain level of palliative care. I do not support that. This bill needs to be debated in its own discrete way and the issues should be addressed as they come up. Palliative care is massively important and I do not underrate it but I am not linking resourcing regional Western Australia to my support for the bill. It is massively important that the government does whatever it can do—no doubt the National Party will continue to prosecute this—to put resources into services in regional Western Australia, isolated parts of the state and remote communities. Also of critical importance is the level of support and commentary on not being able to palliate, if that is the right word, those people who are in unbearable pain. Finding 23 on page 107 refers to the fact that not all suffering can be palliated. Page 11 of the Australian Human Rights Commission article that I quoted refers to the same issue. It states —

For example, the South Australian Voluntary Euthanasia Society explained:

It is widely acknowledged, including by Palliative Care Australia and the Australian Medical Association, that even the best of palliative care cannot help all patients—between 5–10% find their suffering so unbearable that they persistently request an assisted death. Our palliative and medical care is highly regarded, but it can never be 100% effective.

That is a really important point. Likewise, the minister said in his second reading speech —

Equally, when members of the Australian Medical Association were surveyed on this issue in 2016, 67.9 per cent of respondents agreed that there are patients for whom palliative care or other end-of-life-care services cannot adequately alleviate their suffering.

A group out there will suffer irrespective of the best services we can provide for them.

[Member’s time extended.]
Mr D.T. REDMAN: The report refers to advance healthcare planning, advance healthcare plans, advance health directives and enduring powers of guardianship as strategies that are in place now and refers to the roles that they play. Clearly, they are not suitable substitutes for the bill here. They have a range of benefits, but they also have some flaws, particularly advance health directives, for which there is a very clear demonstration of a low uptake. I think page 41 of the report highlights the low uptake. A huge issue is the failure of some doctors to honour advance health directives. As legislators, it is important that we cast our minds to all those things that are in place and how well they deal with the issues that we are highlighting here that are key to this legislation. I am convinced that there is nothing suitable to replace this as a path, and that reinforces the importance of legislating for voluntary assisted dying. I found it an interesting read.

Page 109 of the report refers to lawful options at end of life. If someone had asked me the question, I would have come up with a couple, but there are a few more there. I did not consider suicide as being a lawful option but it is not against the law.

Mr R.H. Cook: It’s pretty hard to prosecute after the event.

Mr D.T. REDMAN: Absolutely. The lawful options highlighted include a refusal to take medical treatment. Depending on the circumstances, it might take a certain time before someone dies as a product of that, but I am very, very confronted by the consequence of refusal to take food and fluids. Someone who has no legislative choices, without breaking the law can choose not to eat or drink and, therefore, simply deteriorate over a time. That is terribly, terribly confronting. We have read and heard of examples of people in our community who have chosen that path. I cannot imagine how terrifying it would be to do that, let alone be a family member or friend watching that occur before my eyes. It is just a terrible situation. Terminal sedation is very, very legally challenging. I have no doubt—in fact, I know, but I am not going to put it on the record here—that a level of sedation has been given under the banner of palliative care. It is done simply to have someone drift off to sleep, which is the outcome that probably everyone sitting around the patient, and the patient, would like to see. That activity happens, but we owe it to our medical fraternity to give a level of protection in these situations by defining those issues. This would give a choice to someone who chooses to take that path and take it out of the somewhat legally limiting path of terminal sedation.

I was intrigued about the report referring to suicide as a lawful option. Page 140 of the report mentions that some 10 per cent of suicides are by people who have chronic illnesses and hence choose to suicide. That really concerns me. In more rural parts of Western Australia, people are massively pragmatic. A lot of them have access to firearms and a very pragmatic approach is taken to managing animals in distress. Their mindset is perhaps quite different from someone who might not have access to options, if you like, to choose a suicide path. I do not like that. I do not like those choices being the only ones that people have. I think that adds to a compelling argument. Page 148 of the report refers to the range of issues that emerge under this heading of lawful paths that are available now and their limitations. If members have not read the four dot points on page 148, I advise them that they are certainly worth a read. It refers to the shortcomings of those choices.

We do not stand here paving a new path. We stand here making legislation on the back of the experience of other jurisdictions around the world and, in the short term at least, the experience of another jurisdiction in Australia. That is a massive benefit because significant arguments will be put up as challenges in this discussion and we can go to the national experience to give us some guidance on the outcomes. We will have arguments about the slippery slope, the safeguards not working and the abuse of the vulnerable. The latter was one of my big concerns. Aged care in regional Western Australia is an emerging challenge. We do not want vulnerable people to be coerced into a situation that they do not want to be in. It is similar for the arguments to prevent suicide. I am comfortable with my reading of the examples in other jurisdictions and the commentary on page 181 where the committee concludes that the risks can be guarded against. There is sufficient evidence—not only a comment by a minister—to suggest that the risks can be guarded against. I do not think that any jurisdictions with voluntary assisted dying legislation, just about without exception, have made subsequent changes to fix anything. I think that sends a very strong signal. That said, if we get through all of this and to the point of supporting this pathway, we will have to put it down in black and white, and that will be the hardest bit. Writing down all the rules, risks and responses will be the hard bit. Hence, I think the consideration in detail stage will be a really important part of this discussion. I will go into that debate in the position of being well-read and well-versed on this topic and how it works, yet this is one of the qualifiers as we work through that. In every likelihood, I will support the bill, but I want to ask a number of questions and listen to other commentary about this legislation.

There are eligibility criteria. There is a whole process for VAD, with an assessment process involving three requests, independent witnesses and two doctors. There are checks and balances and a range of important processes—that reinforce and are wrapped around a very, very robust piece of legislation to manage the complexity and the range of issues that could emerge from a bill that will have such far-reaching consequences as this bill. I believe the bill, as I read it now, does that, but, again, the consideration in detail stage will be very important.

There is a predominant expectation in the community that both houses will support this bill. The community expects that and this is what it wants. I think it is incumbent upon us to deliver on that. I recognise there are strong views on this issue. I absolutely respect the views others have expressed. I expect many will think that this legislation does

Extracted from finalised Hansard
not go far enough. Someone asked me—that this is relevant to the comments the Attorney General made yesterday—if they had an advanced health directive, could they access voluntary assisted dying to ensure that if they developed dementia, they could take action to get on the pathway to voluntary assisted dying. The answer is no, because there is an enduring view that people need to have capacity at all points in time to make a valid decision. I think the Attorney General yesterday dismissed that. He said that this is not a path the government is going down. Certainly, those were the comments of a couple of constituents who have approached me. I think the view of some is that we are not going far enough on this; others will think we can never put enough rules in a bill to deal with all the issues.

I am very pleased that we are taking a very cautious approach, given we are introducing legislation that is controversial, very emotional and very personal, but nevertheless something that people want. If we overreach with this legislation, it will be off the table for a long, long time. People will hold the view that we have not gone far enough, but I think we have pitched the politics right, and I pay tribute to the minister for doing that. It is important for the government to understand the politics and the reach of this legislation to get the support of both houses so the legislation can get through and be put in place. I think that cautious approach is absolutely right.

In closing, the price of getting this legislation wrong is high. It is incumbent upon all of us as legislators to navigate all the issues and to quiz the government and the experts on the various aspects of the bill to ensure that we absolutely understand what the clauses mean, so that when it is passed in this house—I am pretty certain it will come back from the Legislative Council—and gets royal assent, it will be the best that these two houses can do for something that the Western Australian community wants.

**MS M.M. QUIRK (Girrawheen)** [10.43 am]: We all approach the very important Voluntary Assisted Dying Bill 2019 through the lens of personal experience. In this context, I want to particularly make mention of the Leader of the Opposition for sharing what was a very tough account of her personal experience. Throughout this debate, we have heard and are likely to hear harrowing and emotional accounts from members. No experience is any less legitimate than another.

Mr Acting Speaker, I am being distracted by a conversation in front of me.

**The ACTING SPEAKER**: Attorney General and Minister for Health, I am afraid you are distracting your member.

**Ms M.M. QUIRK**: My views are formed from a complex amalgam of factors. Yes, I am an imperfect Catholic and I firmly believe life is valuable but other influences were operative in my approach to the bill. It would be trite to attribute the issues raised by me as being a slavish adherence to Rome. I acknowledge that we live in a pluralistic society and enunciating my views is not an attempt to proselytize those who have differing views. Characterising arguments in this way shows a lack of appreciation of how complex and multifaceted issues such as this can be.

My experience includes time served on the Sir Charles Gairdner Hospital board, co-chair of Parliamentary Friends of Palliative Care for the past two years, work as a former volunteer with Alzheimer’s WA, a background as a prosecutor and administrative lawyer and someone who has personally experienced clinical depression. I also had the great privilege of being Minister for Disability Services; Citizenship and Multicultural Interests; Seniors and Volunteering. In opposition, I was shadow Minister for Seniors and Ageing and grappled with serious policy issues such as elder abuse. As Chair of the Community Development and Justice Standing Committee, we undertook a significant inquiry into policy issues for government in an ageing population. I regularly visit an aged-care facility and I have been at the bedside of close relatives who have died.

As the member for Girrawheen, over the years, in response to constituents’ concerns, I have engaged in an ongoing dialogue with hospital authorities and successive governments for improved palliative care in the northern suburbs. Importantly, the views of constituents who have written to or contacted me about this bill are significant. Finally, representing a multicultural electorate, the cultural considerations and implications of such laws need greater attention.

I acknowledge that I will be mindful of subjective influences such as those I have outlined in exercising a conscience vote. But, members, I cannot stress enough that we also need to dispassionately and objectively consider the individual clauses to assess how these laws will operate in practice, whether there will be any unintended consequences, whether the most vulnerable will be adequately protected and whether these laws will profoundly corrupt the practice of medicine. I also reject outright the assertion that anyone who departs from the orthodoxy lacks compassion. No-one has a monopoly on empathy, and heartfelt emotions are sincerely felt on both sides.

At the outset, before I focus on a number of specific concerns, there is a need to clarify some of the words and terms used in public discourse on these proposals over recent months. There is a level of ambiguity in terms used, which obscure meaning. Some of the words used are capable of having different interpretations and others have an ordinary meaning but have been framed in such a way as to be misleading. For example, we were told in the minister’s second reading speech —

I would like to emphasise that this bill has nothing to do with euthanasia. This is about providing assistance to someone who is already dying. It is not euthanasia and it is not suicide.

*Extracted from finalised Hansard*
This begs the question: why is it not euthanasia; and, if it is not euthanasia, what is it? I am not being quarrelsome or pedantic; this is a legitimate question. Given that this is the term used in the media, on talkback radio and in water-cooler conversation, it is important that we understand what is it we are doing with this legislation. It is true that the term is ambiguous. The distinguished chair of the expert panel, Malcolm McCusker, AC, QC, told a consultation session that I attended that the word had not been used in the panel discussions or report because it carried negative connotations.

The term “euthanasia” derives from ancient Greek language—”I might require the member for Hillarys to correct my pronunciation—“eu” meaning good or noble and “thanatos” for death, giving a literal meaning of “good or happy death”. Used in that sense, I am sure we would all agree that one hopes that everyone is in favour of euthanasia. One of the active groups advocating for these laws calls itself “Go Gently”, which, of course is a direct reflection on the very origins of the term. But I can see that the original meaning has evolved, and there is confusion in that it now means “terminating life intentionally”. In these circumstances, I can understand why it was considered wiser to eschew the term. However, if an opinion poll asks people whether they support euthanasia and the pollster understands the word to mean “giving patients a lethal injection”, some people polled may think it means something altogether different, such as a patient asking for life-prolonging treatment to be withdrawn because it is too burdensome. Then, the results of the poll would be worthless. Those who assert justification for this legislation do so on the basis that there is a grey area for doctors when treating terminal patients, leaving the medical profession in legal jeopardy. Such proponents fail to understand that in criminal law, the intention to kill is routinely inferred from objective circumstances.

Much has been made of the extensive consultation on this bill. A person would be seriously mistaken to think that the word “consultation” is given its ordinary meaning of discussion, dialogue, debate or seeking advice. Anyone who attended these fora will know that comment was not invited nor wanted from those opposed to this bill; the introduction and enactment of the legislation was presented to the audience as a fait accompli. Rather, it was to seek feedback on how the law should operate. Those who were interested in the topic did not have access to a draft bill during those consultations.

It could be said that people opposed to the issue in principle had the opportunity to make submissions to the Joint Select Committee on End of Life Choices, and they did so in volumes. There were hundreds of written submissions from people who are concerned about aspects of the proposals or the legislation for a variety of reasons. Sadly, few of those submissions were given any weight or addressed in the majority report. There were other sections of the community who simply did not participate in the debate whatsoever. The figures and analysis of the demographics of the participants in the appendices to the expert panel’s final report are enlightening. A bit more of that later.

The response by proponents to this would be to say, “Well, people have the choice whether to participate in consultations or similarly to avail themselves of an early death.” Again, this language is opaque, because so-called choice is illusory, especially in regional and remote Western Australia, where timely access to palliative care is largely unavailable. There is also the widely asserted premise that pain management cannot be accomplished in the majority of cases. This does not coincide with current medical experience.

The reasons patients gave when requesting physician assisted suicide in Oregon have been consistent for the last 20 years. Of those patients, 90 per cent reported a decreasing ability to participate in activities that made life enjoyable, 90 per cent reported a loss of autonomy, and 65 per cent reported a loss of dignity. Each of these patients were asked to rate the importance of 29 factors in influencing their request for aided dying. The highest-ranked reasons were wanting to control the circumstances of their death, concerns about future quality of life, concerns about future pain, concerns about the future ability to care for oneself, a loss of independence and a desire to die at home. Among the lowest-rated reasons for requesting assistance were depression, lack of support, financial concerns, current pain and quality of life.

Finally on the language used to frame this debate is the word “safeguard”. A safeguard is a measure taken to protect someone or something or to prevent something undesirable. Many of the so-called 102 safeguards are really eligibility criteria rather than protections. It is worth noting that there are fewer protections than in Victorian law. Surely, Western Australians deserve the same level of protection.

Former Prime Minister Paul Keating referred to safeguards in the context of the Victorian legislation in an opinion piece in the Sydney Morning Herald in October 2017. He stated —

An alarming aspect of the debate is the claim that safeguards can be provided at every step to protect the vulnerable. This claim exposes the bald utopianism of the project—the advocates support a bill to authorise termination of life in the name of compassion, while at the same time claiming they can guarantee protection of the vulnerable, the depressed and the poor.

No law and no process can achieve that objective. This is the point. If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system.

Extracted from finalised Hansard
I have limited time to address all of the substantive issues that we need to satisfy ourselves about in the proposed regime; I anticipate these will be canvassed during the debate at the consideration in detail stage. These issues include: What is a level of testing for capacity of an individual to make such a momentous decision? How can we be satisfied that a decision by a patient is not largely the result of undiagnosed depression or mental illness which could be medically addressed? How is the possibility of coercion tested? Should certain individuals be referred for an expert psychiatric assessment as a matter of course? Is the measure effectively a default position because adequate or timely palliative care is not accessible? Should there be a notation on the death certificate or should the coroner be notified?

People have asked me why Western Australia did not just copy the laws passed in Victoria. The Minister for Health explained this very well in his second reading speech, as follows —

The Victorian legislation presented Western Australia with the opportunity to examine the approach taken in Victoria. However, during the development of the bill, the circumstances and needs of Western Australia have been kept in mind. Western Australia has different clinical models than Victoria due to its geographical size and location. WA is the most culturally diverse state in Australia, with Aboriginal people, migrants and refugees accounting for nearly 30 per cent of its population. Where possible, consistency with the Victorian legislation has been maintained; however, this bill reflects what is suitable for the needs of Western Australians.

The underlying issues to which the minister alludes is that unlike Victoria, there are many remote areas that are not currently serviced by adequate or any palliative care. With a larger First Nation population, more attention needs to be given to cultural distinctions like the need to die on country and the lack of trust in mainstream health services. The final report of the expert panel canvasses these issues well, but it serves to reinforce in my mind the imperative to hasten slowly.

Senator Pat Dodson made a powerful speech in the Senate on the Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015, a private members’ bill, in August of 2018. In it, he addressed the challenges of euthanasia for First Nation communities —

“Any proposed legislation to change assisted suicide legislation must occur in consultation with First Nations health services and communities. It is the First Nations people who are at higher risk of being in a situation where assisted dying may take place.”

Under the United Nations Declaration on the Rights of Indigenous Peoples, article 24.2 states —

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

We know that Australia’s attempt to achieve the realisation of that right through the Closing the Gap program has been an abysmal failure. First Nation people do not enjoy the same quality of life in this country at every stage of their existence, as shown in the national figures. In the womb, a First Nation child is at higher risk of contracting life-threatening bloodborne diseases. Last year, six First Nation babies died of syphilis. Children are more likely to be diagnosed with chronic health conditions such as type 2 diabetes. They are at greater risk of contracting meningococcal and rheumatic heart disease. As teenagers, they watch their friends, cousins and siblings prematurely end their own lives. These facts are true of the Northern Territory and nationally. In the Kimberley region, where I come from, the suicide rate is the highest in the world. By what most Australians call middle age, many First Nation people are already living with kidney failure without sufficient access to dialysis. The burden of disease and disability in First Nation communities is far higher than it is in the general population. First Nation people are more likely to live with a severe or profound disability and to die younger. On a national basis, First Nation men can expect to live to an average age of 69, while non–First Nation men can expect to live to an average age of 80. First Nation women can expect to live an average age of 73, while non–First Nation women can expect to live to an average age of 83. All governments—state, territory and federal—have failed to enact the necessary action to close the gap.

We have failed to address the health issues suffered by First Nation people to date. With so many of our people suffering complex health conditions at an earlier age, there is a desperate need for culturally appropriate palliative care services in regional and remote areas. A review recently commissioned by the Australian government confirmed that more needs to be done to ensure First Nation people receive palliative care within their community. It states —

“Where First Nations people are already overrepresented at every stage of our health system, it is irresponsible to vote in favour of another avenue to death.”

Extracted from finalised Hansard
Paving the way for euthanasia and assisted suicide leaves First Nation people even more vulnerable when our focus should be on working collectively to create laws that help to prolong life and restore the right to enjoy a healthy life. The only concessions I can see to these challenges for First Nation people in remote WA is the ability to use a nurse practitioner to deliver the lethal dose, the use of interpreters, if necessary, and the need to significantly expand culturally appropriate delivery of palliative care.

This brings me to the issues around culturally and linguistically diverse Western Australians. I will make the following observations. Despite consideration of the issues for CALD communities and appropriate representation on the panel, there was little participation by CALD communities in the consultation process or in making submissions, and minimal use of the expert panel’s online vehicle, Citizen Space. A stakeholder meeting with the panel was convened at which only seven people attended. The panel found that awareness-raising would be required for CALD communities and that interpreters who were not family members and had the necessary accreditation would be needed to navigate a patient through the process. I am certainly mindful that for the elderly for whom English is not the first language, there is the tendency to revert to their first language. On complex matters such as exercising a choice between life, ostensible familiarity with English should be treated with extreme caution. The lack of participation of CALD Western Australians in discussions on voluntary assisted dying may evidence either a lack of demand or interest in pursuing this course of action.

Access to palliative care is an issue in not only remote and regional WA, but also the northern suburbs, directly impacting on my electorate. What is optimal palliative care and what is meant by palliative care is not well known within the community. Many consider it to mean solely the last few days of life, a time when many feel trapped in a technologically sophisticated, seemingly uncaring world of medicine. At such a late stage, there is not the same opportunity to markedly improve quality of life as there is if palliative care is engaged immediately upon diagnosis. Palliative care helps people to live their life as fully and as comfortably as possible when living with a life-limiting terminal illness. Palliative care identifies and treats symptoms that may be physical, emotional, spiritual or social. It is essential that options for palliative care be explored at the time of terminal diagnosis. It is about ensuring quality of life in the time remaining. It is about living well with a terminal illness. Sometimes palliative care can be of benefit to a person at their initial diagnosis or useful on and off through various stages of an illness. Many people have long-term interactions with their palliative care team, seeing them during the course of their illness. There are many elements to good palliative care including pain and symptom management, and advice and support to carers. Palliative care ensures patients are kept comfortable and can, as I said, maintain a good quality of life. Ideally, it involves many health professional who can all bring a range of skills to manage illness. These professions include doctors, nurses, social workers, physiotherapists, occupational and speech therapists, psychologists and trained volunteers.

In the context of my constituents, the Joint Select Committee on End of Life Choices found, at page 67 of its report under finding 10 —

Apart from a small number of private beds at Glengary Hospital, there is no inpatient specialist palliative care hospice in the northern suburbs of Perth.

Following that finding, it made the recommendation —

The Minister for Health should facilitate the establishment of an inpatient specialist palliative care hospice providing publicly funded beds in the northern suburbs of Perth.

Surprisingly some members might know that an area built especially as a hospice at Joondalup Health Campus already exists, but it is not currently being used for that purpose. If the other planned extensions can be expedited, patient capacity for palliative care can readily be accommodated at Joondalup.

I welcomed in May the additional funding for palliative care in the 2019–20 budget. I have a table which shows the breakdown of the $41 million allocated in the budget. In accordance with standing order 86, I seek leave to have it incorporated into Hansard.

Leave granted.

The following material was incorporated —

<table>
<thead>
<tr>
<th></th>
<th>2018–19 $'000</th>
<th>2019–20 $'000</th>
<th>2020–21 $'000</th>
<th>2020–22 $'000</th>
<th>2020–23 $'000</th>
<th>Total $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Palliative Care Services</td>
<td>5,081</td>
<td>6,482</td>
<td>8,015</td>
<td>10,586</td>
<td>30,164</td>
<td></td>
</tr>
<tr>
<td>End of Life Choices — Project Funding</td>
<td>1,741</td>
<td>2,279</td>
<td>1,795</td>
<td>5,815</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAD Recommendations</td>
<td>1,006</td>
<td>1,488</td>
<td>1,065</td>
<td>3,560</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care and End of Life Choices</td>
<td>735</td>
<td>791</td>
<td>729</td>
<td>2,255</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital — Carnarvon</td>
<td>4500</td>
<td>500</td>
<td>5,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL PACKAGE</td>
<td>1,741</td>
<td>11,860</td>
<td>8,777</td>
<td>8,015</td>
<td>10,586</td>
<td>40,979</td>
</tr>
</tbody>
</table>

Extracted from finalised Hansard
Ms M.M. QUIRK: This additional $41 million over four years includes $5 million previously planned for aged care in Carnarvon that has now been rebadged as an aged-care and palliative care facility, and $5.7 million for implementing the voluntary assisted dying regime. That is a start, but it is still inadequate. Most of the money has been allocated to regional palliative care, which is sorely needed if we are to provide any access at all in the remote regions of WA. As an aside, I am indebted to the minister’s office, and in particular Marion Huntly, who provided me with these figures and also responded to a range of other queries I had.

It is calculated that the appropriate ratio for palliative care specialists in Western Australia should be two specialists for every 100,000 people. WA currently has 0.57 specialists for every 100,000 people. It is estimated that over the next four years $600 million will be needed, and medical specialists in the field need to increase from 15 to 50.

Despite the ageing population, it is trite to say that the elderly can suffer social isolation and feel as though they have outlived their usefulness and are a burden on not only their family but also the health system and the community generally. We also know that the incidence of elder abuse is significantly under-reported, with victims ashamed to report it because perpetrators are often family members. I am strongly of the view that these laws will be seen as a way out for those poor souls who feel that they have outlived their usefulness, have had a full and satisfying life and do not want to become an unproductive burden. This throws some of the bill’s safeguards into stark relief.

How thoroughly will possible coercion be investigated or considered? This is yet another matter that will be explored in consideration in detail. Senior Western Australians deserve our respect and to be valued. Laws such as this one send the wrong signal to them. For the elderly, feelings of guilt and redundancy may well outweigh the choice that is said to operate under this bill. In the words of former Prime Minister Paul Keating, yet again —

Once this bill is passed —

That is the Victorian legislation —

the expectations of patients and families will change. The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against. A change of this kind will affect our entire community not just a small number of dying patients. It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination.

The passing of this bill is akin to unfurling a white flag of surrender. In waving that white flag, we are conceding that we cannot marshal the considerable resources in our health system to allow those with a terminal illness to enjoy a quality of life in their remaining time. We are conceding that in a state like WA, we cannot provide timely access to palliative to all Western Australians irrespective of where they live. By giving up, we consign the vulnerable, depressed, mentally ill and socially isolated to the risk of coercion or, worse still, that they have no choice but to accede to an early and untimely death. We are ultimately choosing between two systems in which some suffering may be difficult to treat or manage and one in which regulation is very difficult to perfectly enforce.

The final words of Paul Keating are very apt considering the remark of the Attorney General. Paul Keating said —

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society. The concerns I express are shared by people of any religion or no religion. In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

MS E. HAMILTON (Joondalup) [11.11 am]: I rise to make a contribution to the Voluntary Assisted Dying Bill 2019. Let me start by saying that it takes a bold government to deal with a complex issue like the one before the house at this moment—yet here we are doing what is right. To say that there are mixed views on this piece of legislation would be an understatement, and not to recognise that people have strongly held views would be to not understand the issue. Each of us has a personal story, a point of reference for this debate, and we need to ensure that when we talk about this issue, we listen to each other and have a respectful conversation.

What we have before us today—what we, as legislators in this house have been asked to do—is to represent our community’s views on the Voluntary Assisted Dying Bill that the McGowan government has introduced. We are dealing with a conversation that is long overdue and that our community is telling us they want to have—providing those individuals, who are suffering as part of an advanced progressive terminal condition, with an additional choice, which will provide compassion and dignity at the end of one’s life. We know there is 88 per cent community support statewide. This is reflected in Joondalup with over 80 per cent support, which is why I will be voting in favour of voluntary assisted dying.

As a decision-maker, politician, parliamentarian, community leader, or whatever way you want to look at it, each of us have a conscious vote in this place on this bill. To be able to speak to this legislation and represent the views of my Joondalup electorate is a privilege. It is the case that we have so many choices in life. It is one of the benefits of the society that we live in. But as a society, we do not engage in the conversations around death and about what we would like to happen when it is our time to leave this earth. We do not talk about the choices at the time of death.
very openly; it is just not something that we spend a lot of time discussing. In fact, I would go so far as to say that it is an uncomfortable and often-avoided conversation even when it does come up in our families, friendship groups or more broadly. But, what I have found out, and, in fact, what I thought to be the case in my electorate, is that people have strongly held views about what choice they would like to have at their end of life if they were faced with a terminal illness and were experiencing irremediable suffering.

Importantly, this legislation before the house needed to meet twin objectives of providing compassion and dignity for people facing death and ensuring that there are adequate safeguards in place so that no person is being taken advantage of. In this bill, both of these objectives have been achieved. Let us be very clear from the onset: people would rather choose to live than to die, but when faced with death, some may wish to choose voluntary assisted dying. This choice could be for a number of reasons, and, if nothing else, it is a way that that an individual may be able to feel that they are able to gain back some form of control at the end.

The legislation that is before Parliament is not something that people have to choose, but the conversation that we are having right now is about legalising the choice about how a person may choose to end their life. For those who are suffering a terminal illness where death is imminent, it is a decision that they should be able to make. They are already on a trajectory that, sadly, means they will pass. The question is: what will that death look and feel like? Is it a personal choice and one that each individual should be able to have the ability to make. For those who are facing a diagnosis of a terminal illness, it is devastating. We have good palliative care services that are available. We acknowledge in this debate the fact that whilst we as a government are investing significantly in palliative care services, for some this does not provide a reprieve; it just does not work. But it should not be a one or the other decision.

I have taken time to consult my community so that I can stand here and say that I am representing the views of Joondalup. Over 80 per cent of the Joondalup community support this legislation and I will be supporting the bill. For me to be able to arrive at this decision, I took the time to understand the views of my community. I sent a paper survey to the entire electorate of Joondalup and advertised and hosted a joint forum with Hon Alannah MacTiernan, which was attended by Amber-Jade Sanderson, former federal MP Dr Mal Washer and, of course, Dying with Dignity Western Australia. Thank you to the speakers but also to each and every one of the 340 residents from the northern suburbs who came along. The sentiment of the attendees was overwhelmingly in support of voluntary assisted dying, with many personal experiences shared. I ran an online survey, doorknocked, phone called, held mobile and open offices and made sure that I took the calls and the meetings when local residents wanted to speak to me on this issue. I have attended many of the presentations made available to us as parliamentarians. The sentiments in Joondalup reflect those of the broader community. I note that some in our community wished that this legislation went further with regard to people suffering from Alzheimer’s or dementia, but they also recognised the importance of this piece of legislation and the fundamental principle that a person accessing VAD must have the cognitive ability to make that choice at their end of life.

Rather than spend my time here in this place talking to the very important elements of this bill before the Parliament, as it is readily available, I want to take some time to convey to members the views from Joondalup. Whilst I cannot read every comment, I will read those that convey the general sentiments of my community, and I will include the alternative view. I will read them as they have been given to me.

One respondent said —

If people feel that their health is such that they have a painful horrible existence it should be up to them if they wish to terminate their life and go out in a peaceful manner with friends and family around.

Another respondent said that we need this legislation: “To provide people with dignity and choices.”

Another respondent said —

Quality of life issues. We are kinder to our pets and try to stop them from distress. Why can’t I choose when I’ve had enough and be remembered for the person I was, not the skeleton or hinder I am lying there in pain … Let me family and friends remember the best of times with me instead of the burden I became. It is my right to die with dignity.

Another respondent said —

I believe people have a right to choose. If they have decided they don’t wish to live and endure physical and mental suffering, they should have the option of voluntary assisted dying. It should be their right and their choice.

Another respondent said —

Because even just knowing that there is a choice would be a comfort to those fearing years of pain and poor quality of life.

Another respondent said —

The suffering that some terminally ill people have to endure is in humane and here is no dignity left in the final stages.
Another respondent said —

If a person has a terminal illness and their wish is to die by a way of their choosing then their wishes should come above any other consideration.

Another respondent said —

Having seen my mother die on a hospital administered “nil by mouth” method and last for 7 days in this state—note—not comfortable at all—very agitated and on day 5 wake and speak to me about her pain I feel that we owe more to our elders, to our loved ones. In my experience our hospitals are unable to care for people at the end stage of life—in fact they cannot prevent aged people from getting bed sores that penetrate into the bone. My mother begged me to “finish her off” something that I was legally and emotionally unable to do. I could not facilitate this for her through the current legal and medical system. Change is well overdue. For some palliative care is not the answer and as consenting adults we should be allowed the choice and manner of our demise.

Another comment from the survey states —

PLEASE push for our voices to be heard on this issue. It’s not just about palliative care and terminal illness. It’s about QUALITY OF LIFE. I want the right to choose what my family have to deal with if I become sick. I DO NOT want them to go through the pain and suffering I went through watching my most beloved person in the world die an agonizing death. This is INSANE! It causes enormous knock on effects to loved ones and family. Strain on aged care services and health care facilities. This is the number one thing I’m most passionate about so feel free to contact me if you need any advice from someone who has lived and breathed this devastation. Thank you for all of your help Emily. You have no idea how important this is for humanity.

I want to spend a moment talking about Joan, the wife of Ernie, a local Labor branch member. Ernie lost his wife just before Christmas last year. An article in *The West Australian* of 22 December, titled “Perth family share their mother’s plight in support of assisted dying laws”, states —

While most families have been preparing for Christmas, Joan Ellery was waiting to die, surrounded by her distressed husband, children and grandchildren.

... 

It was confronting to see the mother of five, grandmother of 13 and great-grandmother of 20 who was being given just enough morphine to keep her comfortable.

...

For her family, the hope of end-of-life laws that would have allowed her death to be hastened came too late.

...

“She was the most beautiful, hardworking mum to our kids and I was very lucky to have her—but she’s not really here any more and she would have hated that,” Mr Ellery said on our visit. “We discussed euthanasia many times and she was clear that she did not want to stay alive if she had no quality of life.

...

“For the last six months, Mum hasn’t known who I am but sometimes she looked at us as if to say, ‘Why aren’t you helping me more,’” she said. Ms Ellshore said her mother should have been given the right to die with more dignity. “There is no quality of life if someone is bedridden, has to be changed and be fed like a baby, and they have no awareness of what is happening around them,” …

Just two hours after the visit by the journalist, Joan passed away.

I received some diary entries from a wife who was struggling as her husband was passing away in front of her eyes. According to my notes, she wrote on 20 January this year —

The last 27 days of my life have been horrendous in so many ways, it’s called having to face life and death circumstances, making the call and standing your ground in the name of humanity. In the silence I question the long road travelled, does anyone truly understand the journey, of heartache pain and suffering. Yes some do, but we need to unite as one and bring about Change, for our many loved ones but also for our end of life wishes. Addressing them by all coming together, will mean having our voices heard and that makes the difference. It means a better future for all who follow, bring about change in the name of humanity and dignity. For those who do not want Voluntary Euthanasia, I respect your decision, therefore respect my choice to choose, how, what and why. Respect is understanding that each individual is different and that they are entitled to their opinion in making a decision, but most importantly having control over their end of life wishes. It is through life experiences that we become more knowledgeable and our determination forces us the address the injustices of society,. therefore life is meaningless if we
sit and watch the suffering of our loved ones and do nothing about it. God gives man a voice and a choice to intervene, take the stand in the name of mercy and one day you may experience all that I am speaking about, only then will you understand. We are not powerless to bring about change where love is concerned in the name of mercy we should never be afraid to speak the truth for the benefit of the less fortunate in their final hours of need. It is through seeing the pain of life that we become doers, ready and able to bring about change, for the benefit of all. I have asked myself the question, Do I want to suffer? The answer is no, therefore it is my choice to choose, it should be my given right and mine alone.

I have had profound conversations with people from Joondalup and acknowledge that people have very strongly held views on this issue. I respect everyone’s personal views, even though I sometimes do not fully agree with them. I have spoken to people of faith at their doors. I recall a recent conversation I had not more than a fortnight ago with a gentleman who, when I told him the topic of conversation and the reason I was stopping by, quickly told me that he is Christian and does not support the legislation. He held the view that only God will determine when it is a person’s time to pass this earth. Conversely, I have spoken to Christians who have said, “My God is good and would not condone needless suffering.” Others have told me that they would not choose the option themselves, but would not be the ones to stand in the way of someone having that choice should they want it. I have heard people say, “Get on with it already! It had better pass! If I was dying, I would want the choice.”

As I mentioned, not all the submissions that I received or people I have spoken to were supportive of the bill, but I think it is important to understand the alternate view and respect those who hold it. I recently received a letter, one part of which read —

As a nurse I have worked in many areas, including care of the terminally ill and care of the elderly. PALLIATIVE CARE is the ONLY path to take. It is the only safe, loving, dignified, effective and honourable way of treating anyone of any age, in any such situation.

Another person said that they believe that any situation in which someone is assisted to take their own life or have their life taken by another person is morally wrong. Others have commented that any laws such as this will always lead to abuse, as has happened in other countries; that there are many other reasons against it; and that doctors are against the legislation. Another person said, “We shouldn’t kill people; it’s just that simple.” Although I understand that there are alternate views such as this, I say to those who do not support voluntary assisted dying: just do not choose it. But will they be the ones to stand in the way of giving other people that choice? We have to remember that this bill will provide an opportunity to show compassion and dignity to those who are suffering and for whom death is imminent.

This bill is the result of extensive consultation that has taken place over the past two years. A joint select committee inquired into end-of-life choices and, after 12 months, tabled its report, “My Life, My Choice”. The report reflected broad community agreement about the importance of individual autonomy and choice over end-of-life matters. The committee recommended that the government introduce legislation for voluntary assisted dying. One recommendation of the report was that a ministerial expert panel be appointed to develop voluntary assisted dying legislation in WA, and its final report was presented to the government. The reason for my mentioning this process is to highlight that throughout the formulation of this bill, consultation was fundamental and extensive. In addition, the bill includes the important and stringent qualification of having 102 safeguards.

Other jurisdictions, both internationally and within Australia, have dealt with this issue. We need to remember that although we are discussing this bill in Western Australia and it is our own piece of legislation, the topic is not just ours, nor does it stand alone. It is an issue that many countries around the world have addressed and which many communities are asking their parliaments and elected members to consider. The bill before us is the right bill for WA and one that Western Australians are asking for.

I congratulate the joint select committee and ministerial expert panel for their extensive work and consultation, which has enabled us to arrive at this bill. I thank those who have taken the time to brief MPs on this issue, including national and international guests and experts. I say well done to Dying with Dignity Western Australia for its public campaign and to all others who have been involved.

[Member’s time extended.]

Ms E. HAMILTON: I say to those who are active on this issue in my community and who support this legislation that we need this bill to pass both houses of Parliament. I have concerns about the passage of the bill through the upper house. We need to ensure that all MPs are given the opportunity to vote on this important piece of legislation in this Parliament.

We all have a story of a loved one who has passed and whose memory lives on, but whose death is remembered with a heavy heart. There are the questions of: What if there had been another way? Why did it happen that way? What could have helped or have been done? Why did they need to suffer? I know I have those questions. Some of our colleagues and members of our communities, friendship groups and families are struggling with this issue right now. To those people I say that I hope we can say before the year’s end that there is something else to consider—just another option and choice at end of life, when so many already feel so helpless.

Extracted from finalised Hansard
I want to thank my community for the time they have taken to convey to me their views on voluntary assisted dying. Although I know that not everyone will agree with the decision I will make in this place, it is a decision that I have not taken lightly and one that I have ensured reflects the majority view of the good people of Joondalup.

I return to my first remark: it takes a bold government to deal with a complex issue like voluntary assisted dying. Yet here we are, doing what is right. I say yes to providing people in our community who are suffering with the choice to end their life with dignity. I commend the bill to the house.

**MR P.J. RUNDLE (Roe) [11.30 am]**: I rise to speak to the Voluntary Assisted Dying Bill 2019. I congratulate the government, the Premier and especially the Minister for Health for bringing this bill to Parliament for debate. It is a subject that should have been debated for many years and I think it is time to act, so well done to the government for bringing it to Parliament. I acknowledge also the Joint Select Committee on End of Life Choices chaired by Amber-Jade Sanderson, MLA, and also the Ministerial Expert Panel on Voluntary Assisted Dying, which was chaired by Malcolm McCusker, AC, QC. The work of both of those bodies is extraordinary. I thank each member of both those panels for their commitment to the task. I know it has been a long task and one that is very difficult, and I think they have done it well.

From personal experience, I am aware of the amount of consultation that has taken place. My mother was one of those who was keen to talk to the initial joint select committee. She lives in Albany. It was important that the committee ventured out to the regions and gave everyone their opportunity to tell their story. Mum was certainly happy to tell her story about her sister and how she felt about voluntary assisted dying. The committee handled it in a very private and compassionate way. It was important that the ministerial expert panel increased its consultation into the regions. Our party room met with Malcolm McCusker and the panel agreed to increase its consultation through the community resource centre network. That gave people in the regions the opportunity to have their say on the recommendations of the panel.

As will be the case for all members in this chamber, death is something that is personal. We have all witnessed a bad death or we know of someone who has been through it. Hopefully we have all witnessed good deaths that have been peaceful and painless for the person, surrounded by family. Perhaps they have died quietly in their sleep; that is utopia. Unfortunately the reality is that that way of dying is not true for everyone. We enter this world, decide on our fate throughout our entire lives and at the last hurdle that choice, that decision on how we die, is left to the government through laws. My office, like everyone’s here, has been inundated with community and constituent opinions on the subject. Many and varied groups have argued their positions with research and statistics, which in some instances are interpreted in ways that reflect their stance. I have read them all. It is an emotional debate. There is no way we can make these decisions in a purely objective way. The correspondence we have received is emotional. Dying represents grief and we cannot deny that the act of death can be traumatising for everyone concerned. It is critical that we look at this debate rationally, logically and ethically, because we are asking people from the medical profession to act on our behalf as lawmakers, to completely disregard their most sacrosanct vow to preserve life. I am not a clinician but I will, like everyone here, die at some stage. I cannot predict the way I will die, but this bill has forced me to consider my options. I support the notion of the exercise of free will, of choice.

I acknowledge Belinda Teh in the Speaker’s gallery today. Belinda walked across Australia and was quoted as saying —

> My mother died in a way that will haunt me for the rest of my life. There are some things we cannot change and there are some things we can.

I congratulate Belinda on her advocacy. It was great to catch up with her yesterday in the courtyard.

Recently, I attended the premiere of the film *The Broken Hearted* and was particularly moved by some of the family accounts of the slow and painful deaths of their loved ones. At the premiere I met Kirsten Whitby, who was unassumingly talking to me, the member for South Perth and the member for Baldivis prior to the film. It was to my surprise that she was the first person featured in the film. I thought she spoke so well about the tragic circumstances of the end-of-life experience of her husband, Darren—the cousin of the member for Baldivis. That moved me.

I recently noted Howard Sattler going public about how he would like to end his life and some of what I thought were unfair letters to *The West Australian* from people trying to dictate to him about what he should do with the end of his life. To be honest, some of those letters were appalling.

More recently, Dr Colin Clarke came forward and talked openly about how he would like to end his life in a way that he can control, with his family around him. His wife is a qualified nurse, and his children are in full support. He has mesothelioma and as a medical doctor knows better than most that his life will be cut short and will not end in a pleasant way. It is important that we take on board his comments given he has only a short time left in his life. I note also the comments earlier today of the member for Warren–Blackwood whose brother was also afflicted with mesothelioma. He spoke about his family and the way Geoff would have liked to end his life.

I know of many accounts of painful deaths. Stories relayed to me from my constituents are difficult to listen to. The personal accounts from members in this chamber reflect on experiences that are terribly sad. I listened to the

_extracted from finalised Hansard_
Leader of the Opposition today, and the Minister for Transport and the member for Perth last night, and some of the examples they gave are obviously very close to their families. I do not want to dwell on individual cases but this one was close to my family. I would like to give an account of a family friend, Mary Goyder, who had a fall in her unit. She had lived independently since the death of her husband 10 years earlier. Mary made up her mind that that fall was her journey to death. For four weeks her family watched her slowly go from chatting to them in her hospital bed to two weeks later being taken off fluids and food, and then another two-week wait until her body starved to death. The body does many physiological things that are very unpleasant to watch, and with the family on an around-the-clock vigil for their mother, this was traumatising. The attending palliative care doctor who came in for five minutes each morning said that his job was not to end Mary’s life, but to make her death more bearable. The two weeks of that slow death were unnecessarily traumatising for everyone, including the nursing staff, and ultimately were the lasting memory for her family. It was absolutely not how Mary would have wanted to have died if she had been given the choice. There are many more instances that I will not go into, but I cannot with good faith in this debate ignore all those accounts. It is impossible to know the lasting effects of those acts on the families. I know that if they had had a choice about how their loved ones had died, it would not have been like that.

Suicide is an option for ending your life because there is no other way. It is not an option that we should be accepting. At the very core of that decision is that the person wants to die before their natural end of life. Suicide is lonely, brutal and sometimes unsuccessful. I have friends who have had family members die from suicide. They have never recovered from this.

As the Premier mentioned yesterday, Clive Deverall made the ultimate statement of support of voluntary assisted dying by taking his own life on Western Australia’s last election day, saying in his note: “Suicide is legal, euthanasia is not.” Mr Deverall was the highly respected former head of the Cancer Council WA and spoke in an interview of the reality of those who had symptoms that could not be controlled by palliative care. It was a powerful message that he sent on our election day in March 2017. I have dealt mainly with the family who are left to deal with the traumatising events and acknowledge that their pain is significant and longstanding. Interestingly, one of the arguments made by groups against voluntary assisted dying is that a family may coerce a dying person into early death to get hold of their inheritance or alleviate the burden on the family. From what I have read, it is completely the opposite. When a dying person wants to access voluntary assisted dying, the families are the ones who try to reason with their loved one to not go through with it. Not only is the dying person trying to access early assisted dying through the law, but often they have to argue their choice with their family.

A friend recently lost her husband to cancer. Mark Davis was a teacher at Narrogin Senior High School. He was only 58 and he was strong and healthy. His cancer was kept at bay for many months and he continued to work and be the father and grandfather who everybody loved so much. At the end, his cancer was extensive. He endured unbearable pain and in his final few days he told his wife that if there was a box to tick for euthanasia, he would have ticked it many times. When I asked whether I could use his name in my contribution, his wife, Chris, said that Mark would have been so happy to have his say. He strongly believed that an individual should have the choice. During the final stages of Mark’s illness, he spoke frankly with his family about the need for other options. How can we, who are healthy and pain-free, sit here and make a judgement on this kind of suffering? Our perspective is based on what we have seen, heard and imagined. We cannot know exactly what goes on in the minds of people who live in constant pain and whose pain cannot be relieved. We cannot in all honesty make a decision about their life. It is irresponsible of us to imagine that we can. But what we can do is give them a choice to determine their own death.

Mental illness will be discussed during this debate. People have options with living wills and an advance health directive. However, neither allows access to voluntary assisted dying. People with dementia and chronic mental illness may want to determine how they wish to die while they have the capacity to make that decision. Minister for Health, I would like this option to be considered in the future. My view was consolidated after visiting many dementia wards throughout regional WA. I understand that it is not in the mix at this stage but it is something we need to consider down the track. We can determine how we want to die but the current legal system does not allow such a person’s wishes to be met.

Palliative care is at the heart of this debate. I know from experience that palliative care is exceptional but not always effective. I know of people in my electorate who have not bothered with treatment for chronic disease because it is just too hard. As I mentioned during the private members’ debate on health only a week or two ago, we have a perfectly good oncology ward at Narrogin Health Service, but eligible people cannot be treated there because apparently no oncologists are available to supervise treatment. The Minister for Health knows that I will keep reminding him about this. We have to do better in regional areas. Given that the facility has been built and is available for use, we need to work hard to get oncologists and doctors to that area. We have to provide the palliative care resources that people in Perth can access. Many people have spoken about it and others will speak about it, but at the very least we have to provide pain-free options for people in the regions so that they can stay close to their families and die with dignity and without anxiety. We have established, through research and anecdotally, that palliative care cannot help a small percentage of terminally ill patients.
However, it can alleviate pain and suffering in nearly all terminally ill patients. We need to be conscious of the need to increase palliative care funding so that patients are not driven to other means of dying. Some people want to die at home with the support of palliative care and there is no reason why people in the regions should not be able to access this level of care because of where they live. The element of dying at home should not be overlooked. I disagree with the notion that accessing voluntary assisted dying means that people must die in a clinical facility. Dying at home in peace and in a familiar environment surrounded by family is an important part of this dialogue.

It is my understanding that the current laws put clinicians in a difficult position. In a small amount of cases, they are unable to give sufficient medication to make their dying patients unresponsive to the pain in case it kills them. I know in the past that people have relied on morphine doses to hasten death. Families are asked whether they are okay with increasing the dose and, of course, the families say yes because they are already traumatised by the process. This is unlawful. Doctors and nurses put their careers and personal ethics on the line. This practice does not help anyone. Access to palliative care prior to decision-making may ensure that those who decide that they cannot tolerate their future lives can make a decision from a position of support and in as much comfort as possible. This would negate the argument used by people opposed to voluntary assisted dying that an end to life is often desired by those lacking effective and bearable palliative care. Only then will we be sure that their choice is not clouded by a lack of access to appropriate care. To validate this requirement, investment in palliative care that can be accessed by people in the regions is an imperative. Regional patients who require palliative care should not be disadvantaged by distance. There must be a serious effort to improve palliative care in regional areas to minimise the argument that patients who seek voluntary assisted dying do so because palliative care is insufficient or unavailable.

[Member’s time extended.]

Mr P.J. RUNDLE: It is interesting to note that people in jurisdictions in which voluntary assisted dying exists usually opt for palliative care. It is important to note that when people have been given a choice with the option to end their life available, they are happy to use palliative care. As I mentioned before, the part of the bill we need to be extremely careful of is ensuring that medical practitioners do not go against everything they have trained for. We will not be the ones who dispense a lethal drug at the end of life and we will not have to deal with the family and ensure that their emotional needs are met and we will not have to organise certification and end-of-life logistics. The power given to a doctor to perform this task should not be given lightly. I have had correspondence from doctors who are supportive of the bill, and for that I am grateful. Likewise, I have had correspondence from those who are not supportive. I appreciate their anecdotal evidence. Certainly, it is very polarising. Some are against the idea of assisted death and others see it as part of their profession to care for a person to the end of their life. This bill will not make anyone do anything that they are not willing to do. It is not unreasonable to say that most doctors and medical professionals have thought about this extensively. I am comforted by the fact that doctors who are not supportive of this legislation will never have to face performing a procedure that they are ethically bound to prevent. However, regional doctors are everything to everyone. They are friends with their patients. Many have given generational care to families in their town, and, with this in mind, I support any training that offers those professionals a safe passage if they are confronted with patients who wish to access voluntary assisted dying. They may or may not want to be a consulting practitioner for voluntary assisted dying but I feel that given their exposure to their community, they may require further support to assist them with a range of situations. Doctors living in small regional communities are not privy to the anonymity that city doctors experience. They are ingrained in a community and may be exposed to harmful, undesirable or emotive behaviour. The safety and support of our regional GPs is pretty crucial in my support for this bill because of their interaction with their community and, obviously, the Hippocratic oath that they have taken.

When we consider the dispensing of the drug, it is critical that we also consider the pharmacist who will be part of the process. I know of at least one pharmacist in my electorate who made a point of telling my office that they support the bill and would be willing to dispense the drug. I note at this stage that if this process is left to tertiary hospitals in the metropolitan area, our regional communities will be disadvantaged. I assume that as we go through the bill, the minister will make some allowances for the drug to be dispensed from places other than only tertiary hospitals. Otherwise, it will not allow for our smaller regional hospitals. I assume that will be taken into account.

Will this bill provide an overarching and supportive process that everyone in the metropolitan area can access? I have heard that telehealth could be used as an option. We all know that telehealth is a fantastic resource for most health-related incidents in the regions; however, for this issue, I am not so sure. I know that we are looking at the scenario with the federal Criminal Code and the use of the likes of telehealth, and that is something that needs to be explored at the consideration in detail stage. The chances of towns having one medical practitioner trained in voluntary assisted dying will be very low, and this bill requires two independent consultant assessments. Three requests from the patient are required with one written and verified by two independent people who will not gain financially by the death of the patient. Two of these requests will go to registered independent medical practitioners. That is

Extracted from finalised Hansard
a total of four consultations with highly trained specialists in this field. How will someone in Kukerin or Lake Grace, who is already burdened by the disease they are suffering from, access this requirement? I am not looking to soften the laws by any means; I am looking for funding to do what this government has always advocated for, which is for people to live and die in their own community. From the research I have done, access to voluntary assisted dying is not something that will happen very often. A small percentage of people suffering from disease will access this procedure. If people in my electorate are given the choice of dying with assistance, they should be able to see the independent medical practitioners in their own home or their local hospital. As part of this bill, there should be a portion of funding allocated to regional care that offers the same level of care as those who will apply in the metropolitan area will get, or as close as possible to what is offered in the metropolitan area.

This discussion was never going to be easy. I value the contributions of all my colleagues to this debate. I have felt a deep obligation to my constituents that I consider all the briefings, the consultations, the written reports, the available research and, of course, the valuable contributions from individuals and groups to my office. The obligation I have as a member of Parliament for a regional electorate also weighs heavily on my mind. The overwhelming indicators I have had is that this bill has been supported by a majority of people for many years. I absolutely acknowledge those who do not support this bill. As I said earlier, this is a very personal law that we are proposing, but I am confident at this stage that the procedural requirements are rigorous enough to protect the patient, their family and the medical practitioners involved.

Finally, I want to speak about a very personal experience in relation to my aunty, Norma Christensen. She was suffering from motor neurone disease over the last few years and was a very strong advocate of voluntary assisted dying. I recall Andrew Denton saying to me that he felt sorry for my aunty and our family because of what she would go through over the final months. He was exactly right. In her final months she was hoping to go to sleep and not wake up. Unfortunately, she fell over, fractured her hip and was admitted to hospital. From that point, she was not going to have an operation and was administered morphine. Her only method of passing on was to gradually starve herself over a two to three-week period. I spoke to her a week or so prior to passing on and she was happy for me to talk about her and her wishes. Her family, including her daughters, Diana and Lisa, and her sisters, June, Grace and Thelma, were also more than happy for me to speak about her situation. She was very pleased to talk to Hon Tjorn Sibma from the other place during his consultation in recent weeks. She really felt pleased that she had that opportunity to speak to him and also that I would talk about her during this debate. My parents are also very strong supporters and I speak to them quite often about it. Obviously, with the advent of my aunty’s passing, it has been very close to home for them. They were disturbed at the prospect of filibustering and other things in the other place, and I am pleased to read in recent reports that, hopefully, that will not happen. I expect that the bill will be gone over in strong detail in the Legislative Council, but it is really important that it is done in an efficient manner and a respectful way. I look forward to that in the Legislative Council.

It is easy to say to those who do not support the bill that they do not have to do it, but deep religious and ethical beliefs define many of us. I admire those who have such strong faith; however, I do not believe that a belief that defines one should define all. My personal feelings aside, I have a responsibility to represent my constituency and compassion and dignity. It is about creating a regime whereby the terminally ill can choose to have control over the way they leave this life. It is a voluntary regime, and there are 102 clauses within the bill that ensure that is the case. This bill is not about the choice between life and death; it is about enabling the dying to choose a death that is dignified, with as little suffering as possible and surrounded by their loved ones, instead of a death that may be lingering and painful, or, being in a situation in which the terminally ill choose suicide—violent and lonely. It is not a bill to allow euthanasia, which is the act of one person taking the life of another to end suffering, nor is it assisted suicide, being the taking of one’s own life when that person would otherwise continue to live. It is a bill to allow voluntary assisted dying. Both are vital to end-of-life care and end-of-life choice. This bill is about choice. It is right there in the title of the bill—voluntary assisted dying. Should this bill pass, it will be a voluntary regime. Self-determination and personal choice are core beliefs of our society and this bill is entirely consistent with those beliefs.

In conclusion, I say if you do not believe in voluntary assisted dying, then do not do it; however, do not prevent my constituents from having the choice. I commend the bill to the house.

MRS L.M. O’MALLEY (Bicton) [11.57 am]: The Voluntary Assisted Dying Bill 2019 is about choice. It is about compassion and dignity. It is about creating a regime whereby the terminally ill can choose to have control over the way they leave this life. It is a voluntary regime, and there are 102 clauses within the bill that ensure that is the case. This bill is not about the choice between life and death; it is about enabling the dying to choose a death that is dignified, with as little suffering as possible and surrounded by their loved ones, instead of a death that may be lingering and painful, or, being in a situation in which the terminally ill choose suicide—violent and lonely. It is not a bill to allow euthanasia, which is the act of one person taking the life of another to end suffering, nor is it assisted suicide, being the taking of one’s own life when that person would otherwise continue to live. It is a bill to enable the terminally ill, the dying, to access the means to end unbearable suffering at the end of their life should they meet the criteria and, most important of all, should they choose to take that path. This bill is not about palliative care versus voluntary assisted dying. Both are vital to end-of-life care and end-of-life choice. This bill is about choice. It is right there in the title of the bill—voluntary assisted dying. Should this bill pass, it will be a voluntary regime. Self-determination and personal choice are core beliefs of our society and this bill is entirely consistent with those beliefs.

Like the members before me, I sought to understand the views of my constituency on voluntary assisted dying through survey, forum, on the doors and on the phones. It has been a great privilege to have listened to my constituents’ stories of love and loss and the variety of views held across the electorate of Bicton on this issue. I deeply respect every one of those views—views that are overwhelmingly in support of the introduction of voluntary assisted dying legislation.
Madam Deputy Speaker, there are many ways in which the passing of this bill will positively impact on end-of-life choices in Western Australia. I will speak further on just two of these. Firstly, through the creation of a legal framework that will protect medical practitioners, providers of palliative care, family and loved ones from possible prosecution. It will bring important regulation to what is now a largely unregulated space. Secondly, it is my personal hope that it will reduce the incidence of suicides by the terminally ill, to which one in 10 suicides are currently attributed in Western Australia. Death by suicide is solitary and violent and incredibly traumatic for those who are left behind.

On the first way in which a legal framework will lead to much-needed change to end-of-life care, I would like to relate the story of an elderly couple in my electorate—Pat and Mary. I do so because Pat implored me to after having approached me one day recently near my electorate office. Mary had been diagnosed with Alzheimer’s disease some years earlier. Pat cared for her at home. Mary was hospitalised following a fall, and complications from the fall led to bronchitis, which became pneumonia. Pat believes that Mary’s passing five weeks later was hastened by Mary receiving increased levels of morphine. Pat implored me to support the voluntary assisted dying legislation because no-one should ever make the decision to end another’s life under any circumstances. Pat and Mary’s story, unfortunately, is not unique.

The introduction of this bill will provide an important legal framework that will provide protection for medical practitioners and patients alike. I do not have a personal experience of watching a loved one die slowly and painfully and in great suffering. I have listened in empathy to the stories of those who have. What I do sadly have is experience of losing a loved one by suicide. Listening to the stories of those of loved ones dying of terminal illness choosing to end their lives were especially hard as I know firsthand the trauma of those left behind. I know all too well the wrenching sadness that follows the thought that in their time of greatest need their loved ones were alone. Suicide in and of itself is one of the greatest of human tragedies. It is horrifying to know that the terminally ill, due to the current deficiency in end-of-life choice, are choosing lonely, violent deaths. I wish for a future in which no-one dies by suicide. These deaths are, after all, entirely preventable. We do not yet have the answer to the broad issue of suicide prevention, but this bill will reduce the incidence of suicides attributed to the terminally ill.

There are some absolute knowns—things that all of us understand to be true: that life is precious and that whilst everyone wants to live, one day we will all die. In this house, in the other place and out in our communities there are different views on voluntary assisted dying, and on this bill, but one thing we all agree on is that everyone deserves a death that is dignified, with the absence of suffering and being surrounded by loved ones. I ask all members to ensure the passage of the Voluntary Assisted Dying Bill through this place and the other without delay, and that the debate continues to be one of respect and kindness. I thank and acknowledge all members who have spoken already and will speak to this bill. For many, it is a raw and deeply personal thing to do. For all of us, we speak with the knowledge of the great responsibility entrusted to us as legislators to do the right thing by the people we represent. I support this bill. I will be voting yes. I sincerely thank all those who have campaigned and worked tirelessly and with a great diligence to bring this bill to the house.

[Applause.]

MS A. SANDERSON (Morley — Parliamentary Secretary) [12.05 pm]: I rise to make my contribution to the Voluntary Assisted Dying Bill 2019, and I speak strongly in support of this bill. I start by commending the Premier and the Minister for Health for their unwavering leadership on this issue. As most people know in this place, I chaired the Joint Select Committee on End of Life Choices. Medical intervention is giving us more time with our families but it is delivering longer periods of dying, often with debilitating symptoms. I was genuinely surprised by the scale and extent of the end-of-life suffering that is occurring across our community. Over the past two years, I have literally heard hundreds of personal intimate accounts of people who have borne witness to the most profound suffering of their loved ones. People poured their hearts out and told harrowing stories of under-medicating, over-medicating, adverse reactions, severe agitation and of frail people suffocating in their own fluids while their loved ones looked on helplessly—sometimes at home, sometimes in a specialist setting, with access to all that palliative care has to offer. It is going on behind closed doors in people’s homes, in hospices and hospital settings. With this experience, those left behind are left with an intense grief compounded by the trauma of witnessing a horrible death. The sense of guilt and helplessness of those left behind is palpable.

Any member of this place who has genuinely engaged with their community on this issue will not have escaped the horror stories. Those who witness this suffering are also left with a conflicting mix of emotions: on the one hand, a deep gratitude to the staff and organisation that supported their mother, father, husband, and on the other hand, an anger and sense of injustice that this kind of suffering is allowed to occur in a modern medical setting. Experienced doctors tell us that they feel helpless and that they have let their patients down. I have absorbed every one of these personal accounts and we cannot let them be for nothing. We simply cannot let the status quo continue. It would be unconscionable for the government or for me to cut them loose to face whatever end they fear the most when there is a better, gentler and more humane alternative.

We now know from national coronial data that around 10 per cent of suicides in Western Australia are linked to chronic or terminal illness and that people are choosing to escape their pain alone and in grim circumstances to be
found by relatives, neighbours and first responders. The number is consistent with statistics in the United Kingdom and the United States of America. These deaths are primarily by carbon monoxide poisoning, asphyxiation by plastic bag, gunshot wounds, overdose or hanging. Some are successful; many are not. I consider these to be the wrongful deaths driven by the current lack of options for patients and doctors.

During the inquiry, we heard evidence of health professionals in particular stockpiling medications to avoid a bad death. Bill Philips told us of his wife’s condition and her deep fear of her dying of a ruptured bowel or a ruptured stomach. She was an experienced nurse and knew what was coming. She had been stockpiling opiates and made the decision to commit suicide. Bill was in the room with her when she took them, and made a promise not to call an ambulance. As a justice of the peace of 34 years, he was well aware of the consequences of aiding a suicide. But she did not die. After four days at home alone with her, lying in bed with her, it became clear that she was not dying and that the drugs were wearing off. He had to break his promise and call an ambulance. She went on to suffer a very difficult death. The McGee family lost their father, Joe. Suffering from cancer, he hung himself in the garden shed. He left a note for his wife: “Sorry about Christmas. I just could not hang on.” Suicide is a legal option but only alone.

The current laws are not only bad for patients; they compromise carers and relatives who only want to do the right thing by their loved ones. The most strident objectors tell us that more palliative care is the answer, but we know from data collected by the palliative care sector itself, symptoms cannot be relieved and not everyone wants to be palliated.

Up to five per cent of terminal patients will suffer when they die. Bone and nerve pain are incredibly difficult to manage and almost impossible to control. End-of-life symptoms of choking and coughing, especially for motor neuron disease patients, are some of the biggest challenges for palliative care, and some patients choke or suffocate to death. Not everyone wants to be treated with a cocktail of heavy sedatives and antipsychotics. That is the palliative care “toolkit” for complex cases. Specialists gave evidence that they will keep trying out different drugs on a patient until they get a result. It is an important pillar of our freedoms that no medical treatment is compulsory. Well-meaning objectors and some palliative care specialists are asserting that every terminal patient must have palliative care. Frankly, that should not be their only option.

A very experienced Western Australian neurologist who specialises in MND recently told me about one of his patients. She was in her 80s, with all the symptoms of advanced MND. With no other options to escape her suffering, she elected to starve herself to death. It is actually very hard; stopping eating is the easy bit, the hunger pains stop after a few days, but the withdrawal of water is the hardest, and she took 17 days to die. It was very difficult for her and her family who were with her. I have read many submissions and heard so many examples of people electing to escape their terrible symptoms by starving themselves to death. Although palliative care specialists told us that this is very rare and that it is actually just normal for people to lose their appetite, my observation from the evidence we heard is that they are either not being honest or in complete denial about the frequency with which this is happening. I have no reason not to believe the families and doctors who said their loved ones or patients died a bad death and palliative care was not enough. There is no vested interest in their stories—just sorrow.

One woman gave evidence privately of the horrific circumstances of her husband’s death in one of our best hospices. No longer able to swallow, begging for water and under sedation with an ever changing cocktail of drugs, he was often semiconscious, anxious, confused and restless. This was far from the peaceful death he had been led to believe would happen. He had four medication ports, two butterfly ports for breakthrough medication and a catheter. He was nursed intensively, with blood pressure and oxygen level checks, washing and sheet changes. He was moved and then moved again, all adding to the pain—any movement was excruciating. Uncontrollable respiratory secretions left him unable to breathe properly. Eventually his communication was limited to, “I love you” and “Get me out of here”. There was 17 days of this until he died. His wife was left deeply traumatised and unable to cope with her grief. Her greatest regret was that he did not have another option.

No-one could hear these stories again and again and think that the status quo should remain and that there is not something terribly wrong with the current system. One palliative care specialist recently wrote to all members of Parliament describing these stories as “fake news”. Fake news—I have heard many offensive things in the course of this debate, but I found that truly shocking. To deny the real experiences, the suffering and trauma that is occurring in our community, I find to be heartless and dishonest. It is true that some in palliative care truly believe in the redemptive power of suffering, that in most instances unresolved issues are the cause of end-of-life suffering and that people should be conscious to face their deaths regardless of the suffering that they are enduring. I, and I think most reasonable people, would completely reject that notion. It is a notion derived from religious ideology and has no place in a modern healthcare setting. The choice to spend your last days and hours in a loving environment surrounded by your loved ones and pets, while you are coherent and relatively pain free, is a rational and reasonable choice for people who are dying. There is nothing noble about suffering in the name of someone else’s ethics.

Terminal sedation is a current palliative care practice—the sedation of a patient until they pass away—but that is only available if a person is lucky enough to get a physician who will provide that treatment. Many people find themselves...
with doctors, or in a facility, whose policies do not support it. We know of many incidents of under-management of pain and under-medication because of either fear of the law or the ideological position of the doctor. Terminal sedation is usually applied with the withdrawal of all food and water. Our committee heard evidence of patients continuing to contort and wince in pain while sedated; others had adverse reactions to morphine and other drugs. In the words of one of WA’s most respected neurologists, “They make you earn your death.”

Finally, the important principle of informed consent is lost in this treatment. It is ultimately the decision of the doctor, sometimes in discussion with the family, when the patient’s final conscious moment will be. The community has fundamentally rejected this concept; people want control over their last conscious moment when facing terminal illness. We know that doctors are ending their patients’ lives to end their suffering. Anonymous surveys over the years have shown this to be the case. This is happening now. They do it because people beg to be put out of their misery. They can see the suffering and they are compassionate and humane doctors. Our current laws would condemn these doctors under the Criminal Code. This bill will provide a legal and safer framework for all health professionals to work under.

My personal observation on the most strident objectors to voluntary assisted dying is that they do a lot of talking and not a lot of listening. I would firmly place the Australian Medical Association in this category. The WA branch of the AMA opposed this bill before it was even drafted. Inflammatory statements and scaremongering have characterised its contribution to date. Claims that WA would be a destination for so-called VAD tourism is an absurd prospect. Another recent claim is that the government is considering this as a “cheaper form of health care”—equally absurd, also offensive. Michael Gannon recently claimed that there are no safeguards in this bill to stop VAD clinics setting up in shopping centres. These statements insult our intelligence. The AMA was forced to print an apology in its member publication Medicus to the McCusker-led ministerial expert panel, which included the current president of Palliative Care WA, palliative care specialists and two former AMA presidents, for claiming they were “puppets of the government”. Malcolm McCusker, QC, former Governor of this state!

We have also heard from the AMA that end-of-life issues are far too complex for ordinary people to understand and that it is really for doctors. The days of “doctor knows best” are gone. Patient autonomy is a critical feature of modern medical ethics. Objecting doctors often quote the ancient Hippocratic oath of do no harm, which dates back to 470BCE. Some aspects of the oath survive today, but many aspects have no application in modern medicine. The more contemporary Declaration of Geneva builds on aspects of the Hippocratic oath and has been adopted by the AMA. A key feature of the physician’s pledge is: I will respect the autonomy and dignity of my patients. Providing a safe and compassionate death for terminally ill patients is fully in keeping with modern medical ethics.

It is heartening to see that the Royal Australian College of General Practitioners has taken a position of supporting patients to have a choice. Eighty per cent of Australian Nursing Federation members—those on the front line who spend more time than any other medical profession with patients and families and see their suffering—support voluntary assisted dying. Independent research commissioned by Palliative Care Australia shows that where voluntary assisted dying is legal, professional bodies like the AMA start from a position of opposition and move to a more neutral or supportive position. The Canadian Medical Association is one example of that. Palliative Care Australia’s research shows that every jurisdiction has also seen a significant increase in palliative care funding.

We have heard and will hear over the course of the debate so-called examples of wrongful deaths and the slippery slope in other jurisdictions. I say to members: when you follow the credible evidence, it leads you to only one place; that is, these laws have been operating in some jurisdictions for over 20 years without evidence of abuse or misuse. The so-called examples are anecdotal, not fact checked, would not qualify under this bill and in some examples the individuals are indeed still alive as far as we can ascertain. Articles by doctors making claims of abuse and misuse are almost always linked to a faith-based institution and, for whatever reason, these doctors choose not to declare the religious views that form the foundation of their opposition. Having a religious-based objection is valid, but is it not honest to declare your stance so that everyone is aware and can consider that when assessing the evidence?

The emotive term “slippery slope” is used to imply that something is out of control. This is just not the case; we know that this has been working well without abuse for many years.

I expect this bill, if passed, to be operating in the same form in 20 years. The abortion law has not changed in 21 years, and the legalisation of abortion has not led to a huge increase in abortions over time.

Some people say that on this issue, there is an elephant in the room—that is, the issue of steering and coercion. To those people I say that if there was an elephant, a highly trained group of expert handlers has now come in, taken that elephant out of the room and put it safely away. The bill has been shaped by an expert panel of the highest standards, and the safeguards that will be put in place will protect vulnerable people in ways that simply do not exist now. Coercion, elder abuse and other such matters are much more likely to happen under the current system, which has no safeguards, accountability or framework. In effect, opponents of this bill are arguing for the substandard status quo to remain, with no scrutiny, no accountability and no safeguards.

Extracted from finalised Hansard
We know that the public overwhelmingly supports this bill and the concept and principles that underlie voluntary assisted dying. This is evidenced in the increasing number of jurisdictions now moving to legalise it—18 across the world. Three jurisdictions in North America in the last 12 months alone have moved to legalise it. This seismic shift in political sentiment has caused the anti-VAD lobby to develop a new strategy, as it is clear the community rejects religious arguments. The new approach adopted by the no lobby is: not this bill. We see that that is clearly the Australian Medical Association’s approach. It says to members, “We don’t object to voluntary assisted dying; we just don’t think this is the right bill.” It misrepresents elements of the bill, overreaches with an extreme hypothetical example to scaremonger, and then says, “We just don’t think this is the right bill. There are too many potential problems.” This is a well-established strategy used by the AMA and religious objectors, and we see that the AMA is already pushing amendments to what is an incredibly stringent bill. I believe the motivation is to make it unworkable; it is not genuine engagement.

I want to acknowledge those health professionals, doctors and palliative care specialists who have listened and changed their view. It is hard to walk back from a deeply and long-held position. For some on the ministerial expert panel, it has challenged the core of what they have been taught to believe and goes against the views of many powerful and longstanding colleagues. To their great credit, they have played an important role in shaping the legislation before us. The bill before us provides a conservative framework. It has been developed with the strongest clinical and legal guidance, drawing on the best of other jurisdictions, two years of intensive consultation, and with compassion at its heart. The fiercest criticism I have received is that it does not go far enough and is too restrictive. People with dementia want access to voluntary assisted dying. Dementia is the most prevalent neurodegenerative disease, and the suffering is real.

There are two important principles that underpin this bill. The first is the voluntary choice for an individual free from any coercion. The second is a decision-making capacity. I fully support the government’s strong position on these principles. We have never gone further on this journey in Western Australia; for that, I give credit to the Premier, Mark McGowan. Without his leadership and unwavering support on this issue, we would not be here today. My committee delivered to him a monumental medical reform, requiring an enormous use of government resources to deliver it. It is a big ask of any government. It cuts across the political divide.

[Member’s time extended.]

**MS A. SANDERSON:** I have spent the last two years reading and talking about dying and terminal illness. The greatest lesson I have learnt from this is that, overwhelmingly, people want to live, and they will do anything and put up with the most appalling symptoms and side-effects of medications to do so. The committee visited palliative care patients in homes and hospitals. One of the most challenging visits for me, after weeks of gruelling hearings, was to visit a 42-year-old woman with multiple cancers and two and four-year-old boys. That was my age, and my son was two at the time. I am embarrassed to admit that I cried in her room when I met her. It was really the last thing that she needed. I have two big fears in my life. The first is losing one or both of my children; the second is leaving them behind. But if I have to leave them, I cannot bear the thought of leaving them behind with the kind of trauma that Belinda Teh has to live with every single day. If this bill becomes law, people will continue to die—that is a certainty—but far fewer people will suffer.

**MS L. METTAM** (Vasse) [12.24 pm]: I would like to start by thanking the many individuals on all sides of the debate who have contacted me regarding the Voluntary Assisted Dying Bill 2019, and who have shared their personal stories with me. I recognise that for many this has been a difficult consideration, as many think of their own friends and loved ones who have sadly passed or who are suffering from a terminal illness. I would also like to thank the many community and professional organisations that have contributed to this debate and these discussions, such as the Australian Medical Association (WA); Palliative Care WA; the very special Busselton Hospice Care Inc; the Western Australian Palliative Medicine Specialist Group; the palliative care team at Sir Charles Gairdner Hospital, who I had the privilege to catch up with; the Doctors for Assisted Dying Choice; and many individuals in the community who have contacted me to express their view on this legislation. I believe each and every group that has expressed an opinion about this bill has done so with a respect for life and for the individual. I believe great consideration has been given to this bill from all sides of the debate. I recognise that members of our community hold diverse and passionate views about voluntary assisted dying.

My decision on how I will vote on legislation to legalise voluntary assisted dying in Western Australia has been incredibly challenging, and is certainly one of the most difficult decisions I have had to make during my time as a member of Parliament. I have spent many months talking to my constituents, meeting with community organisations and responding to emails, letters and phone calls, and I intend to vote as a representative of the community that I represent, Vasse, in support of this bill. I am voting in favour of this bill so that people who are suffering from a terminal illness and who meet strict conditions have the freedom to choose voluntary assisted dying, should they wish. I am voting in favour of the bill because I believe that the overwhelming majority of people in the community who support this bill are doing so with an awareness and understanding of what it represents. People have a right to die with dignity if living in dignity is no longer an option for them. That does not mean that this bill does not represent significant challenges for our health system and for our community as a whole.

*Extracted from finalised Hansard*
As I stated, I had the privilege to speak with many constituents over several months, one of whom is Peta Quinlivan, who was happy for me to share her story—an all-too-common story that is sadly repeated and is consistent with views I have heard from other constituents. This is an excerpt of Russell’s story—

My husband Russell was ill for 20 years—ten of those in chronic pain, riddled with arthritis in his spine. Even after all that time, when he was first diagnosed with neuroendocrine lung cancer, he was ready to fight—to throw everything at it.

He was so proud, so brave.

Little did either of us know, he’d have just three months to live, and the last three weeks would be ghastly: Trapped in the trauma of pain beyond anything that could be medically treated, with neither dignity nor the capacity to communicate.

Before he was admitted to hospice, he was not afraid to die but he would say he was afraid of how he would die.

Before he was consumed in a world of nothing but pain—absolutely nothing but pain—he begged for release, to hasten the end. But under WA law, we couldn’t help him.

He was monstered by his pain—physically, mentally and emotionally.

Russell was even stripped of comfort from human touch in his last weeks, as it caused unbearable nerve pain and his excessive body heat, from haywire hormones, deprived him from having any more than two people in his room at once.

He was promised that when going into hospice, his pain levels would be managed. But he was in the very small minority where his pain couldn’t be treated medically. His doctors permitted, written in Russell’s medical notes, “break-through” medication of extra morphine.

But under WA law, medics who attended to him in the middle of the night—his face in a locked grimace, his body contorted with pain—could refuse to follow the specialist’s orders, on the grounds they feared any more morphine may be fatal.

In those last two weeks in hospice, I sat by his side day and night, too scared to sleep, fearing he would break his weakened spine—as happened to a man up the corridor—as pain shocked his body.

“Three years on and I still can’t sleep properly, haunted by images of my husband reduced to a skeletal figure, in a nappy.

There was no mercy for my husband Russell—a deeply private man of a strong, athletic build; a surfer, a “specimen of splendour” who would turn heads at the beach and loved the outdoors.

The people of WA need to be allowed to choose medical assistance to ensure a more hasty and dignified death for those who suffer like my Russell did.

She went on to tell of how Russell would have wanted a choice and how she was certain of what his choice would have been.

The decision to support this bill comes from compassion and mercy. It is about the opportunity to provide individuals such as Russell a calm and painless death surrounded by loved ones. However, as I stated earlier, this bill represents significant challenges for our health system and our community as a whole. Western Australia is only the second jurisdiction in this country and the thirteenth in the world to introduce voluntary assisted dying legislation. It is important to recognise that only a small number of people will choose to access this legislation, but for those who do, it will be a significant decision for them and their families. It is also important to keep in mind that the majority of people suffering from a terminal illness will not choose to access voluntary assisted dying, and that Western Australia shares one of the poorest rates of palliative care specialists per person in the country at 0.57 full-time palliative care specialists for every 100 000 people. It is worth noting that we share one of the poorest rates of palliative care specialists with Victoria, the other state that has introduced this legislation. Using Palliative Care Australia’s benchmark of two palliative care specialists for every 100 000 people, we should have 52 palliative care specialist doctors, at least 10 of whom should reside in regional WA. Instead we have 15 in the state, which is why it is essential that palliative care resourcing is improved.

It is an unfortunate reality that many of the tragic stories that have been heard in the media and from the public about terminal illness, will not be captured by this legislation. Given that only a very small proportion of those in the community will be eligible for voluntary assisted dying under this bill, it is essential that this government make a stronger commitment to palliative care. It is unfortunate that some of the concerns I have heard in recent times about the end-of-life phase for terminal loved ones involve poor experiences of palliative care. Sadly, access to palliative care is not equal across the regions. It is further limited in rural areas and almost non-existent in remote areas.

Extracted from finalised Hansard
regions. The Joint Select Committee on End of Life Choices was told of people in regional areas who transferred to Perth to receive specialist palliative care treatment. I took the opportunity to meet with specialist Dr Anil Tandon and his team at Sir Charles Gardner Hospital, many of whom spoke about the heartbreak of patients who are put in the position of choosing between staying close to home and receiving limited treatment and travelling to major hospitals in larger centres, often away from family and friends, to receive appropriate palliative care. There are also legitimate concerns around how the commonwealth legislation will impact the ability for telehealth services to provide advice in regional and remote areas.

I appreciate the Minister for Health accepting my request to meet with the team at Busselton Hospice Care—a team of over 100 dedicated volunteers from the Margaret River and Busselton coastal community who support voluntary assisted dying. I am pleased that the state government has provided an additional $41 million towards palliative care in the 2019–20 state budget. However, I recognise that $5 million is dedicated to building an aged-care facility in Carnarvon and another $5 million will go towards the implementation of this legislation. I am keen to see how the balance of $30 million will be allocated as a priority. We must not lose sight of the fact that more needs to be done to expand palliative care in this state, especially in the regions. Decisions made on end-of-life choices should not be made according to postcode and the quality of end-of-life care.

Before I close, I would like to note other concerns raised about this bill, largely from the medical profession that has a unique appreciation of what this bill represents. One concern of some in the profession is the lack of consultation. One local specialist wrote to me and stated —

I feel it would have been more appropriate to obtain a broad range of perspectives prior to progressing this legislation rather than asking feedback from practitioners such as myself in a latter phase looking at the mechanisms related to the proposed legislation.

I strongly feel this legislation does not provide an appropriate level of protection and safety for practitioners involved but more specifically and significantly for patients in a palliative stage of treatment.

He then went on to note the concerns of the president of the Western Australian branch of the Australian Medical Association, Dr Andrew Miller, that some specialists also had concerns about the absence of the requirement for a mental health examination, given the obvious impact someone’s capacity to make an informed decision would have on this significant decision.

I have also heard very legitimate concerns about how this legislation will work in an environment in which there are many examples of elder abuse, especially in the context, according to the parliamentary Select Committee into Elder Abuse, that there are currently up to 75,000 victims of elder abuse in this state. This would be very challenging to legislate against, which is perhaps why I have heard so many concerns from the medical profession about this.

It is fair to say that I have also heard from many medical professionals and specialists from across WA, and my electorate in particular, who are very supportive of this bill. Some of them who acknowledge the current role doctors undertake in shortening a patient’s life also have a firsthand appreciation that palliative care cannot always eliminate pain and suffering, which can sometimes lead to patients taking matters into their own hands. I note the report of the Joint Select Committee on End of Life Choices found that one in 10 suicides involve people who have a terminal illness, which is consistent with data taken from other jurisdictions and the last five years in WA.

There has been much discussion about the 102 safeguards in this legislation. I certainly believe that we need to be particularly careful with this legislation, given that it represents the hastening of death. This is why we need to ensure that the decision to access voluntary assisted dying is made solely and freely by the individual, not because of a lack of adequate alternative treatments or pressure from family members, and that any issues of mental illness have been considered.

We also need to ensure that our medical practitioners are both properly trained and have the freedom not to undertake voluntary assisted dying, out of respect for their own values. This is why the safeguards are so necessary and why the consideration in detail process needs to be treated with respect and with patience, because we as legislators must feel confident that this bill that promises mercy and compassion for a limited few does not do so at the cost of others.

DR A.D. BUTI (Armadale) [12.40 pm]: I rise today to speak on the Voluntary Assisted Dying Bill 2019 and I wish to acknowledge all the hard work undertaken by the Joint Select Committee on End of Life Choices, the Ministerial Expert Panel on Voluntary Assisted Dying and all involved in bringing this bill before the house. I would also like to thank all those in my electorate and beyond who have contacted me in person, on the phone, via email or through the post to present their views.

The nature of the conscience vote afforded to government members is one that I and my colleagues take exceptionally seriously, and I am sure all members of this house do. My journey to the position that I now hold on voluntary assisted dying and the bill we have before us has been long and convoluted. Until a few years ago, although I understood the calls for euthanasia and assisted dying, I personally was not in favour of legalising voluntary assisted dying. But since then, my research and interactions, plus examination of the bill, has seen a shift in my position. However, I still have concerns with one issue, which I will detail later in my contribution.
I will not be relaying stories of people I know who have died an awful death or have been denied dying with dignity. In the main, my focus today is on the philosophical and legal aspects of the bill and voluntary assisted dying. Such a discussion involves issues of morality, ethics, religious belief and political and legal theory. Among members here and in the other place there may be disagreement with the title of the bill. Although terminology is important, I dearly hope we do not get bogged down in consideration in detail on this issue. As the member for Girrawheen noted, the term euthanasia literally means “good death” or “dying well” from the Greek “eu”, meaning good, and “Thanatos”, meaning death. Some people, even speakers in this debate, may argue that the process this bill is dealing with cannot be referred to as euthanasia, but I am not sure that is the case. Professor Cameron Stewart of the University of Sydney has stated that euthanasia is a general, non-legal term that covers a variety of legal and illegal behaviour and it involves voluntary assisted dying in which a person competently requests and receives help to die. Like the member for Warren-Blackwood, I also refer to the Australian Human Rights Commission paper, “Euthanasia, Human Rights and the Law”, which states —

*Active voluntary euthanasia*—when medical intervention takes place, at the patient’s request, in order to end the patient’s life;

In this bad death narrative, the person is in pain and soiling himself, with tubes and machines humming away (although, if these are life-supporting tubes and machines, the patient can request they be removed and shut off). Why must a patient endure this? Why can the patient not exercise his autonomy and choose to end this mockery of his existence with the assistance of …

What we would call voluntary assisted dying. To permit any less denies the patient the choice to die with dignity. Lindy Willmott, Andrew McGee and Ben White, in an article published in the online journal *The Conversation* on 14 November 2017, reported that four major themes of objection were raised by MPs in the Victorian parliamentary debate on its voluntary assisted dying legislation. The themes were: first, the bill does not have adequate safeguards to protect the vulnerable; secondly, legalising assisted dying presents a slippery slope; thirdly, palliative care services must be improved first; and, fourthly, a doctor’s duty is to treat, not to kill. I want to tackle these objections now, as I have also heard the same objections in the lead-up to this debate, although I will leave the protection of the vulnerable to the end of my contribution, as this has a personal dimension for me.

The slippery slope argument contends that even though our model, like the Victorian model, is currently a conservative one, that does not mean it will not evolve over time. But our bill is to a large extent modelled on the Victorian model, which, in turn, is modelled on the Oregon Death with Dignity Act, which has not been amended since it was enacted 20 years ago. That is the jurisdiction we should compare ourselves with, not the Netherlands or Belgium, which have a very different system and model from what we are seeking to introduce. But in the end, it is up to the legislators of this Parliament to ensure that we do not go down the slippery slope. That is our responsibility and the responsibility of those who follow us in this place.

Opponents of the bill and voluntary assisted dying will say that the focus should be on palliative care and that only when we fix that up can we move on to looking at voluntary assisted dying. I agree that palliative care should be the main game and main focus. It is. The Minister for Health has a focus on palliative care and has increased funding in that area. Of course we need more funding for palliative care, but that will happen whether or not this bill is passed. It must also be realised and acknowledged that there will always be a small percentage of people who are suffering who will never find comfort with palliative care.

Extracted from finalised Hansard
Doctors should not harm, and as the authors of The Conversation article state —

This argument holds that an assisted dying bill will undermine the nature of the doctor–patient relationship, which is based on trust. Arguments in this theme also contend assisting patients to die is the very antithesis of what doctors do. Reference is often made to the Hippocratic oath, noting that it says, “first, do no harm.” But it must be realised that under this bill, the time of healing has passed. The person is terminally ill and will inevitably die—actually, death is imminent. What counts as harm depends on context. For example, as noted in the article on The Conversation, we do not normally think surgeons violate the Hippocratic oath when they cut into the skin during life-saving surgery, yet cutting into our skin is a form of harm. We accept this harm because it is outweighed by the fact that the surgery is life-saving. The author similarly argued that helping people die more comfortably is not a form of harm but is actually a benefit. In fact, not allowing for voluntary assisted dying may cause harm.

Before moving on, I should mention the doctrine of double effect. That is when doctors are legally allowed to administer painkilling medication to patients even if they know that death will occur as a result or that there is a high risk of death occurring. It is not uncommon for healthcare professionals to risk administering high doses of drugs such as morphine to control pain, even though it is foreseeable that there is a reasonable likelihood that the dosage will kill the patient. The intention and motive is to control pain, although resulting death is foreseeable. This is allowed as the intention is to relieve pain and suffering. If death occurs as a result, it is viewed as incidental to the intention to relieve pain. It seems somewhat strange to allow the doctrine of double effect to occur but not allow a tightly legally controlled voluntary assisted dying regime.

Debate interrupted, pursuant to standing orders.

[page 6127]

Resumed from an earlier stage of the sitting.

DR A.D. BUTI (Armadale) [2.49 pm]: When we adjourned for the lunchbreak, I was talking about the doctrine of double effect. I said how it seemed somewhat strange to allow the doctrine of double effect to occur, but not to allow a tightly legally controlled voluntary assisted dying regime. Now I will move on to some political philosophy and also reflect on religion and faith in this debate. English philosopher John Locke’s social contract theory, which forms the basis of the constitutional structure of the United States, states that there is no right to commit suicide based on theological and conceptual grounds. Although this bill under clause 11 excludes the permissible act from being labelled suicide, let us for a moment accept the term. The basis of Locke’s theological argument was a form of Thomas Aquinas’ classic argument against suicide; that is, our lives are not ours but are God’s property. But as Professor John Mitchell states, “However convincing one may find this argument, a faith-based argument can have no purchase in a legal decision in our pluralistic society.” Mitchell was referring to the US, but Australia is an equally a pluralistic society. Locke’s conceptual concern comes out of the nature of the social contract as a mechanism to protect property—in this case, the individual person. What Locke wanted to prevent was providing a theoretical basis upon which it could be claimed that individuals have ceded to the state the right to arbitrarily kill them as part of the contract. If one’s life ultimately belongs to God and is not one’s own, one cannot give it to the state as part of a bargain for social contract. But this again, as Professor Mitchell notes, is a theological argument that an individual’s life is God’s, and such an argument has no legitimate place in our legal arena, although I fully understand some people have a strong faith-based objection against voluntary assisted dying. What I say to them is that this bill will not compel anyone to act against their faith as it is voluntary. This also goes for doctors who can utilise the conscientious objection provisions of the bill to opt out of being involved in the voluntary assisted dying process.

Professor Sonu Bedi from Dartmouth College has postulated a justification theory when discussing liberty and democratic debate. He argues for a justification theory that limits the reasons and rationales on which polity may act. We need to turn to the democratic state’s reason for acting. In relation to voluntary assisted dying legislation, it may be helpful to think about it via a justificatory constraint rather than the language of rights. Those who seek to limit our liberty to end our life must proffer a publicly available reason that is made in good faith. Currently, in most cases, the state permits terminally ill individuals who would like to die to refuse lifesaving treatment or to remove a life-support tube that would end their lives. The state prohibits individuals only from being able to self-administer drugs to end their life. The Supreme Court reasoned —

Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational.

But a justificatory constraint would push against this analysis. In both cases, we are concerned with a group of individuals who are terminally ill and of sound mind who wish to end their lives. The law allows these individuals

Extracted from finalised Hansard
to remove lifesaving treatment to do so but does not allow them to administer drugs to do so. If the reason or rationale here is to prevent harm to those who are terminally ill, one could argue that the state should prohibit both, lest it run afoul of the good-faith requirement of the justificatory constraint. So in banning active euthanasia or voluntary assisted dying but not passive euthanasia, the state may be operating on some conception of the good life. By allowing one practice but not the other, the state says that it matters how a terminally ill patient decides to die. If they decide to remove lifesaving treatment, that is permissible. If they decide to administer drugs, that is not permissible. That seems to be based on a particular conception of the good life; for example, a good life is one that ends by refusing treatment, not by administering drugs. That seems difficult to square away with a commitment to liberal neutrality. In effect, one could argue that a ban on voluntary assisted dying is a kind of morals legislation. Who is to decide what is the appropriate moral? One could argue that these kinds of laws are all based on a particular moral or religious view of the good life, failing the liberal requirement of justification.

[Member’s time extended.]

Dr A.D. BUTI: Currently, we allow certain individuals—for example, the terminally ill and people of sound mind—to end their lives by refusing lifesaving treatment. A commitment to neutrality means that the law should allow them to end their lives by administering drugs as well; otherwise, we are privileging one conception of the good life—or in this case, perhaps, it is privileging one conception of the good death—over another. Then we could ask: why is one way a better or superior way to die, especially when voluntary assisted dying may cause less physical suffering than its passive counterpart?

I now move back to where I commenced my contribution, which was on the main themes of opposition to voluntary assisted dying. I now turn to look at whether there are adequate safeguards in this bill to protect the vulnerable. In the current bill there are 102 safeguards, but whether they are sufficient to protect the vulnerable is difficult to ascertain. That is why, although supportive of voluntary assisted dying and this bill in general, I await consideration in detail to see whether I am prepared to support all the clauses. The Leader of the Opposition articulated in a personal and eloquent way this morning how pressure can be expressly or implicitly placed on a person in relation to seeking to hasten their death. I do not think it will be possible to provide a 100 per cent guarantee against undue influence, but I do believe this bill can be improved, which I will outline shortly.

In relation to the vulnerable, those opposing this bill or similar bills often refer to mental illness, elder abuse and those with disabilities. But before looking at these vulnerable groups, let me briefly mention the First People, the Indigenous people of this state. Some concerns have been expressed that voluntary assisted dying is of concern for some Indigenous people and culturally a foreign concept. I would hope that dialogue can be continued with Indigenous people to allay their concerns and to ensure that the voluntary aspect is emphasised and protected. But I acknowledge these concerns, which I came across when working at the Aboriginal Legal Service of Western Australia in the 1990s. Before moving on, I should say I am not so sure about the bona fides of the Catholic Church’s attempt to emphasise Indigenous concerns with voluntary assisted dying, as there are many other areas of Indigenous concern where the church has been missing in action.

This bill acknowledges concerns about possible impacts of mental illness on the end-of-life choices and as a safeguard, a person with only a mental illness will not meet the eligibility criteria. If the person’s mental illness causes them to lose decision-making capacity, they will also not be able to access voluntary assisted dying.

What we need to do as a society is to work towards preventing suicide, and I know that the Minister for Health is keen to do so. The reasons people suicide are complex. There are a number of reported reasons for suicide, but legislation for voluntary assisted dying has not been identified as one of them. I refer members to a 2017 article by Lowe and Downie in the Journal of Ethics in Mental Health, which refutes the link and also criticises and discredits the 2015 article in the Southern Medical Journal by Jones and Paton that argued such a link. In the US, the five states that had the highest rates of suicide in 2015 were Wyoming, Alaska, Montana, New Mexico and Utah, none of which had legalised voluntary assisted dying. Oregon in contrast was ranked thirteenth. For the other states with voluntary assisted dying legislation, the rankings were: California, forty-fifth; Vermont, twenty-sixth; Washington, twenty-second; and Colorado, ninth.

When it comes to concerns about elder abuse and this bill, I say that we need to do more to prevent elder abuse and we should look at some of the work being done in some US jurisdictions to establish special prosecuting units to specifically deal with elder abuse.

I now turn to people with disabilities. When euthanasia or voluntary assisted dying legislation was being discussed in the UK and in Victoria, many people living with disabilities and their advocates expressed concerns. A poll done by Scope, a disability charity in the UK, showed that 64 per cent of people with disabilities were concerned about moves to legalise voluntary assisted dying. However, such a view is not universal, and UK Professor Tom Shakespeare, a person with a disability, said —

… there is already a right to refuse medical treatment. This means that people who are dying and are kept alive by interventions can refuse them, and die. Yet those who are dying but are not reliant on medical interventions still cannot control the timing and manner of … death. This is surely unfair. Why should

Extracted from finalised Hansard
Although I have some sympathy for and agree with Professor Shakespeare, I am still concerned about the bill and whether it may affect the vulnerable, be they elderly or someone with a disability.

I will now get personal. My eldest child has a disability. Her name is Alkira and later this year she turns 26. She is in many respects a capable person. But whether she will ever be able to independently live by herself in the future is very doubtful. When I think of Alkira’s future without me or Mandy, I get very anxious. I am very concerned as to what will happen when Alkira no longer has her mum or dad around. Unless you are in a similar situation, it is difficult to truly understand the anxiety we as parents have on that front. I would be much happier if society valued people with disabilities better than is currently the situation. I put out a challenge to members of the Dying with Dignity Western Australia organisation and all those who have been strongly advocating for this bill, including many of my colleagues in this house. The challenge is that when this bill becomes law, which I think it will, please then turn to directing some of your energies and compassion and love to improving the lot of people with disabilities in our society. Because right at the moment, we have a long way to go—and it starts with valuing people with disabilities more.

I am concerned that the bill does not prevent a medical practitioner from raising the issue of voluntary assisted dying with a patient. I am concerned that someone may take advantage of someone like Alkira and other people such as the elderly. The power imbalance between a doctor and patient, particularly one with a terminal illness, could be great. Many people are influenced by what their doctor says. I do not want to deny anyone the opportunity of dying with dignity or to not have a chance of rejecting a bad death, but I want people to self-initiate the discussion with their medical practitioner. I can see no reason for not inserting in the bill a clause that would prohibit a medical practitioner from initiating the discussion of voluntary assisted dying. If this bill becomes law, I think it is highly unlikely that the residents of WA will not know that accessing voluntary assisted dying is legal in this state. Thus, when considering the power imbalance between the doctor and the patient, I see no plausible reason for a medical practitioner to initiate the discussion. Therefore, I flag here that I am exploring the option of introducing an amendment to deal with my concern. But having said that, I believe that this bill should pass, subject to a thorough examination of the contents of the bill in consideration in detail.

This bill will give people in the last weeks or months of their life a real choice. Palliative care may provide relief for many at the end of their lives, but not for all. There are some circumstances in which pain cannot be appropriately managed. One of the issues that the bill does not outline is what we mean by mental capability or competence. I refer to a very good article by Cameron Stewart, Carmelle Peisah and Brian Draper called “A test for mental capacity to request assisted suicide”. Generally, the common law concept is in the negative in the sense that every adult is presumed to be competent and then has to prove that they are not competent. One could argue that when we are looking at providing consent for voluntary assisted dying, a stronger test should be in place. This article discusses what is needed. One example is for a legal test for competence to request assisted suicide. Firstly, the patient must be able to comprehend and retain treatment information regarding their decision to end their life. They should be able to understand and retain the extent of their illness, the available treatment, the available methods of dying and the risks of adverse effects on the method utilised. Secondly, patients must be able to weigh up the decision when they are highly dependent on others for care, their decisions must truly be ones that they have made, rather than decisions which they have been forced to make or feel they should make to relieve others of burden. Undue influence must be assessed by having regard to both the patient’s strength of will and level of pressure being placed on the patient by others …

By legalising voluntary assisted dying—that is, allowing people access to medicines that will enable them to end their lives—for many, that in itself is a relief. As noted in the Victorian Parliament, in Oregon, approximately one-third of all people who are prescribed the medication do not actually take it. Every Western Australian should have the choice if they are terminally ill and comply with the criteria contain in this bill to end their life with reduced pain and suffering. It should be their choice, but it should be a choice free from pressure.

MR C.J. TALLENTIRE (Thornlie — Parliamentary Secretary) [3.06 pm]: Where do I begin a speech that is about the ending of life? In an ideal situation, we would not need legislation like this. But we know that we are in a human world, a world with all sorts of failings and a world of human frailty. There are times when we see people experience what we might call a good death. For some it is a quick death. For some it is a death when family are
around and a sad occasion is shared and it goes with dignity and a sense of compassion. But for some, and we have heard the stories here, there are agonising deaths. There are cases in which the best palliative care in the world—acknowledging the advancement of the whole science of palliation—does not work for some types of illness. Maybe it will in the future, but there are some types of terminal illness for which palliation cannot nullify the pain. That pain is acutely felt by the person who is dying, but it is also acutely felt by those who are around—the family members.

One concern I have is that for some, the enduring memory of the death of a loved one might be the images, the actual sounds and the whole experience of what may seem to be the agony of that person. I say “what may seem to be” because I have heard of cases in which the dying person was perhaps not in great pain. But to witness the event of that person’s passing was indeed an awful thing. Dying with dignity is what we are trying to establish in this legislation.

I am thankful that we have had so much discussion in the community about this legislation. I regret that other pieces of legislation that impact on the lives of our citizens and all of us do not receive the same level of scrutiny. Just to draw one comparison, I think of the plight of homeless people—the whole homelessness situation in Western Australia—and the fact that somebody who sleeps rough is likely to have a lifespan 30 years shorter than someone would normally expect to have, yet we do not have the same level of policy and community discussion about an issue such as that. Fortunately, we have great interest in this issue. That is a good thing. I am encouraged. I welcome the fact that the community is actually observing us at work with this legislation, as difficult as it is. I appreciate that. The community is in fact sharing the challenges that we are all facing as we go through this.

It is important to quickly run through those essential things that set out who will be eligible for voluntary assisted dying. Obviously, it will be open only to people who have a terminal illness and who, in all probability, will die within six months, or 12 months in the case of neurodegenerative disease. The person must have decision-making capacity. This is an important point to touch on, because it has to be realised that that will rule out many people who are suffering, in pain, very frail, very elderly and have a terminal illness, but who will be deemed to not have decision-making capacity. I think especially of people with some form of dementia; they will not be able to be involved in this process. Voluntary assisted dying will be open only to people over 18 years of age who are experiencing a pain such that their suffering cannot be made tolerable. I think those criteria actually do confine things. When I have consulted experts about this and asked how many people a year we expect to die in this way, the estimate seems to be around 50 or so people. The legislation will have limited scope. I am actually thankful for that. I think the only way this legislation can proceed through this place is by applying it in a tightly confined way that can make it acceptable.

I will give some of the reasons I have had concerns about this legislation. Eleven years ago, when I first got into Parliament, there was discussion that a bill could potentially come on for debate. At that time it was put to me that palliative care would be able to cope with most cases of terminal illness. It has really been an awakening for me to find that that is not always the case. I wonder whether sometimes there is an element of people assuming what people who are dying want. I often hear people say, “I’m so sad that my husband or partner died without any of the family being around.” I am not convinced that at my final moment I will necessarily want other people to be around, but there does seem to be an assumption that we do want people around as we leave this world. I worry as well that there will be potential for people who are just fed up, who have had enough of life and who are perhaps suffering from some form of depression to in some way be included in this end-of-life process. I am encouraged, as I study this legislation, that I do not think that is the case.

I do not know the man’s personal circumstances, but one high-profile voluntary assisted dying case was that of Dr David Goodall, who went to Switzerland to die. So far as I could tell, Dr Goodall had a lot to contribute. This was a man who was giving interviews as he was getting onto the plane to go to Switzerland. For all I know, he could have been in a condition of unbearable suffering—far be it for me to judge.

I worry about the notion, as others have touched upon, of people having a sense of being a burden. I have worried about that. Again, I think the parameters of this legislation guard against that. That is when we come to the whole process by which someone needs to ask for voluntary assisted dying three times, and for one of those times to be in writing. They need to be examined by two doctors, who have had all the necessary training and who are capable of judging whether coercion is involved—they will have been trained to see whether somebody has just been subtly somehow convinced that they are a burden. The medical advice I have received from those who work with people in this situation—those who work a lot in nursing homes—is that, if anything, the coercion is only ever the other way, and that it is family members who are trying to convince an aged relative that they should hang in there, keep fighting and that somehow the medication is going to start working and they will feel better. A very complex, emotional whirlpool of events and feelings are going on—all sorts of emotions are involved. That is when it is critical that our legislation be as clear as possible and that it guard against any of those misuses, if not to say abuses.

I want to say a little about palliative care and express my gratitude and respect for all people who work in that area. I recognise them as dedicated professionals. For many, working with the dying is a vocation. It is much broader than the mere prescription of opioids. It is all about counselling, nurturing, relationships with family, encouragement and empathy—all those things that make up good palliative care. It is much broader than the simple prescription of opioids. We have had the discussion that more can always be done for palliative care. Of course,
constituents in nursing homes, and sometimes that can be quite a grounding experience. We meet people who are
would maintain a strong friendship following this legislation. He put to me that he was concerned about the subtle
In preparing for debate on this legislation, I sought advice from some faith leaders in my area. One conversation in
the case that a lot of the people we see in those high-need facilities will not be able to access this whole process.
It is probably
the issue of suicide, and the community’s concern around suicide. Those of us who have studied this more closely
worried about the potential for this to be seen as inconsistent with our strong messages around and our investment in
nature of some versions of coercion, and that that was something he was particularly worried about. He was also
passed away. It was a beautiful heart-wrenching moment in that film, but a very well-told story.

I want to come back to the point I touched on earlier that we as members of Parliament get the opportunity to visit
constituents in nursing homes, and sometimes that can be quite a grounding experience. We meet people who are
in a very frail condition physically, and quite often they are not particularly mentally strong as well. It is probably
the case that a lot of the people we see in those high-need facilities will not be able to access this whole process.

In preparing for debate on this legislation, I sought advice from some faith leaders in my area. One conversation in
particular I had was with Catholic priest Father Philip Pierot, a lovely man. We agreed that whatever transpired, we
would maintain a strong friendship following this legislation. He put to me that he was concerned about the subtle
nature of some versions of coercion, and that that was something he was particularly worried about. He was also
worried about the potential for this to be seen as inconsistent with our strong messages around and our investment in
the issue of suicide, and the community’s concern around suicide. Those of us who have studied this more closely
can see that the two things are very different; there is not a connection. However, there is a concern that there is a false
role for the oversight board, which is not a body that just gathers statistics; it is involved in every stage of the process.
I know there is some discussion about how long that process can be and that it can be as short as nine days in some
cases; nevertheless, that oversight board is involved. That is also a strength of this legislation.

I want to come back to the point I touched on earlier that we as members of Parliament get the opportunity to visit
constituents in nursing homes, and sometimes that can be quite a grounding experience. We meet people who are
in a very frail condition physically, and quite often they are not particularly mentally strong as well. It is probably
the case that a lot of the people we see in those high-need facilities will not be able to access this whole process.

In preparing for debate on this legislation, I sought advice from some faith leaders in my area. One conversation in
particular I had was with Catholic priest Father Philip Pierot, a lovely man. We agreed that whatever transpired, we
would maintain a strong friendship following this legislation. He put to me that he was concerned about the subtle
nature of some versions of coercion, and that that was something he was particularly worried about. He was also
worried about the potential for this to be seen as inconsistent with our strong messages around and our investment in
the issue of suicide, and the community’s concern around suicide. Those of us who have studied this more closely
can see that the two things are very different; there is not a connection. However, there is a concern that there is a false
role for the oversight board, which is not a body that just gathers statistics; it is involved in every stage of the process.
I know there is some discussion about how long that process can be and that it can be as short as nine days in some
cases; nevertheless, that oversight board is involved. That is also a strength of this legislation.

I want to touch on the issue of the Hippocratic oath for the medical profession. This is something that is sacred to
medical doctors. The oath was devised nearly 2 400 years ago. We can well imagine how much society has evolved
since those original words, very worthy words, encapsulate the idea that a physician must treat the ill to the best
of one’s ability, preserve a patient’s privacy, and teach the secrets of medicine to the next generation. They are
wonderful ideals that are sometimes put up as an argument to say that therefore the doctor could not possibly be
the person who oversees or administers something that will terminate a person’s life. That is a valid point.

I want to touch on the issue of the Hippocratic oath for the medical profession. This is something that is sacred to
medical doctors. The oath was devised nearly 2 400 years ago. We can well imagine how much society has evolved
since those original words, very worthy words, encapsulate the idea that a physician must treat the ill to the best
of one’s ability, preserve a patient’s privacy, and teach the secrets of medicine to the next generation. They are
wonderful ideals that are sometimes put up as an argument to say that therefore the doctor could not possibly be
the person who oversees or administers something that will terminate a person’s life. That is a valid point.

[Member’s time extended.]

Mr C.J. TALLENTIRE: However, I point out that civilisation has evolved. We have seen the near phasing-out
of slavery and we have seen a dramatic change in the attitude of society towards women, to name just a few things
that we have now as hallmarks of a civilised society. I think, again, that we can see that there needs to be an
evolution of something as important, and indeed as sacred, as the Hippocratic oath. When I think of the death of
loved ones whom I have been close to, I have a sense that the need for people to be around at the final moment
was not something that occurred, maybe through bad luck or perhaps through the wishes of the dying person. That
is an interesting one. I contrast that with an amazing film from 2003, The Barbarian Invasions, a Canadian film
that tells the story of someone going through to the final moments and having the family around them as they
passed away. It was a beautiful heart-wrenching moment in that film, but a very well-told story.

Extracted from finalised Hansard
I commend the general tone of this debate in not only this place, but also the community. What I have witnessed has been very respectful. The last forum I was at was in Kelmscott and was hosted by the member for Armadale and Hon Matthew Swinbourn. We had the pleasure of having Dr Scott Blackwell and Dr Michael Gannon debating one another. It was a very respectful, useful and informative debate. That is something from which we can all take inspiration as we continue to go through this important legislation. I also thank the members of the Ministerial Expert Panel on Voluntary Assisted Dying, especially Malcolm McCusker, and the member for Morley, the chair of the parliamentary select committee, and all the people who made submissions and engaged with the deliberations of the various committees. This legislation is ultimately about someone having the choice to not endure the pain from an illness that is going to kill them. I support this legislation.

MR M.J. FOLKARD (Burns Beach) [3.28 pm]: I rise to support the Voluntary Assisted Dying Bill 2019. Before I start, I thank other members of this house for their fantastic contributions and for the sad, heartfelt stories they have relayed in their speeches. In this debate I have seen the very best of us in this place. I thank our Premier, the member for Rockingham, for his comments early in the debate regarding first responders and the difficulties they face day to day when dealing with this difficult topic. As members are aware, in a previous life I was a long-term serving senior police officer. My values and thoughts on voluntary assisted dying have come about through many years of attending countless sudden death scenes that related to people passing from chronic illness. I have attended so many over the years that I cannot even begin to quantify the numbers. I have attended murder–suicides when partners have killed sick loved ones and then taken their own lives. I have attended scenes when partners have attempted to kill their sick loved ones and then taken their own lives, but have failed in taking the life of the sick partner, resulting in that partner dying in loneliness.

I have attended scenes when a partner has taken the life of a sick loved one but has been unsuccessful in taking their own life and has become nothing more than a living vegetable. I have seen simple suicides after individuals have been advised that they have a terminal illness. Some havejumped in front of trains. I have even been to situations in which individuals have created complicated machines and used them to take their own lives. I recall one situation in the wheatbelt in which an individual, upon being advised that he had terminal prostate cancer, built a machine. He rang the police, put himself in the machine and took his own life. The instrument he developed was such that once he put himself into it, there was no way of getting out of it until it completed its tragic task. The individual knew that it would take the police 40 minutes to get him but that the mechanism would complete its horrific task in 20 minutes. I had forgotten about this and only remembered it recently when I was thinking about and preparing for this second reading contribution.

I have also attended palliative care situations in which palliative care sedation has led to the death of an individual and a complaint was made that hospital staff murdered the dying patient. The complaint came from an aggrieved family member who felt that he was not involved in the care of the dying person and that, in his opinion, his views were not taken into account before the final stages of sedation took place. I have investigated circumstances on behalf of the coroner and I have supervised investigators on behalf of the coroner. I have cried with officers who have been overwhelmed in those circumstances. As a country police officer, I have held loved ones in my arms and shed tears with them as they have come to terms with the passing of their loved one. These people were strangers to me, but they sought my console and being the only person there, I did what was needed to negate their suffering. I doubt that no-one in this house has seen more death, more deceased persons or more tragedy in relation to this topic than I have, with the possible exception of the member for Kalgoorlie, who was also a long-term police officer.

My view on voluntary assisted dying formed over many, many years, before the Joint Standing Committee on End of Life Choices parliamentary inquiry, before the Ministerial Expert Panel on Voluntary Assisted Dying, before the consultative process I ran in my electorate, which involved extensive cold-calling, doorknoocking and meeting with constituents, and before the end-of-life forum that I held at the Joondalup Sports Association in Iluka. I noted from the recently published survey that at least 90 per cent of people in my electorate—possibly as high as 95 per cent—support voluntary assisted dying. But my views were developed through real-life experiences. It is interesting that with all the years of working in and dealing with these tragic circumstances, the real driving issue behind this is fear. I say that again: the real issue is fear. Let me explain this. It is not a fear of death; rather, it is a fear of suffering through the process of dying. The best example I can give is the recent conversation I had with my father. My father was a Vietnam veteran. He was a past member of the Special Air Service and served in Vietnam. He was in the field when the Battle of Long Tan was fought. Some would say that he is a very brave man, and I would agree. He is not scared of death—but he is terrified of suffering when he is dying. He has pleaded with me on numerous occasions that if I have a choice, he would prefer that a decision be made at the earliest point rather than allow his suffering to continue. This fear was evident during a recent home visit to discuss this topic with an elderly couple in my electorate who are in their 90s. They are a lovely couple, so proud and full of life, but they are so concerned and worried. When it comes to their final journey, they want to have control and maintain their dignity when the time comes.

I must note that during all the consultative processes that I have conducted about voluntary assisted dying, as a general rule the discussions have been mature and in good standing. Some nasty things have been said, particularly in emails that I have received from lobby groups. They do not deserve a response. What really worries me is the experience of real anger because this legislation does not go far enough and does not cover dementia or Alzheimer’s disease.
I recall talking to a particular gentleman at his doorstep. He was very passionate about the topic and it became clear to me that he had genuine fear in his eyes; it was obvious from his tone and the language he used when he spoke to me. I had no answers for him. I took his views on board.

I have not ignored the religious views of my constituents. I took the time to speak to Kay Goldsworthy, the leader of the Anglican Church of Australia, to hear her views on this topic. They were very interesting. I sought out senior members of the Western Australian Muslim community and spoke to them about this topic. Again, their comments were very interesting. Having been raised as a Catholic, I know that Muslims’ views are very similar in some ways. They view this as one of life’s challenges and they believe that how individuals deal with it is their choice. That is very similar to the view of the Anglican Church; the Anglican Church’s views are very mature. I found solace listening to these individuals.

The second group that approached me that opposes this legislation is the palliative care lobby. I really worry about that group. In addition, I really worry about palliative care in Western Australia. Voluntary assisted dying should be part of an individual’s life-ending choices and should be included as part of their palliative care plan. Over many years of dealing with the fallout of chronic illness, I have formed the view that palliative care is only for the rich. In the report “My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices”, I read with interest finding 9, which states —

Access to inpatient specialist palliative care in Perth is limited.

Finding 10 on page 67 states —

Apart from a small number of private beds at Glennngary Hospital, there is no inpatient specialist palliative care hospice in the northern suburbs of Perth.

This concerns me. During the briefings I received on this legislation, no-one could tell me how many palliative care medical specialists are in Western Australia. I was told 15 or possibly 19, but no-one could accurately tell me how many specialists we have. The area of Western Australia comprises 2 529 875 square kilometres, with a population of approximately 2.72 million people. That means there is one doctor for roughly 182 000 people who are spread around 180 000 square kilometres. I served extensively in regional WA. In nearly 30 years of policing, I have no recollection of there being any palliative care doctors in regional WA. I have a real concern that regional people are restricted in their end-of-days options. Western Australia’s regions are divided into seven health districts, and each region, if divided equally, is around 360 000 square kilometres. My understanding is that possibly two palliative nurses cover those districts. With such limited numbers in an area of such a great size, there are clearly some major issues.

I have also read with interest about the major issue that our oncologists have such little faith in the palliative care specialists that they are not referring people to these specialists at the earliest opportunity. I wonder whether that is because there is not enough of them or they do not have any of them, or whether it is because they are only in the metropolitan area. I note that in the northern corridor, the only inpatient palliative care available is at a private hospital in Glengarry. This reinforces my thoughts that palliative care depends on the thickness of your wallet rather than the needs of the individual. Further, I note that the thicker your wallet, the easier it is to access these services and the closer they are to your home. On my review of the sector, and what limited service providers there are, I found that they are generally located in medical infrastructure rather than out in the local community. They are all focused on the metropolitan area, where medical services such as MRIs, pharmacists and oncology services are co-located, and the likelihood is that they are closer to where you live if you live in the metropolitan area. This is a concern that clearly demonstrates that the more isolated or the poorer you are, the less likely it is that you will be able to receive proper palliative care, and the less likely it is that you will receive it at all. The further you are away from the city, the less likely you are to get good proper palliative care or supervision.

We really need to do better in this place. I see that this government has committed an extensive sum of money to try to rectify some of this, but I think there is a long way to go. Earlier I stated that I have done some investigation into palliative care in hospitals and hospices. During those inquiries, the term “palliative care sedation” was raised. This is not a new term. This is when palliative care teams start increasing medication to ease the pain of the patient. The medication is increased to reduce suffering, but it is increasing the medication that eventually leads to the patient’s death. It was interesting speaking to nurses during my consultative processes because on several occasions these different nurses stated that they, through the palliative care process, could tell a family almost to the hour when a person was about to die. This, to me, seems to be effective euthanasia by another name. It was unsupervised, there were no checks and balances, and the possibility of abuses in that process were clearly evident to me when dealing with the situations I had previously dealt with. It is something to think about when there is a royal commission into elder abuse in this country. I watch this space with interest to see what its findings will be.

I read with interest that there are 102 checks and balances within the Voluntary Assisted Dying Bill. I hope that these will counter some of the arguments put against an individual’s right to die. This bill is about empowerment. I say that again: it is about empowerment of an individual when it comes to their time to die. Canada has had voluntary assisted dying legislation for at least 10 years and possibly longer. When a couple of practitioners came to our Parliament to speak, it was interesting to learn that it was their experience that of those individuals who
were firstly administered the instrument of their final choice, one-third of them who qualified for the end-of-life choice chose not to administer that instrument. This, to me, is evidence that voluntary assisted dying is more about an individual’s right to choose, and, more importantly, that they have ownership of the way that they want to pass.

Voluntary assisted dying is about owning your own journey. It is about knowing the when, the where, the how and the who. The “when” is to know the time you are going to pass; the “what” is about what is going to happen, so that you fully understand the process, thereby empowering the individual; the “how” is knowing what is going to happen and knowing that not some third party, but you, have control; and the “who” is about who has control of your final journey and who is around you when it happens. Over the years I have worked with many inspirational people and leaders. Some of them will always be nameless and faceless. One of them whom I would call a wise man once said to me that the best way to combat fear is through empowerment.

Mr M.J. FOLKARD: I believe the reason there is such wide support for this legislation is that our community believes that when it comes to dying, everyone has the right to decide the direction of their final journey and how that journey will take place. This bill attacks the fear that is associated with the current horrific passage of passing. This bill empowers an individual so that in certain circumstances, they will own their final journey. It is their death. I believe my community believes that that should be the case. I commend the bill to the house.

MS C.M. ROWE (Belmont) [3.45 pm]: I rise today to speak in favour of the Voluntary Assisted Dying Bill 2019. Arguably, this is one of the most critically important bills that we are likely to deal with in this place. Firstly, I acknowledge the hard work of the Minister for Health and congratulate him for introducing this historic legislation. I also acknowledge the hard work of the joint select committee, especially the member for Morley for chairing the committee, and, of course, the ministerial expert panel. I can imagine that the last two years have been an incredibly challenging and emotional journey to get through.

Like all of us in this place, I have delicately considered my position. I have received letters, emails and phone calls from people right across my electorate who have bravely shared their stories, like so many here today, and told me their view on this very sensitive issue. I conducted a number of surveys. One was online and then I mailed out surveys to my whole electorate. I hosted a community forum because I wanted to make sure people of all different views in my electorate had the opportunity to come forward and share their opinions with me on this particular bill. Overwhelmingly and probably not surprisingly, like everybody else has mostly experienced, my constituency is overwhelmingly supportive of this legislation. I support this legislation wholeheartedly as well, because, ultimately, at its heart, this bill is not about dying; it is about dignity. It is about compassion and, most importantly, it is about reducing suffering. I am exceptionally proud to be part of the Labor government that is bringing this bill to the state Parliament, but to be clear, I respect those who do not share my view on voluntary assisted dying.

I would like to take this opportunity to acknowledge the contribution of the Leader of the Opposition, who earlier today reflected on her very personal and painful experience of watching her husband die of cancer, as well as the member for Bicton for sharing her heartbreaking contribution, along with many other contributions that we heard yesterday and last night. Your loved ones would be really proud, and I know that it has been tremendously difficult for people to share their heartfelt experiences.

This bill is not about suicide. Voluntary assisted dying is not suicide. This bill is about giving those who are diagnosed with a terminal illness—when they are likely to die within six months, or 12 months if it is a neurodegenerative condition—a choice about the way in which they die. It is about providing patients with autonomy over what should be their most fundamental right, in how they die.

In 2017, the state government established the Joint Select Committee on End of Life Choices. As we heard from the chair and many other members of that committee, it was an exhausting process, embarking on extensive consultation right across the state. It received 700 submissions and heard from 130 witnesses. The work that the committee conducted was really critical in the formulation of this legislation that is now before this place.

This bill enshrines the right of a terminally ill patient to access voluntary assisted dying if they so choose. The key word in the bill is, of course, “voluntary”—that is, for the patient and, importantly, for health practitioners. Furthermore, in order to be eligible to access voluntary assisted dying, the person must be at least 18 years of age, an Australian citizen or permanent resident and have been a resident of WA for at least 12 months. They must be diagnosed with a disease or illness that will lead to death within six months, or 12 months in the case of a neurodegenerative illness, and be deemed to be suffering such that they cannot be relieved to the extent that the patient finds tolerable. It is my firmest belief that it should not be up to another person what level of suffering is tolerable to another individual. In addition, for a patient to be eligible to access voluntary assisted dying, two independent doctors need to determine that the patient is making an enduring decision, so it must be verbal on two occasions and then written, so a decision cannot be made on a whim, and no coercion can be involved. Also, they need to assess the patient’s decision-making capacity, which is, of course, critically important. There are 102 safeguard measures within the bill to ensure the protection of vulnerable and terminally ill patients and to

Extracted from finalised Hansard
provide a safe and transparent framework for end-of-life choices. This is an important point. We need to establish a legal framework for end-of-life choices. Currently, there is no real framework. This will invariably benefit patients and medical practitioners. There are very few means available for terminally ill patients, which is very traumatic for their end-of-life choices. Many choose palliative starvation and dehydration. This process of dying is terrible for the patient and their loved ones and can take up to two weeks.

As I mentioned, I have spoken with and heard from so many people in my electorate of Belmont, who have various opinions on whether the bill is the right thing to do. It has been really important and a great opportunity for me to listen to everybody’s personal stories. I would like to express my thanks to everybody who contacted me and for sharing their stories with me because they are deeply personal and very difficult for them to share.

I recently held a voluntary assisted dying forum in my electorate with Hon Alannah MacTiernan, who spoke, along with the member for Morley. We were lucky enough to have Dr Grube with us. He has been working under a voluntary assisted dying framework in Oregon, which has been in place for 22 years. He was able to provide his insight and firsthand experience of operating within that framework for the full 22 years that it has been operating in Oregon. I was really pleased to see so many people come to that forum so they could not only hear about how this legislation will work, if it passes, but also hear firsthand from a doctor. Most importantly, they were able to come along and be involved in a forum where they could share their opinions and show respect, regardless of those opinions. It was fantastic to see so many people—120 people—come to that.

One elderly woman at the forum—I found this really confronting—grabbed me before the forum started because she wanted to share something with me that I have not come across before, but no doubt others have spoken about it. She desperately wanted autonomy over her final moments if she was unlucky enough to develop a terminal illness. She did not want to endure an agonising end to her life, which she witnessed so many of her friends and loved ones go through. She came up to me to say that she desperately hoped that this legislation would go through because she and her friends were sick of seeing one another stockpiling their prescription medication for use down the track should they need it if they were enduring a terminal illness. She shared a story with me. One of her very close friends was diagnosed with a terminal illness and was in immense pain. She tried to overdose on her thyroid medication. I have a thyroid issue and take thyroid medication daily. I can only imagine how much she would have had to consume. Sadly, it was not successful in her case. I say “sadly” because instead of dying, she is now rendered a vegetable, according to my constituent. This has created enormous fear for many of my constituents because, like their friend, they had been stockpiling medication. This is a really tragic scenario and outcome for not only the terminally ill woman, but also all her friends, family and loved ones who have had to watch her fade away as a vegetable, which were the words that she used. That is a really tragic outcome.

Another woman at the forum called me over. She was sitting up the front. She was struggling to breathe. She was very angry. She said, “Cassie, come over here. I’m furious. I am a practising Christian. I go to church every week and I do not understand why you or anybody else has a right to decide how and when I die.” She had a degenerative disease. She did not go into any detail about that disease, but she was outraged that a patient would not have the ultimate say about when it was their time to go and how much pain they should suffer. She said that regardless of people’s religious views, she believed their religion should not impact on how they chose to die and whether they should access voluntary assisted dying. I fundamentally agree with that. Religious views do not belong in the examination room.

In July, Kerry Robertson became the first person to access voluntary assisted dying in Victoria since that legislation passed. She was only 61 but she had suffered from terminal cancer for years. In fact, she battled with cancer for nine years. Her two daughters, Jacqui and Nicole, told the advocacy group Go Gentle Australia that her death had been beautiful and peaceful. That is in stark contrast to other reports and research I have looked into relating to end-of-life scenarios involving people in palliative care and who are mostly experiencing pretty horrendous and painful deaths. They said of their mum, Kerry —

“Her body was failing her and she was in incredible pain. She’d been in pain for a long time.

“Palliative care did their job as well as they could. But it had been a long battle. She was tired, the pain was intolerable and there was no quality of life left for her.

“We were there with her; her favourite music was playing in the background and she was surrounded by love. She left this world with courage and grace, knowing how much she is loved.”

This bill gives us the opportunity to recognise the importance of giving people a genuine choice and autonomy over their decision-making—allowing eligible people at the end of their life to access assisted dying. It will provide a safe and compassionate option for people with a terminal illness who will suffer, even in the best palliative care. Many have said that palliative care will be able to manage and treat pain, providing comfort for those at the end of their life, but unfortunately it has its limitations and it cannot relieve all suffering. Some suffering simply cannot be alleviated through palliative care. Palliative care, however, is a really important care option. Voluntary assisted dying is not a substitute for palliative care, nor is it an inevitable extension of palliative care. That is why our government will invest $206 million in palliative care over the next four years.

Extracted from finalised Hansard
Data shows us that about five per cent of people with a life-ending illness suffer irremediably, even in the best palliative care situations and settings. I would like to share with members Mr Bill Spanbroek’s comments to the Joint Select Committee on End of Life Choices about his experience with his stepson Michael Watkins, who was diagnosed, tragically, with juvenile Huntington’s disease. For the last year of Michael’s life, under the care of his parents at home, he had to be fed intravenously, having lost all ability to swallow, and he could barely walk. He had lost control of his bowels. Michael was eventually hospitalised after a brain haemorrhage. In his submission, Bill said —

We took him to the hospital where our neurologist was looking after him and he was given painkillers, morphine and what have you. We kept saying to the neurologist, “Peter, he is in pain.” He said, “But I have given him the limit of morphine; I cannot give him anymore”, and he said, “But he is not in pain.” Well, I can tell you the last thing he said. He lifted his head from the pillow and said, “Bullshit”. He was in hospital for five and a half weeks, and every night we drove home my wife and I said to each other, “He won’t be there tomorrow.” Five and a half weeks later, he passed away.

Belinda Teh, who was here earlier today, has publicly shared her grief at watching her mother’s excruciating final days battling terminal breast cancer, in the hope of raising awareness about voluntary assisted dying. Many of us have followed her walk across the country. When her mother, Mareia, was told that the chemotherapy treatment was hastening her death, she simply said to her oncologist, “Please help me go now.” As this was not currently an option, she was sent to a hospice to die. After three days in palliative care, she made the same request to doctors. Those final days sound nothing short of harrowing for both Mareia and her daughter. Belinda said in an interview —

“She was twitching and gasping for air, like someone was choking her,” …

“My mother was totally unrecognisable. She stank. She looked awful and her skin was all these different colours—grey, purple, yellow and blue.”

Belinda also said in the same interview —

“As a result of the law, I watched my mum spent the last hours of her life in complete agony. The final four hours haunt me.”

One of my closest friends, Heather, had to watch her beautiful mum, Judy, suffer immeasurably in her final moments, after she lost her battle with terminal cancer in 2016. Heather shared with me the pain she endured witnessing her mother’s suffering. I quote —

Those last few days watching your loved one suffer, I wouldn’t wish it on my worst enemy.”

She also told me —

Some things you can never un-see and those last few hours of your mum or dad dying you will never forget.

[Member’s time extended.]

Ms C.M. ROWE: In an article by Andrew Denton, published by The Wheeler Centre, he tells of the experience of journalist Spencer Ratcliff who had to bear witness to the shocking suffering of his partner, Deb, while in palliative care. I quote the article —

Spencer, a journalist who had reported from war zones told me: ‘I’ve never see pain like it.’

He asked the nurse, ‘How can you sit and watch her in such pain and tell me she can’t have more morphine?’ ‘Because the doctor says I can’t’. The night palliative care team told him the same. ‘We’re not allowed to do any more.’

To whose benefit was Deb kept alive for a few more days of pain?

A number of concerns have been raised with me about vulnerable people and how they could be coerced into ending their lives. I believe these have been fully addressed with strict eligibility criteria and strong safeguards to ensure they apply only to those for whom the law is written. These safeguards specifically include that the decision is well informed, that there is a requirement for more than one practitioner to be involved, that practitioners are appropriately trained to detect risk of coercion or abuse, and that there are multiple occasions in the process during which the person affirms their wishes. Twenty years of peer-reviewed evidence from North America shows that such safeguards work. They work because someone cannot be coerced into an advanced incurable illness that they do not have. It is even harder to coerce two doctors, whose work will be subject to review, to agree with them.

Former Perth radio veteran Howard Sattler, who is battling a degenerative brain disease, recently spoke out about wanting to end his life. He is quoted as saying —

“I just can’t go on much longer like this.

“I don’t want jump off a bridge or anything like that … I just want to take a pill sometime, a nice gentle pill.”

Without voluntary assisted dying laws in place, many terminally ill people, or people with an incurable illness, who are experiencing immense suffering are attempting to end their life in violent and undignified ways. This can
end in major physical and/or psychological damage to those people, if unsuccessful, as well as to their loved ones who must endure the trauma of losing someone to suicide. A person attending the planned suicide of a loved one may be charged with a criminal offence; therefore, the terminally ill person must end their life alone rather than with the support and love of the people around them.

Dr Grube was asked a confronting question by one of my constituents at my forum on voluntary assisted dying. He was asked, as a Christian and a doctor who worked in the voluntary assisted dying framework, whether he ever regretted any of his actions. His response floored us—he said yes; he regretted one case. One of his patients did not yet meet the eligibility criteria. He was terminally ill but did not yet meet the criteria. He regretted not being able to provide assistance. He did not specify what assistance; he just said he regretted not being able to provide assistance to this patient because the patient then took his own life. He hanged himself. Dr Grube said that the family never recovered from the grief of losing his patient to suicide.

In Western Australia, the parliamentary inquiry found that 10 per cent of all suicides were by people with terminal or debilitating chronic illnesses who saw no choice other than to take their own life; often, if not always, violently and alone. The most common method of suicide is hanging. Other methods include asphyxiation by plastic bag, or gunshot.

During the inquiry into voluntary assisted dying in Victoria, Coroner John Olle gave evidence of elderly, terminally ill people taking their lives. This makes for really harrowing reading, and no doubt harrowing deaths. He told of a 75-year-old man with prostate cancer who shot himself with a nail gun; a 93-year-old woman with agonising arthritis who bled to death after using razor blades; and an 85-year-old woman who did the same with the use of a number of knives and scissors. I feel sick even reading this out. This is not how anyone wants to die, and nor should they, if they are terminally ill and experiencing pain.

There needs to be compassion in our end-of-life choices. The Voluntary Assisted Dying Bill 2019 will alleviate the stress of people taking matters into their own hands and provide them with the freedom and autonomy to live the remainder of their life, and end it, with dignity and without enduring unbearable suffering.

Eight countries already have voluntary assisted dying laws, including Australia, with the state of Victoria making it legal in 2017. This state has had the opportunity to learn from those jurisdictions and the laws that they have in place. I believe the voluntary assisted dying laws that are proposed in Western Australia are among the safest and most conservative in the world. As has been the case with other members, my constituents are most upset that these laws do not go further.

I want to see this bill passed and voluntary assisted dying become enshrined in legislation so that terminally ill patients can die with dignity and be free from suffering. This is our opportunity to establish a transparent legal framework that has one objective for terminally ill patients who are suffering: compassion. This bill is long overdue and I desperately hope we are able to provide terminally ill patients who are enduring interminable suffering a choice about their own lives and the manner in which they end. This should be the most fundamental of rights.

I commend the bill to the house.

MR Y. MUBARAKAI (Jandakot) [4.10 pm]: It is not a choice in life to suffer from a chronic disease. Chronic diseases can strike down people at any age at any given moment, and they do not discriminate. Some diseases are quick to take over and can rapidly reduce people’s quality of life. They inevitably send them to a stage at which it is a struggle to live without pain—without hope and without dignity. This whole space has changed from 50 years ago when our grandparents and older members of our families simply passed away in their beds in their homes. Let us fast-forward to today when medical breakthroughs are giving the ill or dying longer in this world, but with zero quality of life, causing havoc, despair and heartache for all involved. The change represented by this Voluntary Assisted Dying Bill 2019 will allow medicine and law to catch up with dying in this modern day and also give the people who are in this space the decision to die with dignity. I am of the view that when people are incarcerated by chronic disease, when the illness takes away any hope of a future, and they are reliant upon palliative care and awaiting the inevitable, they deserve the right to choose, and I am fully supportive of the individual having that choice. What the Voluntary Assisted Dying Bill 2019 will do for those vulnerable people of Western Australia to whom it will directly apply is to give them the freedom to choose. This bill will require people to discuss their situation with trained health professionals and be made aware of alternatives, without the pressure of commitment, and with the opportunity to change their minds at any time. I refer to clause 18 of the bill, which is titled “No obligation to continue after making first request”. It has three subclauses. They state —

(1) A person who makes a first request may decide at any time not to continue the request and assessment process.
(2) The request and assessment process ends if the person decides not to continue the process.
(3) If the request and assessment process ends under subsection (2), the person may begin a new request and assessment process by making a new first request.

Extracted from finalised Hansard
Clause 26(1)(i) states —
that the patient may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying;

Clause 52 again states —
**No obligation for patient to continue after completion of request and assessment process**
A patient in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

There is truly the opportunity and freedom for the person assessing this end-of-life choice to withdraw from his or her options.

Let me share the experience of a young family man, of a Western Australian family, with terminal tumours found in his stomach. He was told the news, along with his wife, on the night before their second son was born, that he had approximately six months to live. Words simply cannot describe the effect that this has had on them—a family’s life absolutely shattered by this discovery. He had terminal cancer; there was no way out of this. Acting on the medical specialist’s advice, they chose a pathway that saw him in the last few months of his life enduring this illness that was killing him and struggling to overcome the sickness from the medicine being used to prolong his life. He had no quality of life and no dignity. He was dying a very public, undignified and deeply sad death. He was losing control, and you could see the panic in his eyes. He did not want to go. So deeply embattled in trying to survive, he followed the advice of doctors who only had options that dealt with prolonging life, leading to his last five months on earth being spent fighting to live at the cost of being unable to function. He was not given a choice. In his dying days, when his mum arrived from Queensland to say goodbye, he was out of control in pain whilst his body was shutting down. His refusal to see his mum was a choice he made, and his mum was left distressed and so deeply wounded that her son was living his last days and that she could not get to him. But that was the only choice he had and it was not a choice he wanted to make. No-one wants their loved ones to live in memories of sadness; they want them to grieve in good memories. I would like this house to know that the man’s wife, Chev, requested I share her views first hand. To this day, and moving forward, she struggles with her loss and wishes that by members supporting this bill other families may not have to endure similar pain.

In Western Australia we have the fewest publicly funded palliative care inpatient beds per capita, with limitations to specialist palliative care across the state. This was the single largest issue addressed throughout the inquiry, and more work is needed to ensure that this sector stays up to speed with growing demand and expectations from our community. With an ever-growing and ageing population, a renewed focus on palliative care is important. The “WA End of Life and Palliative Care Strategy” outlines the government’s strategic statewide policy direction of the vision, values and priorities for improving the lives of all Western Australians through quality end-of-life and palliative care in Western Australia. Everyone should have access to timely, equitable, good-quality end-of-life care, with access to specialist palliative care whenever appropriate. Palliative care helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness, and I support the view that more needs to be done in this space to better cater for anyone in their days of ill health. Hon Roger Cook, MLA, Deputy Premier; Minister for Health; Mental Health, convened a palliative care summit on 17 August 2019 for health practitioners, stakeholders and the community to explore ways to develop high-quality palliative care services for all Western Australians. I commend the minister for his efforts in addressing this issue front and centre.

In his speech, the Premier told the same story shared by our parliamentary colleague the member for South Perth, John McGrath, from election day 2017, of Clive Deverall. It cut deep. I know that me expressing Clive’s wishes today is fitting to this bill. As members have already heard, Clive was the former head of the state’s Cancer Council and its palliative care association, as well as being a Palliative Care Australia board member. Clive sent a message to Western Australia by ending his life this way, with a note that read, “Suicide is legal, euthanasia is not.” Clive made a choice to end his life, staying in control and ending his suffering when his prognosis showed no hope, no cure and no chance of him beating his disease. According to national coronial data, around 10 per cent of suicides in Western Australia are by people with a terminal or debilitating illness. People who commit suicide due to a terminal illness die lonely and often violent deaths.

Planning ahead brings many benefits in day-to-day life, and when applied to the end-of-life choice it can help alleviate some of the distressing factors that hit hard when one’s life is simply slipping away, such as the fear of dying. Planning end-of-life choices with trained health practitioners will assist individuals to cope with emotional, physical and mental trauma, and give them more time to make well-informed decisions and help them to get their affairs in order. The Voluntary Assisted Dying Bill will provide safe and compassionate access to voluntary assisted dying for eligible Western Australians with a terminal illness who would suffer, even with the best palliative care. It is an issue that has had ongoing support from the community for many years, and this legislation is based on compassionate grounds for people who are eligible to choose the timing and circumstances of their death.

*Extracted from finalised Hansard*
I will tell members another personal experience of one of my constituents, Murray, and his wife, Sharon, who lost her battle with breast cancer three years ago. Murray contacted my office to share his story and his views on this bill and the need to get it through. The story that Murray shared with me about his wife, Sharon, struck a chord deep inside me, and it would be all too familiar to many other families in Western Australia. In 1996, Sharon was diagnosed with breast cancer. It was a shocking diagnosis for the family, but with no option but to push forward, Sharon pushed through the breast removal and the treatments to be given a clean bill of health, or so Sharon and Murray thought. Fifteen years later, in 2011, Sharon found another lump and upon getting it checked out by a doctor, they received the dire news that it was now stage 4 breast cancer. Again she pushed forward with the procedures and the chemotherapy, this time taking years, until the day came that her oncologist revealed that it was not working and that she needed to increase the dosage of chemotherapy.

I am saddened to say that that is when it all started to go downhill for Murray and Sharon, with Sharon’s health diminishing with each treatment of chemo and the realisation by both Sharon and Murray that she was losing the battle against this aggressive cancer. The mental effect it had on them both was overwhelming and intense. Sharon was a proud woman and took great care with her appearance, but the effects of the treatment were prominent and Sharon’s appearance was noticeably unhealthy. Her great will to live conflicted with the fact that she was dying. There was nothing that they could do except to live until that day came.

Murray reflected on the assisted dying bill, and said that if it had been legal then, a lot of pain and mental anguish could have been spared. Murray said that he and his wife discussed her end of life and they had both decided that at the end Murray would ask for the palliative care staff to assist in any way that they could to help end Sharon’s life in a humane way—in a dignified way. Sharon and Murray’s stepdaughters—one of whom lived overseas—returned home as often as they could. They started to prepare, but nothing could have prepared them for the turn that the end took. They did not see what was coming. No-one had told them that in palliative care, in the end stages of dying, their beloved wife and mother would become a mentally scared, sad and confused patient and start slipping away from life. She was unable to control any bodily functions. Being no longer able to swallow, she became dehydrated. Being unable to eat, her body began to starve and she eventually slipped into a coma. There was nothing for Sharon, and only pain for her family, who played a waiting game. They felt guilty when thoughts of hope that she would pass soon entered their heads, when they did not want her to go at all. Murray was sad that Sharon had no option or choice. She had to die like that. Murray would have liked for his wife to have had the control that this bill will allow.

The Voluntary Assisted Dying Bill is not an easy way out. It will allow people who are eligible to access this choice, based on 102 safeguards. For Western Australians, I am hopeful that this bill gets through because it will enable the people of Western Australia who still have decision-making capacity, and who have been diagnosed with a disease, illness or medical condition that meets a specific and limited set of criteria—those that will die within six months, or 12 months for neurodegenerative conditions—to make a choice. All eligibility criteria must be met. All process requirements must be met. Disability and mental illness alone do not satisfy the eligibility criteria. Assisted dying must be a choice made without coercion or force. It must be made voluntarily.

These safeguards, as well as the palliative care services being expanded, will support a more humane, better informed end-of-life pathway for those who are at that stage, and will reduce the psychological and spiritual distress that we have heard spoken of by other members in this house today. There needs to be a choice. My friend needed this choice. Sharon and Murray needed this choice. The people of Western Australia want a choice. The Joint Select Committee on End of Life Choices heard from many people who would have loved for their loved ones to have had that choice.

Mr Y. MUBARAKAI: Clive Deverall highlighted the need for this choice by taking his own life and leaving a strong message with his dying note.

This Voluntary Assisted Dying Bill is a choice. It is my choice to speak so strongly for it. Finally, I will leave members with a quote from the final paragraph in the chair’s foreword of the report into end-of-life choices—words by Mr James Hindle. He stated —

The ultimate act of compassion is surely to allow someone to choose to end their suffering, even when we want them to stay with us.

In the memory of Jonathan Ralph and Sharon Paddick, who would have wanted all Western Australians to have the freedom to choose and to not experience their pain and suffering in years to come, I fully support this bill and I respect the choice to choose.

Extracted from finalised Hansard
With that, I commend the bill to the house.

DR M.D. NAHAN (Riverton) on end-of-life choices and, specifically, this bill. It is a bill that the public wants and is demanding and, quite frankly, I conclude my remarks with a quote from Ecclesiasticus 30:17 —

I admit that I come from a straightforward family and I had parents whose strong, simple faith I have inherited. for another time, maybe. If others do not want to use it, I respect their right not to. But please accept that it might be my wish, and I think that I should have the right to take that path if that is my wish. It is not a sophisticated argument.

Likewise, I would like to acknowledge some other clergy who have spoken to me, and others who have offered to help me with these issues if I thought I was finding them a bit hard to understand: Pastor Jon Paschke of Lighthouse Uniting Church; Pastor Graham Fabian of Sun City Christian Centre; Gavin Hirschhausen of Strathalbyn Christian College; Kevin Merritt of the Geraldton Family Fellowship—80 per of whose congregation are Aboriginal people—and assistant Imam Daftie Kudus from Geraldton Mosque.

At a time like this, I think all members look back in particular to their childhood and formative years, and remember things said, generally in passing, by their parents. I think both my parents would have supported this bill. They were both strong country people who had a very strong Christian faith. They would not have seen supporting this bill as being un-Christian, although I do understand others who would see it that way; personally, I do not. Although this bill does not address this issue, when I was speaking about this bill with my sister recently, she recalled how disturbed my father was to see his mother spend seven years in a nursing home, for the last four of which she was a virtual vegetable, with dementia. As others have noted here, this bill does not go near this issue. Many people will be unhappy with that, but I understand the different legal complexities of that issue.

I would like to reinforce the concerns of the member for Warren–Blackwood: without something like voluntary assisted dying legislation, the acceptance of the use of firearms to dispatch livestock when there is no other help possible for them—which I personally have had to do fairly often—means that the incidence of suicides in the bush will continue. Of course, if it is not by firearms, it will be by vehicles or by drinking toxic chemicals. I am sure most country members will be aware of cases like these.

The other deciding factor for me in supporting this legislation was the passing of my father-in-law, Pell House, of Kojonup. Pell had inherited a family condition called polycystic kidney disease. My mother-in-law drove him three times a week from Kojonup to Albany, which is 170 kilometres each way, so he could have dialysis. When my mother-in-law reached the age of 80, they decided to move to Albany to live. In his eighty-seventh year, Pell fell and broke his hip. Life was already becoming hard, with a lot of pain from his knees; he had had a lifetime of hard physical labour, clearing and developing his farm. Pell decided to refuse to have any more dialysis. The family respected his decision. The doctor said that he would gradually fade away, and simply go to sleep—somewhere between three and seven days. As it was, he lasted for about five days. Nobody suggested that we should pin Pell down and insist that he have dialysis. Frankly, I do not see any difference between his decision to stop dialysis and fade away and a request by somebody who has a clear cancer prognosis, for example, and an unpleasant end coming, to take a simple mixture and have a pain-free end, surrounded by their family, as I am told people can do in other places.

I am not what you would call a very strong libertarian. For the good of the community, I accept that government sometimes has to tell people what to do. But I do see this as a simple right, and I do not think anybody has the right to tell people that they cannot have access to this if it is what they want. It is probably what I would want. Personally, if I were in the early stages of dementia, I would want it in that case as well, but that is something for another day and for another time, maybe. If others do not want to use it, I respect their right not to. But please accept that it might be my wish, and I think that I should have the right to take that path if that is my wish. It is not a sophisticated argument. I admit that I come from a straightforward family and I had parents whose strong, simple faith I have inherited.

I conclude my remarks with a quote from Ecclesiasticus 30:17 —

Death is better than a miserable life, and eternal rest than chronic illness.

It is how it is brought about, I guess.

With that, I commend the bill to the house.

DR M.D. NAHAN (Riverton) [4.35 pm]: I could say that it is a pleasure to speak on this bill, but this is a difficult one. It is difficult for all of us. First of all, I would like to congratulate the government on bringing forward this debate on end-of-life choices and, specifically, this bill. It is a bill that the public wants and is demanding and, quite frankly,
a bill that we need to debate. I would also like to thank the government for bringing forward a wider debate on end-of-life choices. Unfortunately, even we baby boomers will die some day. We might not like it, but it is coming more quickly than we might think. It is something that we do not like to think about, but we need to, and we need to plan for it, and the government has planned a wider debate on that, so I thank it for that.

I would like to also thank all members here for a very constructive debate and the various people who made submissions—the proponents, the opponents, the experts and all. It has been a painful, not enjoyable, but necessary process. I would like to thank the many hundreds of people who have responded to the request from my electorate office to give me their views, and many have been forthcoming. I also made some efforts, as did the member for Vasse, to talk to the people who are at the pointy end of these issues—that is, older people—and I will talk a little about their views.

This is not meant to be the point of this debate, but I would like to thank the Australian Medical Association and Hon Nick Goiran for their contributions to this debate. I do not necessarily share their views, but they have made important contributions. Let us be honest: this bill is, in all but name, a government bill. The Labor Party has a structure under which it does not allow public dissent on collective decisions. Obviously, people in the Labor Party have different views, and it is therefore a government decision. The Premier made it clear in 2017 that he wanted to bring in a bill in 18 months’ time—that is now—that would allow assisted dying. It was all pre-determined. He appointed a parliamentary secretary to produce it, and they have done so.

This is a bill that was always going to go down a certain path. The government allowed all people to participate, but the debate was skewed in one direction, which is probably a necessity to get things done in this Parliament. But one of the important things that I have learnt in this place is that it is often the opponents who add the most value to a bill and to a set of actions. The AMA’s view surprised me, to some extent, but it was really constructive, and I have a lot of respect for it and for Hon Nick Goiran. I do not necessarily share Hon Nick Goiran’s conclusions, but his arguments for improving this bill have been profound.

Clearly, this is a popular issue. It is not the 88 per cent support that The West Australian came up with, but who believes polls in The West? It is overwhelmingly popular. My point is that people not only want this bill, but they want to go way beyond where this bill goes, and where I would accept it to go. I do not think this is the end point of this debate. As the member for Geraldton indicated, a large number of people would want voluntary assisted dying to come into play if they have dementia, or just to pre-empt what is to come. That is not what this bill will do, and I would not support that. However, if the public wants to go there, that is a debate we will need to have. That is why, when we face difficult issues such as this, we in this Parliament have to make judgements on behalf of our constituents, and that is what we are doing today.

I congratulate Liberal Party members for their actions and behaviour in this debate. When I was Leader of the Liberal Party, there was a rumour, in the media in particular, that the Liberal Party would be taking a stand against the euthanasia debate. That was never the case. I indicated from the start, as the then Leader of the Liberal Party, that I welcomed the debate, and the process, and I still do. I also indicated from the start that Liberal Party members would be given a conscience vote, and they will. We have never contemplated changing that. Some members of the Liberal Party support this legislation, and some are against it. Some would like more evidence. There is a wide range of views. The Liberal Party participated in the joint select committee process on this bill. Hon Nick Goiran was against it. John McGrath, the member for South Perth, did not want to go on that committee, but I shoehorned him into it. He is a big man—it is difficult to shoehorn him into anything! He went into the committee with an open mind, and he came out in support of the legislation. That is a constructive contribution to a difficult debate.

I have received a lot of aggressive emails and correspondence about this bill. I can take that. Like many members in this Parliament, I have experienced a lot of this stuff firsthand. I am not saying I am an expert on it. I am not saying my experiences are emblematic of the general situation. However, I have a story that is interesting. My mother had breast cancer, and over a 10-year period, it metastasised, and she died. She lived in Oregon in the United States of America, which has assisted dying legislation. She fitted the legislation that applied in Oregon. My brother, who lived in Vancouver, Canada, which has a similar program, contracted Parkinson’s disease at a young age, and died 15 years later. He also fitted the legislation that applied in British Columbia. I will come back to that.

I have to say that I am concerned about some of the language that is used in this debate. We are dealing with a very important issue, and we need to use the right words. This is a program of voluntary assisted suicide, or euthanasia. I will not dwell on that, because other people have debated it, but that is what it is. By the way, if the safeguards are strong enough, I will support the bill. However, too many times in life we use politically correct language to hide from the real issues. That is why more restrictions are in place in this legislation than the public really wants. The member for Girrawheen quoted Paul Keating from an article in The Sydney Morning Herald. I do not often agree with Paul Keating. However, on this occasion, he is right, although I do not come to the same conclusion. We are crossing the Rubicon. We are crossing the boundary of where our definition of civilised society has not gone up until now—that is, allowing the state to sponsor voluntary assisted suicide, or euthanasia. We are. This is an important issue. It is premature death. That does not mean you do not cross that line, but you cross it with your eyes wide open, knowing that there is no going back. That is why it is vitally important that the appropriate
safeguards are put in place. Paul Keating said also that this is the pursuit of a utopian game or process, and that we cannot put in place adequate safeguards to ensure that people are not coerced to take this course of action, and, more importantly, that people do not use it prematurely. It is a slippery slope. That is a very big ask. However, we need to try. All sorts of social activity—welfare and others—are utopian to some extent, but we have to try.

People have said to me that my Catholic upbringing will push me along the route of caution, and it has. However, I am also a libertarian, so I am kind of confused here. Nonetheless, if the target group is restricted to people who have a terminal illness and death is imminent, and for whom palliative care has been tried and failed, but who are still able to make a conscious decision, and do so voluntarily, I support the bill. However, I have a number of concerns. I am concerned and dismayed about the availability of palliative care. As the Australian Medical Association has said, quite rightly, we are proposing to give doctors another option for people who are facing a painful death. We are giving doctors, and patients, of course, the alternative of voluntary assisted suicide, or euthanasia. That is what we are doing. Again, I call it what it is. Palliative care must have been tried and failed. All the evidence I have seen put forward—I may not have the best evidence; I do not know—is that we underspend on palliative care, not just in regional and rural areas, although clearly there we do, but overall. I am surprised that the government did not enter into a parallel process of examining voluntary assisted dying at the same time as it examined not just the level of funding, but also the delivery of palliative care services in the metropolitan region and in regional and remote areas. If those two processes were progressed at the same time, we would have been able to have had, not a cognate debate as such, but an understanding of the enhancements in palliative care before we had to make a decision about voluntary assisted dying. One thing is true: if people do not have adequate palliative care services, but they have voluntary assisted dying, they do not have many options. Therefore, I am surprised the government did not pursue these two things in parallel. That creates a problem for me in supporting the bill, and I am not sure how I will work through that.

In the government's last budget, it allocated approximately $41 million for palliative care. I understand that $10 million of that amount will not go to palliative care at all. However, I welcome the funding for palliative care services in regional and remote areas. It is not just about money. As the member for Warren–Blackwood said, we will never have enough money to meet the demand for palliative care services. I do not live in utopia, and I do not have utopian beliefs. However, the evidence is that Western Australia spends less on palliative care than the other states do. We should address that at the same time as we progress this bill. The two are not independent.

I want to go back to the situation with my mother. My mother, who lived in Oregon, did not need to access voluntary assisted dying. That is because she had excellent palliative care. She was blessed—she had two daughters who were palliative care nurses, and a son-in-law who had been a palliative care doctor. Palliative care can do a lot to avoid the need for voluntary assisted dying. That is the message. Another issue from the expert in Canada—my brother also went through this—is that when someone is given a death sentence, as my brother was with Parkinson's disease, it is traumatic, especially at a young age. It traumatises the patient, their loved ones and friends. They know where they are going with this disease. They do not know how quickly, but they often think the worst and want to pre-empt it. We are a society of people who like to take control of our domain. We like to take control of our lives, live our life the way we want and die the way we want, and we act in a pre-emptive manner. All sorts of psychological factors are at work. Everyone knows the physical attributes of Parkinson's disease, but the worst ones are mental; they are profound. My brother was a senior mining executive, and he had to quit his job because he could not take the stress. He could not sleep. Luckily, he was wealthy enough to see a psychiatrist and deal with the trauma of facing the finality of life. It was a blessing. He contracted the disease early. Most of the data on prognosis was based on people 20 years older than him, and I do not know how it fitted. From memory, the prognosis was something like one to six years, but he lived 15 years. The disease progressed more slowly than is the case for older people, but, more importantly, the medicine improved significantly. If he had acted pre-emptively, he would have ended his life early and done away with some of the best parts of his life. Yes, there were some negative attributes, but he lived 15 more years with his wife and children.

That is the pain of this discussion. I understand that in Canada, 60 per cent of people who apply for voluntary assisted dying are suffering from existential trauma—the news that they are going to die within a certain period and that it is likely to be painful. I might add that this is prior to the palliative care not working. How do we deal with this? We would have to deal with this through widespread psychiatric treatment of people who have received the news. We all have experience of people getting the dreaded news and looking at where they are going in life. We need assistance on that. We need to try. All sorts of social activity—welfare and others—are utopian to some extent, but we have to try. We need greater resources for screening to address the existential trauma of people trying to pre-empt bad news. Submissions from the psychiatric community made this clear to the committee, and I think it needs to act on it. [Member's time extended.]

Dr M.D. NAHAN: One of the issues that I am surprised about, particularly coming from the Labor Party, is coercion. Ninety-five per cent of the people who get into the situation in which they have a loved one on a pathway to a painful death, when palliative care is not working, would hold back, reluctantly. Certainly, that is my experience. For most of us, it is just unheard of that family members, doctors or anybody else would try to coerce people into a premature death, but I assure members that it is there. Go through the elder abuse issues. As a local

Extracted from finalised Hansard
member of Parliament, I am shocked by what some kids do to their parents and its subterranean psychological impact. I know that a range of processes are underway to prevent or mitigate the problem, but, on the basis of overseas data, dismissing it is wrong. We have to do more to identify, pre-emptively, the risk of coercion. We will discuss that in consideration in detail. We have general practitioners, as has been the case overseas, specialist doctors providing this service will spring up. I am not criticising the specialists in this area. A lot of people do not have a GP who sees them regularly. A lot of people, especially those on low incomes, go to bulk-billing clinics and see the doctor on duty, and the doctor does not know the patient except from the data. Some people will be professional witnesses—witnessing, quite rightly, what the patient says—but we have to go beyond that. I am surprised that there has not been more concern about coercion in the various debates to date, because I think it will be a real issue. As with suicide, after it happens it is too late. There could be all sorts of issues with disabled or elderly people, dysfunctional families, or the Aboriginal community. We have heard all these issues. More effort must be put in to address, root out and identify coercion. Even if there were coercion, it does not mean that a person would change their decision, but—this is the issue of crossing the Rubicon—we are dealing with death, and one premature death is one too many.

I stand ready to support this bill on certain conditions. I expect to see from the government not just more resources, but a clear strategy to address the investment in and access to palliative care. I am not making a political point here. I guess I am a politician, but this is what has been highlighted vigorously by the experts. Secondly, we need clear access to psychiatric screening for both the existential stress or trauma and the pressure that gives rise to someone ending their life prematurely. The issue of coercion is fundamental and needs to be addressed. We have to look at that in consideration in detail.

To go back to the issue, the process that we have gone through has been traumatic but important. There has been a lot of argy-bargy in the debate about how the Liberal Party would approach this issue, but most of it was wrong. I praise Hon Nick Goiran for his contribution. He probably disagrees with my decisions and statements, but he has made a profound contribution to this bill and this argument. His arguments were very forceful and in support of the Australian Medical Association. Most importantly, I look forward to consideration in detail, when the government explains and discusses palliative care, coercion, and enhancement of expenditure on psychiatric treatment, and also goes out into my community to discuss in great detail why this bill is rightly more restrictive—although not enough, in my view—than what most people in the community and want. In other words, we have another stage of debate to go through on this issue. Yes, it is popular, and popular is important, and we as politicians have to respond to that, but it is also important to know that we as politicians need to guide and discuss with our constituents the problems of going where they want us to go on this issue. Thank you very much.

MR S.A. MILLMAN (Mount Lawley) [5.58 pm]: I rise to make a short contribution to the debate on the Voluntary Assisted Dying Bill 2019, and I state at the outset that I will be voting in support of this legislation. What I have seen over the last two days would have to go down as Parliament at its absolute finest. People have come here with reasoned and considered debate, and they have delivered it with passion and conviction. They have clearly and unambiguously articulated their positions, and approached it thoughtfully. I have seen this Parliament play host to many guests in the gallery who have listened to the debate with keen interest—advocates for and against the proposal that has been brought forward for debate. I heard the former Leader of the Opposition congratulate the government in the most magnanimous way for bringing forward this bill.

When I participated on the Joint Select Committee on End of Life Choices, at the tabling of the report I said that when this matter comes on for debate in this house, as it surely will, I urge members to consult their constituents, to hear their views and input into this debate. This is a very difficult and complicated debate and we can serve our communities and the state of Western Australia by listening attentively to what our constituents have to say. Once the Premier sat down, the member for Dawesville, the shadow Minister for Health, stood and told us in clear and unambiguous terms precisely how he had gone about the task of identifying the views of his constituents. In exactly the same way, the member for Perth, thoroughly and with great diligence, listened to his constituents, to hear their views and input into this debate. This is a very difficult and complicated debate and we can serve our communities and the state of Western Australia by listening attentively to what our constituents have to say. I have seen this Parliament play host to many guests in the gallery who have listened to the debate with keen interest—advocates for and against the proposal that has been brought forward for debate. I heard the former Leader of the Opposition congratulate the government in the most magnanimous way for bringing forward this bill.

Many people have spoken about their religious convictions, and as a member of the Anglican Church, I respect that. As a representative of a community of many Greek Orthodox, Roman Catholic and Jewish people, I can see that religion plays an important part in this debate. I do not propose to talk about the religious convictions of the opponents of VAD, but I understand them. In particular, I would like to thank some of my friends, such as Peter, Tim and Eric for discussing the issue with me at length. The evidence of Rabbi Dovid Freilich before the Joint Select Committee on End of Life Choices was particularly compelling.

Extracted from finalised Hansard
I also listened with keen interest to the contributions to this debate of people of faith, such as the member for Girrawheen, the member for Southern River, the member for Kalamunda, the member for Geraldton, who just now told us he also consulted religious leaders in his community, and the incredible speech delivered by the Attorney General this morning when he spoke about the role of faith and religion in how he came to make his decision.

I want to talk about the leadership that has been provided in this debate. Many members have thanked the Joint Select Committee on End of Life Choices for all the work it did in the preparation of this legislation. The members of that committee—I count myself amongst them—have done an incredible job in demonstrating the necessary leadership for this debate. As the member for Riverton just said, Hon Nick Goiran represented the contrary position. However, I listened to the contributions from the member for South Perth and the member for Baldivis. I recall the discussions and debates we had with Hon Dr Sally Talbot, Hon Robin Chapple and Hon Colin Holt, the deputy chair of the committee. I know that great leadership in this debate has been provided by my fellow members of the Joint Select Committee on End of Life Choices. It was great to listen to the contribution from the member for Morley as she thanked the Premier, the Minister for Health and the Attorney General for their leadership in this debate. In no uncertain terms, I add to that list the member for Morley, who, both through the chairing of the Joint Select Committee on End of Life Choices and all her conduct thereafter, has shown tremendous leadership and great fortitude in prosecuting the case for this modern VAD legislation.

In arriving at my decision to support this legislation, I have been very fortunate. I was honoured to participate in the joint select committee and I was especially grateful to be asked by the Attorney General, together with the Minister for Health, to chair the Ministerial Expert Panel on Advance Health Directives. It gave me a rare opportunity to look into my own conscience and determine what issues would be most pertinent, most important and most relevant to the way I went about deciding which way I would vote. Like you, Deputy Speaker, and the Treasurer, this was not a foregone conclusion. I have always wrestled with this because it is such an interesting philosophical question. When members see how this debate has evolved and the outstanding work Malcolm McCusker, AC, QC, did as chair of the other ministerial expert panel, and the thoughtfulness of the contributions made, the safeguards that have been incorporated into this legislation and how conservative and sensible this legislation is, we can see that it is the appropriate legislation for a modern Western Australia.

I was fortunate to have had access to all that information, all that evidence and all the compelling stories we heard as we sat in those committee hearings. However, I have been fortified in my view that I should support this legislation by some of the incredible contributions made by members in this chamber. I do not have the personal stories to tell. Thank God, my mum and dad are both still alive and my family are all well—touch wood. I do not have those stories. My constituents have shared their stories with me. They are personal, private stories, so I do not propose to share their stories, but I am fortified because I have heard many incredible stories from the compassionate people in this chamber who have gone out and shown empathy in listening to their constituents and conveying those messages so that we can deliberate properly on this legislation.

I want to make one point on the question of capacity, if I may, because this is something that has come up in debate and a point that people have expressed some reservation about. Can I say this: we are right to identify that capacity is an important consideration, but I would like to put forward a number of arguments to suggest that this legislation is well crafted and has the appropriate safeguards to make sure that we need not maintain those concerns about capacity. I would like to refer to a couple of things. Members will have had the opportunity, I am sure, to review the report of the Joint Select Committee into End of Life Choices. Chapter 4 of the majority report deals with current lawful options at the end of life. Chapter 4 of that report confirms that refusal of medical treatment is not suicide, and confirms that a competent individual could refuse medical treatment and refuse food and fluids. I refer members to the paragraph under the heading “Refusal of medical treatment” that states —

Patients can, and do, choose to refuse medical treatment—including refusals that may result in death.

We are talking here about a medical intervention, or non-intervention, that may result in death —

Patient autonomy—the right to choose health care—emerged as a dominant medical ethical principle during the twentieth century and is usually associated with allowing patients to make their own health care decisions. The ethical principle of autonomy is contained in some form in most modern medical codes of conduct in the Western world.

The refusal of medical treatment, as it exists under the law of Western Australia, does not require a capacity assessment by a psychiatrist.

Can I talk about the refusal of food and fluids. The report states —

A competent individual can lawfully end their life by opting to stop eating and drinking. In accordance with the ethical principle of patient autonomy, and the legal principle of self-determination, the common law recognises the right of a competent adult to refuse food and water.

This is from the journal article of White, Willmott and Savulescu, which I think the member for Armadale quoted in his contribution earlier.
I refer to the evidence of Professor Max Kamien, a very prominent practitioner, particularly within the Jewish community. He told the committee about a friend who had deliberately starved himself to death. I will quote his evidence, in the time that I have —

He developed an oesophageal pouch—that is a pouch on the oesophagus—and food gets caught in it. You have terribly bad breath. It is very difficult to swallow. The operation is very difficult. It nearly always cuts the recurrent laryngeal nerve which is the nerve that goes to the voice box. If he had that operation, he would never sing again. The other thing is the operation has a mortality rate in itself which is, depending on who does it, quite high. He said, “If I can’t sing, I can’t speak properly, and if there is the possibility that something goes wrong and I finish up a vegetable … I will not have that operation” and he ceased food for four months and he starved to death.

My point is that no psychiatric capacity assessment is required for people to exercise these existing lawful options at the end of life, the refusal of medical treatment and the refusal of hydration and nutrition. Hence, finding 25 of the joint select committee states —

A competent person’s absolute right to refuse to eat and drink is clear at law …

We need to proceed by analogy. That is the current state of the law with respect to capacity assessments.

I take members to chapter 2 of the report, “Advance Health Care Planning”. I know quite a bit about this, having finished my work as the chair of the Ministerial Expert Panel on Advance Health Directives. Rather than summarise it, I will quote chapter 2 of the joint select committee’s report —

Many people worry about losing the ability to make their health care preferences known in the event that they lose decision-making capacity. People also commonly worry about being kept alive in unacceptable circumstances with greatly diminished ability to advocate for their preferred care—for example, with dementia or in a persistent vegetative state following traumatic or non-traumatic brain injury.

…

In Western Australia when a person is unable to make reasonable judgments —

That is, when a person lacks capacity —

in respect of any proposed medical treatment, and there is a need for a treatment decision, the Guardianship and Administration Act … determines which treatment decision will be given precedence.

If members look over the page, they will see the way in which capacity is already assessed in accordance with the legal provisions in Western Australia. There is a presumption under Australian law that every adult person has capacity. It states —

Generally, when a person has capacity they can
• understand the facts and choices involved;
• weigh up the options and the consequences; and
• communicate the decision.

In everyday life, people who have capacity make decisions about where to live, what to buy, how and when to travel, when to see the doctor, and numerous other daily decisions that ordinarily enable them to live independently.

Capacity is decision specific and is about the decision-making process

If members are concerned about capacity, they can see that it was the focus of a great deal of attention during the deliberations of the joint select committee. We were particularly concerned about this. Other members have expressed their thoughts about whether the legislation goes far enough for people with dementia. The government’s position on that is abundantly clear and does not need to be repeated. We considered the current law on refusing medical treatment or refusing hydration and nutrition and then looked at how capacity is assessed under the Guardianship and Administration Act 1990. Chapter 7 of the report of the Joint Select Committee on End of Life Choices set out the essential elements that would be necessary to ensure that this legislation was properly safeguarded. It considers things such as the expected time of death. A narrowly defined sample set of people would be able to access this. We set out the level of suffering experienced and the age of the person. Paragraph 7.49, “Capacity and capacity assessment”, states —

An individual must have decision-making capacity …

That is unambiguous and unequivocal —

at the time of their request in order to be eligible for voluntary assisted dying.

Paragraph 7.50 states —

Although capacity assessments can be complex, General Practitioners routinely assess capacity …
To come to this conclusion, we relied on the evidence of none other than the Royal Australian College of General Practitioners. It continues —

- patients making decisions about consenting to or refusing medical treatment;
- individuals making legally binding instruments (such as enduring powers of guardianship, enduring powers of attorney and Wills);
- the State Administrative Tribunal …
- referral under the Mental Health Act …

The committee received evidence from the Chief Psychiatrist about decision-making capacity. But more relevantly and more persuasively, we received evidence from Dr Roger Paterson, a psychiatrist, who told us that the view of the Chief Psychiatrist was not in keeping with the consensus in other jurisdictions that general practitioners should—not would or could; that is, it contains a moral imperative—ordinarily make the assessment. Quoting from his evidence, he said —

He is out of step with every jurisdiction internationally and nationally. The Victorian legislation does not propose it. He is out of step with the Royal Australian and New Zealand College of Psychiatrists who say it should be considered, and he is out of step with the local branch who, as I say, recognise that there are practical logistical problems as to why it is not so.

We also ascertained —

A requirement that there be a referral for specialist psychiatric capacity assessment is likely to involve considerable delay …

We should bear in mind that this legislation provides for people who have a prognosis of six months left to live. The very last thing that these people should have to do is wait and wait and wait while they get a psychiatric capacity assessment when their general practitioner can already make that assessment and when, under the existing law of Western Australia on refusing medical treatment or refusing hydration or nutrition, that capacity assessment is not required. We concluded with finding 51 —

An individual must have decision-making capacity at the time of their request in order to be eligible for voluntary assisted dying.

[Member’s time extended.]

Mr S.A. MILLMAN: The capacity assessment is routinely made in current circumstances. Those members who are concerned about the provision on capacity assessment contained in this legislation need not be. People can be comforted that this legislation deals with the question of capacity in the most appropriate way. That is my submission.

I want to conclude with my thankyous. I wish to thank a number of people. I will miss people and, to those people, I am sorry. I thank Nigel Haines. He was mentioned by the Minister for Culture and the Arts, the member for Mandurah. Nigel is a constituent of his. Nigel Haines not only bravely came before the Joint Select Committee on End of Life Choices to give his evidence about the circumstances surrounding the death of his wife Susie, but also then, despite how significant and burdensome the emotional weight was for him, nonetheless participated as the community member on the advance health directives panel.

I thank Max Kamien and all the people in the public gallery, who have sat here and listened to this debate—many advocates for and against. I thank all members who have already contributed. I thank witnesses who gave evidence to the committee—again, some in favour of and some opposed to the introduction of the legislation. All members have already commended the Minister for Health for the excellent work that he has done, along with the Attorney General and the Premier. Many members have already thanked the ministerial expert panel and Malcolm McCusker for the work that they have done. I thank all the members of the AHD panel and all members of the joint select committee.

I finish by individually thanking members of the joint select committee, including Hon Nick Goiran, who, as the member for Riverton said, was the voice of the opposing argument. The community appears to be significantly in favour of this legislation, with a minority opposed. The speakers in this Parliament appear to be significantly in favour of this legislation, with a minority opposed. The Joint Select Committee on End of Life Choices was significantly in favour of this legislation, with a minority opposed—Hon Nick Goiran. It is relatively reflective of the state of people’s opinions. I thank Hon Robin Chapple, Hon Dr Sally Talbot, and Hon Colin Holt, who did an excellent job as the deputy chair of the committee. I thank the member for Baldivis and the member for South Perth, and, finally, like so many others, I express my thanks to the member for Morley.

Let me finish by making two points; one of them has already been made by the Premier in his contribution to the second reading. I quote from the copious notes I made yesterday. The Premier said —

For those in this chamber who approach politics through the paradigm of freedom and rights … is this not an incredibly simple issue to decide? This is the ultimate act of personal choice, of freedom, of individual rights.

Extracted from finalised Hansard
I agree with that sentiment. I guess in one way people could say I am a John Stuart Mill-man!

Mr Z.R.F. Kirkup interjected.

Mr S.A. MILLMAN: Thank you.

The second thing I would say is that our Constitution requires us to make laws with respect to peace, order and good government. The point at which I finally decided to support this legislation was when one of the witnesses who appeared before the committee said, “If you pass this bill, such a small proportion of the population will think about it, and an even smaller proportion of the population will use it, but everyone who is worried about it will have peace of mind.” When our Constitution enjoins us to make laws with respect to peace, order and good government, it also means peace of mind. When I heard the earlier contribution that there would be nothing quite like leaving your children to remember a painful, prolonged, nasty death for the rest of their lives, I thought: what great peace of mind I would have, were this legislation to pass, to know that I would never impose that burden on my two sons.

I have been incredibly impressed with all the contributions that have been made by members in this chamber. I am incredibly honoured to have been part of this historic debate. I commend the bill to the house.

MR D.C. NALDER (Bateman) [5.21 pm]: I, too, stand to make a contribution on the bill before the house, the Voluntary Assisted Dying Bill 2019. I say at the outset that I am quite envious of those members in this chamber who have a solid position, whether it be for or against. I have heard arguments on both sides of the debate that I agree with. I am envious because I am sure that most people have had far better sleep than I have in considering this issue over the last few months. I will ultimately reserve my judgement until the consideration in detail stage because I believe that some concerns need to be worked through, as many speakers before me have mentioned.

This bill really challenges my beliefs and values. When I talk about that, I strongly believe in the freedom of choice, but I also strongly believe in the sanctity and preservation of life. I find myself conflicted on both of those issues in consideration of this bill.

I would also like to acknowledge, similar to the member for Mount Lawley, that all the members of this place are acting with compassion. Compassion is at the front and centre of members’ minds. I believe that no-one in this day and age should suffer in agony. I believe that it is incumbent on us to ensure that laws and protections are in place for people who are dealing with end-of-life issues and that they can do so with dignity and respect and in the most comfort that can be provided.

I would like to acknowledge some comments made earlier by the Minister for Health in his second reading speech that resonated with me. The minister said that decisions are already being made about ending life when life support systems are turned off or when it is decided to cease fluids or food. We know that the outcome will be death. We impose that burden on our two sons.

I have great respect for Malcolm McCusker. I was really pleased to see his involvement in the drafting of the bill. He should be acknowledged for his standing in our community; he is someone who is respected by all.

I would also like to acknowledge that palliative care does not provide for all people in the manner we would hope. That is an issue that confronts us today. I see that as the primary purpose of this bill. In saying that, I will now step through my concerns and demonstrate that there is a balance to this argument that I have given consideration to. Describing it in simplistic terms, my primary issue is that it feels as though we have jumped to the endgame. For me, the issue of palliative care needs to be resolved either in conjunction with or prior to us getting to that point. That is a stumbling block that I have and that is why I will defer my decision until the consideration in detail stage.

I believe that as parliamentarians we should be ensuring that we deliver world’s best palliative care. We live in one of the best places in the world. We have some of the highest living standards in the world. It is incumbent on us to ensure that we deliver the best possible palliative care. I know there are regional challenges and so forth, but if we are not delivering on that, I fear that we are not giving people a choice when it comes to voluntary assisted dying. Some people will see it that they have no choice. That really concerns me; it is a fear that I hold. Although I acknowledge that there are people we are desperately in need?

I have great respect for Malcolm McCusker. I was really pleased to see his involvement in the drafting of the bill. He should be acknowledged for his standing in our community; he is someone who is respected by all.

I would also like to acknowledge that palliative care does not provide for all people in the manner we would hope. That is an issue that confronts us today. I see that as the primary purpose of this bill. In saying that, I will now step through my concerns and demonstrate that there is a balance to this argument that I have given consideration to. Describing it in simplistic terms, my primary issue is that it feels as though we have jumped to the endgame. For me, the issue of palliative care needs to be resolved either in conjunction with or prior to us getting to that point. That is a stumbling block that I have and that is why I will defer my decision until the consideration in detail stage.

I believe that as parliamentarians we should be ensuring that we deliver world’s best palliative care. We live in one of the best places in the world. We have some of the highest living standards in the world. It is incumbent on us to ensure that we deliver the best possible palliative care. I know there are regional challenges and so forth, but if we are not delivering on that, I fear that we are not giving people a choice when it comes to voluntary assisted dying. Some people will see it that they have no choice. That really concerns me; it is a fear that I hold. Although I acknowledge that there are people we are desperately trying to help, I am also fearful that we may create an outcome that forces people down a certain path. I have an inkling of concern—not the same level of concern—about people acting with compassion, although I acknowledge that everybody in this chamber has spoken responsibly and ethically about this bill and has acted with concern and compassion for patients who are suffering from a terminal illness. When it comes to my experiences in life, I do not believe that all people act with compassion. I have seen people act with very little compassion. Sometimes it might be in their minds that they are acting with compassion. They may believe they are acting in the best interests of someone when in fact they are not. I will stretch that a little further and say that when it comes to money, people act with even less compassion. I am fearful that if we do not address palliative care in its complete form, it could become an economic decision that people ultimately choose to end their life. We are going to be relying on future generations to assess this:

Extracted from finalised Hansard
if we do not address palliative care, what choice are we giving people? I fear, albeit a lesser fear, that in the future people might see it as more convenient for people to end their life rather than follow the costly process of palliative care. I would hate for our community to ever walk down that path. It is a concern that I have within my community.

A number of concerns were raised by other members in this place. I concur with a lot of those concerns. I wrote them down to go through them, but I would just be repeating them and I will not be repetitive.

I would like to acknowledge the Leader of the Opposition. She raised a number of pertinent points that warrant further investigation through the consideration in detail stage of this bill. I felt the Leader of the Opposition’s speech was very powerful in sharing with us the challenges that she has faced with this particular issue. I personally have had experience. I do not wish to elaborate on it further but I understand the issues that people go through.

I have other issues with this bill that I am concerned about, and they are about the safeguards to be put in place. I know a number of measures have been put up. I have to admit that I am not an expert on those measures and therefore look forward to exploring them fully in the consideration in detail stage. That is part of the reason I will defer my judgement on this bill until we go through it adequately.

I would also like to share that I, too, polled my electorate. I removed all the spam, group emails and emails from people who were not from my constituency, and focused on people who took the personal time to contact me, write to me or email me. Interestingly, my data shows a different result. It came in at 58.9 per cent of people being opposed to the bill. These were not necessarily emotional approaches. This contact was from people who took the time to personally write to me to share their experiences both for and against. As I said, there were arguments made on both sides that I found myself agreeing with, which is causing me a lot of challenges in trying to work out the right thing to do here. I do not think I could have ever dealt with this bill if the vote had gone down party lines. I would like to acknowledge that at least we as a Parliament and have made the decision that this should be decided on a conscience vote. I believe it is the only way we should approach it. I would like to share an email just to give a sense of the communication I have been receiving and the considerations that certain people have provided. This one is from someone who is opposed to the Voluntary Assisted Dying Bill. It says —

I am a Registered Nurse and my husband is a Palliative Physician and Geriatrician. We have been working in hospitals for many years and have a great deal of experience caring for those with chronic and terminal illnesses. Through good medical and nursing care we have witnessed many patients pass away when nature intended them to, with dignity and comfort. We have also witnessed time and again, the errors medical professionals make in diagnosing and treating patient’s conditions. Just the other day my husband discovered the underlying cause of a patient’s condition which five medical teams before him had missed. This patient was referred to him for palliative care. It is erroneous to presume that any person is so enlightened and perspicacious they may judge when a life should end.

I urge you to vote against this form of legalised killing.

That is just an example of the types of communication that I have received. This is from someone who is far more professional and experienced on the issue than me. I can only dwell on my personal experiences. It just highlights the challenges that all of us have possibly faced in discussing this issue with our community. As I said at the outset, it is my intention to reserve judgement on this bill until we have gone through the consideration in detail stage. I will not go any further. I have made the key points I would like to make about this bill. I appreciate the contribution of all members of this place and the manner in which this debate has been held.

**MS J. FARRER (Kimberley)** [5.33 pm]: I, too, rise to contribute to the debate on the Western Australian Voluntary Assisted Dying Bill 2019, with the greatest respect that I hold for the differing views of those in the chamber and across Western Australia. I would like to thank my constituents and many others who have taken the time to write to me, email me, phone me or speak to me. I am both impressed and moved by the quality of feedback and arguments for and against the bill. I would also like to congratulate and thank all my colleagues for their informative, heartfelt and emotional contributions to this debate. As members of Parliament we are often required to make difficult decisions and create laws that affect the lives of all Western Australians. To be eligible to access the provisions of the Voluntary Assisted Dying Bill a person would have to be 18 years old; be an Australian citizen or have been a permanent resident of Western Australia for at least 12 months; have decision-making capacity in relation to a decision about voluntary assisted dying; and be diagnosed with an eligible disease, illness or medical condition that is advanced, progressive and will cause death or is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable. I am satisfied with the numerous safeguards that this bill has, and I believe they are strict and most appropriate. I, too, share the view that even the best of palliative care cannot always deal with the issue.

Over recent months I have had many discussions with my constituents. I would like to share from my notes a couple of the responses that stood out to me. One person said —

You have to be very careful as an Aboriginal person. If you support someone in assisted dying, you may be seen as helping them to die, and if the family is not ready for that person to pass on, you could be tribally punished.
A second person said —

As an Aboriginal person, helping someone end their life goes against what we are taught. It goes against empowering our people and our cultural wellbeing, but watching my mother-in-law and nanny in the time when she needed, was suffering and became bedbound was one of the hardest things I have ever had to do. Her frailness still haunts me to this day. I do not know if she would have used voluntary assisted dying, but I do wish she had the choice to be able to access it.

A third constituent said —

I am now a retired nurse, but I have seen the torment, the pain, the loss of control, the loss of dignity and loss of one’s self. This is not living.

Right now I would like to tell a little story about a young woman in my electorate and where I came from. She was not even 30 years old. I brought this up in 2015 when we were in opposition in regards to the breast cancer scans around the Kimberley in the breast cancer bus. I asked a question. It was at the time when the Minister for Health was Dr Kim Hames. I asked whether some of our young women could have this breast screening done, because there were problems with some of them. The answer I got was that they had to be 40 years old or over to have it. I respect that, but I think sometimes some of those policies or laws need to be reviewed and changed. The reason I asked that question was this young woman. She was only 30 years old, but she had done lots of work on some of the pastoral stations up there. It was at a time when she worked on the Kidman brothers’ property. She was a very reliable young woman. She was not married and did not have kids. The way this young woman passed has always haunted me. She was shooing a horse one day and she said something freaked the horse out and the horse ended up kicking her. It kicked in the breast on the left side. She was on one of the outstations of the Kidman brothers’ station, and she was taken back to the main station and then to Halls Creek to have some medical attention. She had an open wound from the horse’s kick. She was seen to by the doctor at that time. We have a lot of doctors who are there on locum, so they do not really know much about Aboriginal people’s history and their medical history. She was flown from Halls Creek to Darwin and she was up there for a few weeks. When most of our people come back from hospitals, they are put on Greyhound buses, so members can just imagine if a person is suffering and they are put on a Greyhound bus. She came home and the doctor said to her that she was okay and she could go home. She went back out onto the property that her parents lived at. She constantly had a weeping in her breast. She went back and saw the doctor again and they placed her in one of the wards of the hospital, and that is where she lived. The time frame of this happening was not even eight months. The parents asked me, “Josie, why didn’t somebody do something about this?” As the mother said, for a woman with problems with her breasts, surely somebody should have done a lot better. I said that I did not have the answers, but I would table this, and I did that. I asked the Minister for Health at the time in Parliament about it. I took the answer back and gave it to the parents. The father was not very impressed with the answer, but there was no advice about where they could go. It was a big letdown for me as the member for Kimberley and as an Aboriginal person—knowing those families and giving them that advice.

I asked whether they could go back and talk to the doctor again. But the doctor who had assisted her at the beginning had gone back to wherever he came from because the doctors were locums. There was no tracking history of what the medical side had given her. When people go in with health issues and checks with doctors, there is all that stuff about confidentiality, so her parents were not able to acquire a lot of information from the doctor. She started getting sicker and sicker, so she was placed back in the hospital in Halls Creek, where she was given a ward where she stayed. She had the company of her younger sister, who slept with her in the same bed and was always there to make sure she was given her medicine and to assist her with anything else. She sent word with her mother for me to go and see her. Having known her since she was born, I was not feeling too happy about going to see her because I knew the condition she was in, but I ended up going. Most visitors were not allowed to see her, but when I asked to, they had to ask permission and she said, “Yes, I want Mum Josie to come and see me.” I am not her mum, but that is in our tradition. When I walked through the door of the ward she was staying in, her eyes lit up. She was lying there and looked very frail. She had a great big smile on her face and was very happy to see me and that I had come to visit her. I walked over and put my arms around her and said, “I’ve come to see you because your mum sent word that I needed to come and see you.” She said, “Mum, thank you for coming. I’ve been sick. But my greatest ambition as a young woman with the work I am doing is that I want to go to Canada to compete in the Calgary Stampede.” That is a big dream for some of our young kids. She asked me whether my son was still in Canada and I told her he was. She asked me to contact him and let him know that she wanted to go there to compete. We had a talk and I told her I would ring my son and let him know. I rang him and he told me that he would look after her if she came over.

I came back down for Parliament, so I missed her for a couple of weeks. When I came back, they told me that she had been flown to Perth. There was a very short time from when she was diagnosed when she got hurt until then; it was July to November. She had to come back to Halls Creek and I went to see her again. At that time she was permanently living in the hospital ward. She said to me, “Mum, did you tell brother that I’m going over to Canada? Because I really want to go and compete in that rodeo.” She was a young woman who competed in rodeos. She

Extracted from finalised Hansard
also starred in the movie Australia. I do not know whether anyone has seen the movie, but she is the young woman in the red dress who was riding a horse. Her greatest ambition was to go to Canada and compete in the rodeo. She asked me whether I had told him and I told her I had. She said, “When I get better, I’m going.” I asked whether the doctor had told her anything more about how bad she was. She sort of smiled and said yes. When her mother came into the room, I asked her whether the doctor had explained to her and her husband about what she was going through and whether this could be a terminal illness because of the contribution of what took place. She said, “No, we do not know nothing.”

When we talk about voluntary assisted dying, there needs to be not only consultation but also interpreting services. In the Kimberley we have a hugely diverse range of language groups. To get this message out, there has to be a lot of consultation in place. There need to be interpreting services and people who can speak different languages. In this case, the mother could not understand a lot of the medical jargon when the doctor was talking to her.

It is a really sad story because all she wanted to do was do what she dreamt about, but that was not for her. She had Christmas in hospital with her family around her. They came from the outlying communities where her family lived—Yiyili, Bayulu, Fitzroy Crossing, and even from Balgo. I think they could see that she was not going to make it. As Aboriginal people we look after each other and share our pain. We share any information; even though in the health and medical world it is all confidential, as Aboriginal people we talk about it. Her family all shared Christmas with her in the hospital. Each time anyone went to visit, she always had a smile on her face. Even though she went through a lot of pain, she was able to deal with that in her own way. For me as an Aboriginal person, this bill has been particularly challenging. Where I come from it is our belief in our traditional culture that if a person receives assistance in passing on, their spirit will be trapped. We believe that when it is your time, it is your time. However, I stand in support of this bill because I believe it is the right thing to do and I support people having the right thing to choose, which is a big difference between our cultural beliefs and the western world that we live in.

One of the many reasons I became a politician was to try my very hardest to expand people’s opportunities to have choices. I do not believe that voluntary assisted dying is a matter of choice between life and death. I believe it is a choice for those who are going to die. There is a difference between how we see things in our traditional culture and how they are seen in the western world. I have personally seen the effects that it has had on quite a number of young people and older people for whom death is inevitable and imminent, but this woman’s story inspired me to talk about the difference in how we see things. I still believe that if this legislation is ever to be endorsed, let people have the right to make that choice. Choice is a big thing in life; we all go through life making choices. You make choices as to whom you want to marry, you make choices whether to have kids, and I believe that if your time has come and you know that you are going, you should have the right as a person to make that choice. That was just one of the sad stories, but it also gives us an understanding of what some people experience.

Once again, I would like to say thank you to everyone who has taken part in this debate. Hopefully, we can make legislation that will make people’s lives a lot easier. As Aboriginal people, we love to be buried back in our own country, because we have a very spiritual belief. I would like to see some more exploration of that because, as I said before, as an Aboriginal person your spirit goes back to where you come from. That is our belief. It does not matter what anyone thinks, that is our belief. As Aboriginal people we have a very spiritual belief and we need to make sure that this is understood. Thank you.

MR S.K. L’ESTRANGE (Churchlands) [5.50 pm]: All of us in this place and all the people in our communities have a view on the topic of voluntary euthanasia. I want to take this opportunity to thank the many constituents and non-constituents who have reached out to me to offer their thoughts in regard to this matter. I have received many impassioned pleas to oppose this bill, and I have received many impassioned pleas to support this bill. Notwithstanding the differences of opinion in the eyes of the community, there will be rights, wrongs and consequences linked to either outcome with regard to how we, as a Parliament, choose to vote on this legislation. The test for each MP when voting along conscience lines is to make a genuinely informed decision that they believe is in the best interests of the community and the state they serve. That is why I, like many members, have listened to constituents and read their letters and emails. I have also attended information briefings, met with medical practitioners and sat down with palliative care experts to hear their views.

Another source of understanding of life, death and suffering that makes us think about voluntary euthanasia is, of course, found in our own lived experiences. For me, I had the challenging experience of witnessing my mother being diagnosed with breast cancer at the age of 36 and given two years to live—a time span she hid from my sister and I at the time. I was 16 and my sister was 13. Our mother received the best medical care and we got on with life as a family, as normally and as positively as possible. In the end, she died just short of her forty-second birthday, beating the two-year diagnosis by three years. She put on a brave face and pushed on throughout her cancer journey so that the reality of her impending death was concealed from my sister and I for much of the time. Her brave fight and the medical support that extended her diagnosis by three years meant she got to see my sister and I graduate from school, both attend university, and my graduation from officer training. In the end, she received palliative care up to the point at which she declined further futile treatment and, in her final days, received the best possible relief from symptoms so as not to prolong the dying process.

Extracted from finalised Hansard
My father lived on for almost another 30 years, but he, too, had to deal with cancer on three separate occasions over an 18 to 19-year period. The first was bowel cancer when he was about 60. It was caught late, but it was dealt with before it was able to spread to other organs. He was on a colostomy bag, receiving chemo, and struggling on as best he could, but with a very positive outlook. He always considered living to be better than the alternative, and he fought hard to beat off the cancer, again with excellent medical help, and succeeded.

Ten years later he was diagnosed with prostate cancer; this time, he had grandchildren. Again, his fighting spirit and treatment—albeit uncomfortable and painful—also saw this cancer off. But at age 75 came his biggest challenge, when he developed cancer in the lower back. He received intensive chemo, which made it very difficult for him to eat as the skin in his mouth was burning. He did his best to blend nutrients and eat through a straw while living alone, and he fought hard, but his body deteriorated and he went from being a big man of 95 kilograms down to 65 kilograms. My sister and I at Christmas that year had a private chat; we did not expect dad to last six weeks. However, we underestimated him. His goal was to attend his first grandfathers’ day at his old school, to continue to interact with his family and his many friends, and to beat the cancer. Remarkably, he did so, and with his PSA levels down to almost zero after a couple of years, and back to a healthier weight above 75 kilograms, his specialist called him her miracle. He made the grandfathers’ day, along with many other family milestones, but in the end, four years after his third battle with cancer, he died of a heart attack in the driveway, fully dressed on his way out to go to the shops and to see friends.

I share these stories because they are examples of the strength of the human spirit in the face of mortal adversity. What concerns me is that had euthanasia been an option for my parents, would it have hung over them like a difficult decision embedded in their subconscious when they were in their darkest hours? Would they have felt the need to access voluntary euthanasia? But it was not an option, and for us as a family, their lives were extended, and many milestones were achieved, shared and enjoyed by virtue of them living beyond what was expected. The reality is that many of us do not like to think about our own mortality. We certainly do not want our end of life to be miserable.

A good quality end to life is an outcome or goal that our health researchers and practitioners strive to make the norm. This goal drives the motivation for new medical discoveries, gives people hope that they will be taken care of, values the ageing and supports families and communities. However, it is the examples of the horrific cases—the small percentage of people who will face incredible pain, suffering and humiliation, for themselves and their families, in the final stages of life when dying of a degenerative terminal illness—that motivates the yes vote for voluntary euthanasia. I, too, am empathetic to the need to help people when they are facing this traumatic end to their lives.

This is evidenced by a Roy Morgan poll on assisted dying and euthanasia taken in November 2017. It states —

... 87% —

That is, of Australians —

are in favour of ‘letting patients die when they are hopelessly ill and experiencing unrelievable suffering with no chance of recovery’ compared to 10% (down 7%) who say doctors should ‘try to keep patients alive’ and 3% (down 11%) who are undecided.

The genuine concern I have is that, on the one hand, this bill is motivated to support Western Australians who hold the view that the hopelessly ill, who are experiencing unrelievable suffering with no chance of recovery, will be offered voluntary euthanasia, but, on the other hand, the bill could be open to misuse and capture a broader group, as evidenced by clause 15, under the heading “Eligibility criteria”. I am particularly concerned about how people facing chronic diseases, as my parents did, will approach life when this legislation takes effect. What is needed, prior to any serious consideration of voluntary euthanasia, is to explore all options for the hopelessly ill and to properly resource a highly effective palliative care regime that is able to adequately care for people facing chronic or terminal illness. For those over 65 years of age, the possibility of having to deal with one or more chronic life-threatening illnesses rises considerably, and many have to juggle multiple health issues, most of which are considered life threatening. Accessing quality palliative care early is therefore a key support requirement for people facing life-threatening health issues.

The commonwealth Department of Health makes the point that chronic conditions often lead to a gradual deterioration of health and loss of independence, and are the most common and leading cause of premature mortality. The key chronic conditions in Australia are high blood pressure, Alzheimer’s or dementia, heart disease, depression, arthritis, osteoporosis, diabetes, chronic obstructive pulmonary disease, cancer and stroke. The commonwealth Department of Health website notes —

2014–15 National Health Survey data also indicated that nearly a quarter of all Australians (23%), and 3 in every 5 Australians (60%) aged over 65 years, had two or more chronic conditions

It also states —

Chronic conditions accounted for around 9 in every 10 deaths in Australia in 2015. Often more than 1 disease is associated with a death and 3 diseases is the average. About 20% of deaths have 5 or more associated diseases

Extracted from finalised Hansard
This data is compelling, but it is the current reality of ageing. As a society, we have continued to work hard at improving health and wellbeing outcomes, with the goal being to prolong a healthy life for as long as possible. Nevertheless, death for all of us is inevitable. The former head of palliative care at Royal Perth Hospital, Professor Doug Bridge, was recently reported as saying —

“The truth is that dying is hard work and unpleasant and causes grief, but that’s just normal dying,” …

Therefore, the most pressing need to support those with chronic or terminal illnesses is to have a highly effective and readily available palliative care service throughout Western Australia. Our focus should be about advancing medicine and procedures to support the patient through to their end of life while their suffering has been negated.

Furthermore, while I have highlighted the effect of chronic illness as a reality of ageing, one of the eligibility criteria under clause 15 of the bill is that the person is only required to be over 18 years of age. I cannot imagine how difficult it would be for an 18-year-old, and their family, to be placed in a situation in which they would need to contemplate voluntary euthanasia as an option. Even when facing the reality of chronic illness, the majority of people will have an intrinsic desire to fight off any illnesses, and to live for as long and as meaningfully as they can.

Therefore, the questions to pose are: What impact will the introduction of voluntary euthanasia have on the sick at a time when we are yet to build up the most effective palliative care regime? How will voluntary euthanasia influence how we as a society support and harness each person’s will to live? If we combine these thoughts with the statistics offered earlier on chronic diseases, when we heard that 60 per cent of those aged over 65 have two or more chronic conditions, we can deduce that will mean that in order for more than half the population to live to the current mortality age of 79 to 84, they will have to battle with chronic diseases for up to 14 to 19 years before they die. I offer this perspective because it highlights the need for us to continue to build our society’s motivation to support people in the over-65 age bracket, who are dealing with ageing, to assist and support them to look forward to the joys they get out of life, which come from experiences such as meaningful employment, learning, family and grandchildren, travel, friendships and ongoing leisure pursuits. In terms of a person’s end of life, most would wish to get to that current mortality age of 79 to 84, or older, with good mobility and a sharp mind, while remaining in close contact with friends and family, being as pain free as possible, and then dying quickly, naturally and without a fuss.

The questions can then be asked: Why can this not be achieved without the need for voluntary euthanasia? Is it a question of resources? A question of concern then follows: will voluntary euthanasia, once enacted as law, have a negative influence over attempts to achieve better non-euthanasia end-of-life care goals and outcomes? We must also then think of the person who is confronted with the reality of impending death. Will voluntary euthanasia devalue life in the eyes of those who are demoralised when confronting a chronic or terminal illness? Will voluntary euthanasia put undue real pressure, or even subliminal pressure, on a person to choose to die prematurely?

These questions drive to the dangers of moving along the voluntary euthanasia path when the eligibility criteria for accessing death are broader than what appears necessary to satisfy the question in the Morgan Poll that I mentioned earlier—that is, “letting patients die when they are hopelessly ill and experiencing unrelievable suffering with no chance of recovery.” We need to think carefully about the impact of the option of voluntary euthanasia on the decision-making of the demoralised person who is living with a chronic or terminal illness.

I will provide some commentary by Anthony Fisher in the Weekend Australian on 22 June 2019. He said —

A few years ago I was close to death. I had a severe case of Guillain-Barre and was totally paralysed from the neck down.

I was in terrible pain. I was powerless to feed myself, wash myself, toilet myself. I was a burden on others and didn’t want to be. I spent five months in hospital alongside others with conditions such as multiple sclerosis and motor neurone disease who were not going to recover as I might. Some were heroic, some demoralised. So I came to understand why some people want early death for themselves or others. I know the humiliations and the temptations of serious illness. I hear the cry: “They shoot horses, don’t they?”

Still, I don’t think the lethal jab is the way to go.

He said also —

Those who advocate euthanasia say it’s about mercy and autonomy. No doubt those are real motives. But every place that has gone down the euthanasia path has left the frail, elderly, sick and disabled with fewer options, not more; with a less care, not more. It also has encouraged other classes of non-terminal sufferers to consider a state-sanctioned death.

Despite the culture of the quick fix, despite demands for governments or health professionals to make everything nice, some suffering is unfixable.

Then our resilience, our character and our hope are really tested. Then our community’s resolve to stand with us, to invest itself in us, not only financially and pharmaceutically but also emotionally and spiritually, is tested. Then the hard loving starts. I have known such hard loving when I was close to death. I ask that others receive it also.

Extracted from finalised Hansard
Fisher’s commentary should motivate us to see the value in striving for better health outcomes to support the chronically sick and terminally ill. This is where money, research and effort should be placed. This effort can be grouped under the heading of palliative care.

The minority report submitted as part of the parliamentary inquiry, titled “The safe approach to End of Life Choices: License to Care not Licence to Kill”, provided the following in finding 3 —

The provision of quality palliative care affirms a patient’s right to choose their therapy, decline futile treatment, choose their place of dying, receive the best possible relief of symptoms and to refuse to prolong the dying process.

As outlined by Dr Shane Kelly in The West Australian of 31 August 2018 —

We believe that the provision of excellent and compassionate end-of-life care, that alleviates pain or distress, means no person need resort to contemplating assisted suicide.

Sometimes, when diagnosed with an illness, or during treatment, patients will talk to their clinicians and family about a desire for a hastened end to life.

Most often these discussions are driven by a person’s fear of being a burden, or feelings of depression, hopelessness, and fear.

Our years of experience in providing end-of-life care demonstrates that with compassionate assessment and intervention, these concerns can be addressed.

Australians have every right to expect that their care needs will be met at each stage of life.

The experiences of pain and suffering should motivate us to do better, with policies and budgets to vastly improve palliative care outcomes.

The report of the Joint Select Committee on End of Life Choices, titled “My Life, My Choice”, provided evidence in findings 16 to 20 outlining the parlous state of Western Australia’s palliative care offerings. Finding 16 states —

Access to hands-on specialist palliative care is limited for metropolitan and non-metropolitan patients.

Finding 17 states —

Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population.

Finding 18 states —

There is a gap in care for people who are seriously unwell but not close enough to death to be admitted for inpatient hospice care.

Finding 19 states —

There is limited access to palliative care medical specialists in regional Western Australia.

Finding 20 states —

There is limited medical oversight, coordination or governance of medical palliative care services across WA Country Health Service.”

I believe that before we, as Western Australian legislators, cross the euthanasia Rubicon, we must do all in our power to improve our medical end-of-life care outcomes, so that pain and suffering is managed to a point whereby euthanasia does not need to be an option. However, if recent media reports are anything to go by, it is anticipated that the state Labor government has the numbers to pass this voluntary euthanasia bill through this chamber and possibly the Parliament.

As I said earlier, I am empathetic to the need to support people who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. Efforts should be made, possibly through legislation, to work closely with the palliative care sector to see what more can be done; for example, in the area of terminal sedation.

Bethesda Health Care, at page 4 of its response to the parliamentary report titled “My Life, My Choice”, states —

Bethesda asserts that ‘terminal sedation’, as a primary aim, is not consistent with good care at the end of life, but recognises care and treatment intended to manage troubling symptoms may have a secondary sedating effect. Bethesda supports the Committee’s recommendation to the effect that ‘terminal sedation’ should be clearly defined, and that clear guidelines be developed for the use of ‘terminal sedation’ should be developed and implemented.

Bethesda Health Care goes on to say —

… Bethesda (consistent with the latest evidence and our extensive clinical experience) proposes that the suffering of most people who are approaching death is ameliorated (or even eliminated) when they access

Extracted from finalised Hansard
quality palliative care in a timely fashion. Further, Bethesda notes the Committee’s own findings that access to quality palliative care within Western Australia is highly variable, and encourages the Government of Western Australia to continue to invest to improve the health system’s capacity to support people at the end of life, their families and friends, and the broader community.

Only when all palliative care efforts and endeavours have been exhausted, and all terminal sedation methods explored, should we as a society look to the concept of voluntary euthanasia. However, it should be tightly controlled through the prism of supporting those who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. That is because to cross this euthanasia threshold early brings with it inherent risks, as evidenced in countries around the world which have decided to move in this direction.

The minority report submitted as part of the parliamentary inquiry, titled “The safe approach to End of Life Choices: License to Care not Licence to Kill”, provided a large number of examples of where, once the legislation had been introduced, irreversible errors were made, eligibility criteria were softened, and efforts to support the sick and dying were weakened. Time does not permit me to go through them all but I will paraphrase and provide some examples, quoting from my notes —

Finding 31: Redress in any assisted suicide case is an impossibility.
Finding 32: The presence of undue influence can be difficult to identify and is easily missed.
Finding 76: The Dutch courts incrementally increased the scope to include adults with psychiatric illness.
Finding 77: In 2001 the Netherlands extended euthanasia to allow for children as young as 12, subject to parent consent.
Finding 80: Doctor shopping in the Netherlands has become commercialised with at least one organisation providing assisted suicide to patients whose own physician has declined.
Finding 81: The Netherlands is debating whether euthanasia should be extended to those who are ‘tired of life’.
Finding 90: Similar to the Netherlands, Belgium allows assisted suicide for patients diagnosed with a mental illness.
Finding 94: Belgian physicians, the subject of a peer-reviewed study in 2010 confirmed the use of life ending drugs without an explicit request from the patient, including because they considered discussion would have been harmful or because they considered the decision was in the patient’s best interest.
Finding 98: In Switzerland in April 2013, a retired Italian magistrate, aged 62, was assisted to suicide on the basis of a terminal illness diagnosed by Italian and Swiss doctors only for an autopsy to find no terminal illness.
Finding 103: In the first nine months following the passage of an assisted suicide law in Quebec it was found the law had been breached in 21 cases. In the second year of operation, breaches occurred in 31 cases.

I will conclude with extracts from an article by former Prime Minister Paul Keating titled “Voluntary euthanasia is a threshold moment for Australia, and one we should not cross”, published in The Sydney Morning Herald of 19 October 2017. It reads —

There is probably no more important issue in contemporary bioethics or a more serious ethical decision for our parliaments …

This is a threshold moment for the country … it constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human.

The justifications offered by the bill’s advocates—that the legal conditions are stringent or that the regime being authorised will be conservative—miss the point entirely. What matters is the core intention of the law. What matters is the ethical threshold being crossed …

An alarming aspect of the debate is the claim that safeguards can be provided at every step to protect the vulnerable. This claim exposes the bald utopianism of the project—the advocates support a bill to authorise termination of life in the name of compassion, while at the same time claiming they can guarantee protection of the vulnerable, the depressed and the poor.

No law and no process can achieve that objective. This is the point. If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system. Beyond that, once termination of life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law. And liberalised they will be …

Once this bill is passed the expectations of patients and families will change. The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional
arrangements. It stands for everything a truly civil society should stand against. A change of this kind will affect our entire community not just a small number of dying patients. It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination.

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society.

MR K.J.J. MICHEL (Pilbara) [6.14 pm]: I rise to make my contribution as the member for Pilbara to the debate on the Voluntary Assisted Dying Bill 2019. I commend the Minister for Health and his department for their evident hard work in bringing the bill before the Assembly. It is clear that the bill is a result of extensive consultation across the state, building on global debates on the issues surrounding end-of-life choices over the last couple of decades. I thank the minister for bringing the consultation to the Pilbara earlier this year. I have also requested that my constituents contact me to provide their views, and I thank those who have taken the time to email me and speak to me on this issue. This bill is very hard for me to speak on. Like many others, I did not have the opportunity to be with my parents when they died. I have not had the experience of seeing anyone suffering in pain before they died. I pray to God I do not have to go through what others have gone through. I cannot say honestly that I feel people’s pain, as it is their experience, and not mine. But, as a human being, I have feelings.

Noting the sensitive nature of this bill, I am pleased that this government took the time to develop the legislation and that significant consultation was undertaken as part of the two major reports that preceded its drafting, those being the report of the Joint Select Committee on End of Life Choices, “My Life, My Choice”; tabled on 23 August 2018, and the “Final Report of the Ministerial Expert Panel on Voluntary Assisted Dying”, chaired by Malcolm McCusker, AC, QC, which was tabled in Parliament on 27 June 2019. This bill poses ethical questions for many of us in the community—the terminally ill, their families, healthcare professionals, religious leaders, concerned citizens and us, the members of the Legislative Assembly who will vote on this bill in consideration of the views of our electorate. It is important we take the time to debate and consider the issues involved.

As many members are aware, I am a committed Christian. For me, this debate is a balance between the doctrines of my faith and providing choice for those who are suffering. As followers of faith, we are taught about the sanctity of human life, that not one of us can take another’s life. “Thou shalt not kill” is the fifth commandment that most Catholics live by. We are also taught about the value of compassionate care, the need to look after our fellow human beings, and to care for the poor, the aged, the sick and the vulnerable. Within the Christian community, there is debate, and I have received correspondence from Christian organisations and constituents presenting arguments on both sides of the debate.

In the context of discussing this bill, we need to note the importance of maintaining and strengthening palliative care services. I am pleased that, as part of the 2019–20 budget, this government announced $47.4 million towards palliative care and end-of-life choices. I hope that there is longevity in this support of palliative care. It is the largest investment to date in Western Australia’s palliative care services, and I am particularly pleased with the focus on distributing funding to regional communities. It is vital to maintain and strengthen palliative care and continue to focus on improvements to quality of life. However, while pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimal palliative care.

The legislation before us carries with it an enormous responsibility that all of us in this house have been elected by their constituents to bear. For the debate on legislation concerning matters of life and death, I believe that our constituents should inform our work, not our personal beliefs or our religious faith. The stories that I have heard, the emails I have sent and the phone calls I have received from my Pilbara constituents are overwhelmingly in support of this legislation. It is important we take the time to debate and consider the issues involved.

Dear Kevin Michel MLA

My husband was diagnosed with Stage 4 terminal cancer in late 2012 and given a best estimate of 3 years. He finally passed away and I hope that he finally found peace, peace from the pain and suffering, in January 2014.

He was 48 years old... our 3 children, young adults. Each night we would kiss each other goodnight and hope that it would also be good bye. He would say that he was holding his ticket up high—his ticket out. He finally passed away because he simply stopped eating, and his heart finally gave out.

He worried that he was still alive at Christmas time and into the New Year and he didn’t want his death to impact on our future family memories of Christmas.

If only he’d been able to choose the day and time of his death.

He was an active man who loved living life and being a part of fishing adventures, sport outings and sharing time with his family and friends...

Extracted from finalised Hansard
I don’t know if you’ve been personally touched by cancer or the death of a loved one from an terminal illness, and if you haven’t I hope you never will because the grief and loss will never leave you.

But please please please be a voice in support of this Voluntary Assisted Dying Laws and share my story, and the story of my husband’s death.

If only he’d had a choice, if only he’d been able to choose the day and time of his death.

We must make a compassionate choice about this legislation and I must make a responsible choice on behalf of the majority view of my electorate. That is why I am commending this bill to the house.

I would like to finish my submission with an excerpt of a letter from another constituent living in the Pilbara electorate. Debbie Allcott wrote a letter about the incurable, untreatable and very cruel neurodegenerative disease, progressive supranuclear palsy, or PSP—a disease that took the life of her mother. In her letter Debbie wrote —

Over an 8 year period PSP rendered my mother fully incontinent, gradually and eventually unable to move at all, unable to see because her eyelids shut for the last two years of her life due to the palsy, eventually unable to speak at all and unable to swallow without having constant near death experiences. She suffered the type of end of life she had always tried to avoid with her “living Will” and documented boundaries of what she considered “living”. She did not believe in feeding tubes to keep one alive when in an incurable, terminal state, nor intubation in such circumstances.

My previously vibrant mother eventually became a ‘pulse in a body’. This to her, was indignity and irremediable suffering and it could not be described in any other way. Her journey was long, arduous, cruel. She endured so much as she lost all of herself meaning her last 6–12 months were simply inhumane and heartbreaking. No one should have to endure such an ending that is inevitable and she desperately had wanted to choose a more gentle, dignified end.

Palliative care couldn’t give her back the dignity she’d lost. Nor could it help her move again, or see again or eventually speak again. These are people’s inner values and soul that allows them to enjoy living. The previously “love of life and vivacious, smiling woman” was trapped and no one could fix or change that, not even palliative care. And because of archaic laws she had no option but to suffer it out, even though this is an incurable and terminal disease.

As an intelligent, compassionate and progressive society, we now have a chance to debate and change this in a positive way for our most vulnerable.

Debbie finished her letter with the plea that I ask other members of the house —

ask yourself privately, “if that was me OR, if that IS me .... would I not at least feel comfort in the ability to have a choice?”

Thank you.

MR W.J. JOHNSTON (Cannington — Minister for Mines and Petroleum) [6.26 pm]: Thank you very much. As a member of the cabinet of the McGowan Labor government, I have scrupulously avoided making any comments on the Voluntary Assisted Dying Bill 2019. I want to say that I am determined to be bold, brave and compassionate in deciding how I vote on this legislation. It appears to me that this bill is likely to pass the Assembly and, most likely, it will pass without amendment.

Equally, I recognise that all the evidence is that, overwhelmingly, Western Australians support the passage of the legislation through the Assembly. That is probably true of my own community of Cannington. However, it is also true that only a small number of people beyond the Parliament have actually read the bill. I imagine that very few people know what the terms of the bill mean. In fact, many of the people who have contacted me to say that they support the bill did so because they believe the bill provides for euthanasia. That is not a surprise, given that much of the commentary around the bill has been set out in terms of individual self-determination. Indeed, the report of the Select Committee on End of Life Choices was titled, “My Life, My Choice”. The title suggested that the committee recommended that people should be able to choose to die when and how they want, when that is not the effect of this bill.

Over many years, I have listened to many people discuss voluntary assisted dying and euthanasia and speak about many things, including what is called rational suicide—that is, the concept that a person should be able to access voluntary assisted dying regardless of their health condition. The argument is that if a person is of sound mind, without limit, they should be permitted to choose the time and circumstances of their passing. Further, I have been lobbied by people to support this bill on the basis that they should have the right to end their life via the use of advance health directives in the case of dementia and other conditions that do not of themselves lead to death. That is not unusual, as recommendation 23 of the Ministerial Expert Panel on Advance Health Directives final report, which was tabled by the Attorney General only this week, recommended that.
As many members have pointed out in their comments, many constituents have been in touch with us to say that this bill does not go far enough. Of course, that means that the passage of this bill is not the end of the debate. There will continue to be a debate on end-of-life choices notwithstanding the passage of this bill. It is also true that this is not the first time the question of voluntary assisted dying and euthanasia has been considered by the Parliament.

On each of those occasions, the Parliament decided to reject those bills. The criticism that has often been made to me in the lead-up to this vote is misdirected. Parliament has a duty to consider these issues. Parliament had considered these issues but had chosen not to take this step. The decision by the Parliament to reject those bills is said by some to be a failure. Effectively, there is an argument that a decision to not support this bill is an invalid choice. Indeed, it has been put to me that if a parliamentarian chooses not to vote in favour of this legislation, they are acting inappropriately. I have been told that if a parliamentarian does not support this bill, it means that that individual parliamentarian instead supports inflicting pain on another person. I have been told that because the majority of people support the passage of the legislation, opposition is not valid. I have been told that opposing this bill means that a person is supporting suicide. This is despite the fact that the suicide rate in Oregon increased after the introduction of assisted dying legislation. Indeed, I have been told that having a religious perspective on the bill is also an invalid approach.

I would like to make the point that roughly an equal number of constituents on both sides of the debate on assisted dying have sent me their perspective. I appreciate that this appears not to be true for every member, but there has not been an overwhelming demand for me to support the legislation. This may be because I have not sought to make an issue about my views. Alternatively, it might also reflect the large number of Islamic, Catholic and Assembly of God believers who live in my constituency. I would like to make the point that there are people who make their decision on this bill from a religious perspective, and they are entitled to do so. Further, another valid view against this legislation is that it is not appropriate for the state to authorise the death of a human being, and that is personally the perspective I take. Other people have raised their opposition to the bill on the basis that it misdiagnoses the challenges of end-of-life choices. I have had workers from palliative care facilities explain to me that they oppose assisted dying because they believe it is unnecessary. Also, there are people who argue that the bill should be opposed because effectively it is the “thin end of the wedge”. Of course, people have lobbied me in favour of this legislation, telling me that none of these arguments are legitimate. I do not agree with that. It cannot be correct to argue that our entire history of society has been wrong. I do not agree with that perspective. The law in this state does not permit assisted dying, so I fail to grasp how supporters of this legislation can say that selecting the status quo is not a valid selection.

We should consider some issues when looking at this bill. The number of people accessing the laws in jurisdictions that introduce voluntary assisted dying or euthanasia grows over time. As I have highlighted, this bill does not satisfy many people’s views on access to assisted dying. There will continue to be a campaign, including by many of the people who have been involved in high-profile lobbying in favour of this bill, to extend access to assisted dying to more categories of people. It is important that we all note that the Australian Medical Association does not support this legislation. It has been reported that the AMA opposes this legislation —

The Australian Medical Associations across the country believe that doctors should not be involved in interventions that have as their primary intention the ending of a person’s life.

I turn to a number of specific provisions in the bill. Clause 10 of the bill provides that a health practitioner cannot tell a patient that there is a better way to be treated than to access voluntary assisted dying. Clause 10 states —

A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Western Australia).

That means that if a patient comes to a health practitioner asking to access voluntary assisted dying, the practitioner cannot say to them, “I understand that you are eligible for voluntary assisted dying but I think there is a better pathway to manage your specific illness.” If a practitioner says this to a patient, the health practitioner is potentially guilty of professional misconduct. I do not think that is appropriate. This is particularly the case when clause 112 proposes that a person is protected from liability for assisting a person in making a request. So, a person is protected from liability in supporting or encouraging access to assisted dying, but a medical practitioner is not protected when recommending against voluntary assisted dying, even if their medical opinion is that there is a better healthcare option for a patient than assisted dying. Clause 19(5)(b) requires a medical practitioner with a conscientious objection to provide information on how a patient can access assisted dying.

The bill will also impact medical schools, which will need to include education on voluntary assisted dying in their medical programs. I am unconvinced that this issue is appropriate to be included in the legislation.
I would like to make it clear that I do not believe that there should be any artificial delay in bringing this bill to a final vote. However, I also want to let the minister know that I have some specific questions that I will raise in consideration in detail to clarify some of the provisions in the bill and to ensure that those issues are recorded in Hansard.

In conclusion, I make the point that this is a conscience vote. Each of us must make our own decision on how we vote. As Edmund Burke said —

> Your representative owes you, not his industry only but his judgment; and he betrays instead of serving you if he sacrifices it to your opinion.

It is my judgement that this bill is not suitable to be supported and I will vote against it.

**MS J.J. SHAW (Swan Hills)** [6.36 pm]: Perhaps somewhat naively and very early on in my political career—in fact, as a candidate and very early on in my preselection—I was asked for my opinion on voluntary assisted dying. I very quickly and very publicly voiced my support for it. Reflecting now on how I felt then, it is funny how simple these issues seemed at that time and how easy it was for me to express an opinion—a view that seemed logical and absolutely self-evident. But now I have to make a decision, not just express an opinion, about the lives of people whom I have been elected to represent, about the sort of state I want to live in and the types of values that we as a polity and a community should uphold and preserve—a decision that will affect people that I care deeply about and that affects my own family.

It is one thing to roll off an opinion about the types of choices that we as an individual would like to make about our own life and the sorts of rights we think should be available to others. It is quite another thing to be placed in the position in which we have to make a decision—this decision—because the decision that I take as the member for Swan Hills, the decision that this Parliament will take on behalf of the people of Western Australia, can help or hinder so many others to make decisions about their own lives. This decision is probably the most profound I will ever have to take as a legislator. I have no doubt that all my colleagues in this Parliament appreciate the gravity of the matters that we are now considering.

The past couple of days have borne witness to some of the best work I have ever seen any Parliament undertake. As a new member of Parliament, I am proud to be part of this institution that has debated these matters in a considered, measured and respectful way. We are considering whether and how best to safely and compassionately respect and facilitate an individual’s ability to freely decide to die with dignity in circumstances in which people face an inevitable and imminent death and are suffering in a way that they consider intolerable. This process has shown me that decisions on these matters are not lightly taken. Like my colleagues, I have searched my conscience and thought about this day and night. I found myself genuinely challenged to examine my moral and ethical beliefs.

I have also undertaken extensive consultation with my electorate to ensure that I understand the views of the people whom I have been elected to represent, about the sort of state I want to live in and the types of values that we as a polity and a community should uphold and preserve—a decision that will affect people that I care deeply about and that affects my own family.

During this debate, we have all heard about members’ personal experiences of suffering and grief. Listening to stories about suicides in particular has been very harrowing. It is tragic to hear the coroner’s comments that 10 per cent of suicides are linked to chronic disease and terminal illness, including deaths from plastic bag asphyxiation, hanging and gunshot. As the Minister for Health so poignantly stated, these are wrongful deaths. I believe that we can and should do better than condemn people to suicide.

As I consulted with my community on this issue, I also heard many stories of loss; of people who have confronted some terrible circumstances and who are currently struggling with these issues. I want to thank the people of Swan Hills for being so generous and willing to share their views and experiences with me. I conducted a range of different forms of consultation on this topic within my electorate. I ran an online survey, conducted community forums, attended many meetings with community groups, received letters and emails, and had many direct conversations. Overwhelmingly, the people of Swan Hills have told me that they support voluntary assisted dying.

Polling across Western Australia has indicated that 88 per cent of people support voluntary assisted dying. In my electorate, my own survey—which I was at pains to ensure reflected the views of Swan Hills residents—showed that 92.8 per cent of people supported voluntary assisted dying. Of the 2.7 per cent of people who were unsure and the 4.5 per cent of people who were opposed, about half of these expressed the view that they did not consider the proposal extended choices to a sufficient range of people—they wanted the VAD framework to go further.

I want to briefly give a voice to some of the experiences and views that my constituents shared with me. According to my notes, one constituent said —

> My personal experience is watching a loved one who has put up a fight, in the end have choices taken from them.

> Putting a patient on morphine is inhumane—no food no fluids.

---

*Extracted from finalised Hansard*
Having a choice that if the disease or prognosis results in death, making the choice while capable should be a right.

Prolonging the process and forcing loved ones to live with the anguish of seeing them in pain, or watching them become so emaciated is also inhumane.

I watched my brother wither away, these are my last memories of him.

Another constituent said —

My Father died a painful and undignified death due to throat cancer. He was not conscious in his last days and in too much pain to humanly bear prior to this.

His last months were unbearable suffering, with absolutely no quality time to appreciate these last days with loved ones, so much so that he forbade me from visiting him in Melbourne.

My stepfather is now facing the same death to secondary lung cancer. It is beyond cruel to both the individual who is suffering and the family who love them.

Death in these cases is inevitable but we have within our means a tangible way to prevent the heartache associated with the agonising wait for the unpreventable.

Finally —

Having watched my grandmother suffer a terrible debilitating and slow decline in to death, I would not wish that upon anyone. Human life is valuable but quality of life is important too. People should be allowed to accept and welcome their death with grace and dignity.

A small number of my constituents were against voluntary assisted dying. They predominantly based their views on deeply held religious convictions. According to my notes, one constituent said —

I believe that all human life is sacred and to take one’s life is a mortal sin in my religion.

Another said —

I firmly believe that God is the only one to decide a person’s time of death and that we should not take it on ourselves to act on God’s behalf in this or any other issue.

I respect and acknowledge people’s rights to hold these beliefs and to apply their conscience as they see fit when the time comes for them to make decisions about their own lives. I imagine that being a member of the church and holding these views would be of great comfort at a very trying time, but I cannot accept that the views and beliefs of some should prevent others in my community from accessing a safe and compassionate framework to achieve a dignified and gracious death at a time that they decide. I want to acknowledge all of those people who told me that they did not think their own religious beliefs should stand in the way of others’ rights to make decisions about their own lives.

There were also those who expressed the view that this legislation does not go far enough. One constituent stated —

My mother’s … greatest fear is a stroke which leaves her incapable of looking after herself.

Her advance health directive includes refusal of resuscitation, however should she survive but be incapable of being independent, she wants the option to end her life as there would no longer be any quality of life.

This situation does not appear to fit within these recommendations and yet is a very real situation that applies to many people.

Another constituent said —

Having seen close family members suffer and decline due to dementia and Alzheimers related diseases, I believe there should be the provision for a person of sound mind to make a “living will” by stat dec which indicates the level of decline that they regard as untenable and that this can be evoked as a compos mentis request in lieu of their ability to yield that assent at the stated time.

As someone who, in real time, is experiencing these issues in my own family, having difficult conversations about the decline of a loved one and facing the prospect of some very challenging decisions ahead, I know how hard it can be to share stories of grief, loss and suffering. I know how heavily the weight of decision lies. I want to sincerely thank all of those constituents who took the time to tell me their stories and give me their views and opinions.

My responsibility as the member for Swan Hills is to give the proposal before this Parliament my objective consideration, which is based on the briefings that were provided to members by the Department of Health and a range of other organisations; the work of the Ministerial Expert Panel on Voluntary Assisted Dying; and the findings and recommendations of the Joint Select Committee on End of Life Choices. I would like to thank the members for Morley, Baldivis and Mount Lawley in this place, and the South West Region in the other place, for

Extracted from finalised Hansard
their fantastic work on this initiative. In making my decisions on this important issue, I will be informed by these comprehensive and extensive bodies of work and the strongly expressed wishes of my community. I am satisfied that the government has undertaken a comprehensive and methodological approach to developing this legislation. I congratulate and thank the Minister for Health and his staff for undertaking what must have been an extremely challenging task.

I am satisfied that the eligibility criteria is appropriate: a person must be over 18 years of age, an Australian citizen or a permanent resident, and ordinarily resident in Western Australia; they must have been diagnosed with a disease, illness or medical condition that is advanced and progressive and will cause death within six months, or 12 months for a neurodegenerative illness; and the person is experiencing suffering that cannot be relieved in a manner that the patient considers tolerable.

I believe the bill contains robust and rigorous safeguards to ensure that individuals are well informed and understand the implications of their decision; that they are appropriately assessed for eligibility; that they make their choices completely voluntarily and without coercion; that they have access to medication in a safe and auditable fashion; and that they are appropriately enabled or assisted to finally exercise their choice. I look forward to listening to other members’ views on the framework during the consideration in detail stage of the bill.

There are three issues about the bill that I would like to briefly address. The first relates to capacity and the view that some constituents have expressed to me about dementia, Alzheimer’s disease and advance health directives. Some people have said that this legislation does not go far enough. I believe it is very important that this legislation preserves at its very heart an individual’s complete control over the decision-making process at the time that decisions are taken. Whilst I understand, and have directly witnessed, the tragic decline of family members through dementia, I could not support a framework that places decisions into the hands of others about when someone has reached that point at which their AHD enters into effect. To me, that undermines the concept of “voluntary”. I believe that capacity and access should be determined in real time.

The second point I would like to make addresses palliative care. This debate is not about a choice between voluntary assisted dying and palliative care. Although it is legitimate to call for increased access to palliative care, and I am very pleased to see that significant action is being taken by the government to improve resourcing, the two issues should not be conflated nor traded off against one another. The bill stands alone and we should consider it as such. For some conditions, palliative care simply cannot provide relief, and the only person who should determine whether pain is insufferable is the patient.

The third point relates to conscience. It is appropriate that if a medical practitioner has a conflict of conscience, they should be able to refuse to participate. I note that there are provisions requiring that practitioners must provide information to patients when they exercise their conscience. My constituents are concerned to understand how this framework applies beyond individual practitioners to institutions, and whether institutions may be able to prevent access—particularly public hospitals funded by Western Australian taxpayers that are intended to provide public health services to us all. The main public hospital available to my constituents is operated by a religious organisation. It does not permit women to access the full range of reproductive health choices available to other women at state–owned and operated public hospitals, based on conscience. My constituents will be very interested to understand how the provisions of this bill will ensure that they can step through the stages of the voluntary assisted dying framework, particularly to attend clinical consultations with medical practitioners at their only local, state-funded public hospital. Constituents have also raised concerns about access at aged-care facilities operated by religious organisations and their ability to exercise choice when they may wish to die in their home surrounded by loved ones. I look forward to exploring these issues through the course of consideration in detail.

This legislation will give people the ability to die with dignity when their life may be devoid of it. It will provide the ability to exercise choice and have control, and will perhaps provide peace at a time when, otherwise, life would be filled with fear, uncertainty and pain. It will allow them to be supported, have their freedom to decide respected and be surrounded by their loved ones in a place of their choosing as they exit this life. I want to congratulate the government for having the courage and the conviction to bring forward this bill on a topic that has vexed so many other jurisdictions. The passage of this legislation would bring this Parliament into step with other members’ views on the framework during the consideration in detail stage of the bill.
The contributions I have heard—I have not heard them all—have filled me with pride, based on the sort of contemplation people have had. I acknowledge the member for Dawesville in his leading off, I suppose, after the Premier and the Minister for Health. His contribution was highly researched and highly thought through, and it reflected his community. I also acknowledge the contribution of the member for Armadale, who gave me some pause, I must admit, around some of the issues of the vulnerable and their vote. As is so often the case in any legislation, we are trying to contemplate the unintended consequences of a bill. We are also trying to contemplate the unintended consequences created over a generation after the implementation of a bill, with the changing nature of technology, people’s attitudes and the community. In many ways we are trying to second-guess that by creating legislation, as we do every day in this place. I want to mention in this small contribution the pride I have in other people’s contributions. I acknowledge the courage my friend the member for Cannington had in standing and delivering the sort of conviction he has on these issues. It was not just a simplified yes or no, but an articulated view of what his concerns are and why they are so important. Of course, the generalised respect across this chamber has been something to behold. Now, the challenge for us is to carry that same sort of respect into the subsequent stages of this bill as it passes through our chamber, making sure that when things are brought to a point of choice, should there be proposed amendments or otherwise, we can continue that good intention.

The reason for that was that I felt there was just going to be a line, if you like, of people giving successively repetitive orations of the same experiences, but in fact, I found it was entirely the opposite. I felt compelled to make a statement about how proud I am to be a member of this chamber—how proud to have heard members speak from deep knowledge, deep experience and deep conviction. It is not often that we get the opportunity in this chamber to hear such heartfelt and deeply held views, and some uncertainty I must add. There is a vein of uncertainty across this chamber about what this bill actually means. People in the electorate ask me how I will vote on any of these life matters—whether I am pro-choice or pro-life—and that is just not helpful. More often than not I say that I do not have an answer because I will answer when I am asked to vote, and I will make a decision about the sorts of things that go into my vote on the basis of the evidence. Until we are in that position, in that moment when we have to make a decision on behalf of our constituents in the state of Western Australia, then, and only then, do we have the responsibility to answer that question sincerely. We cannot have a simplistic debate about these topics.

I will conclude on this: in my previous professional life I have been responsible for taking life. I have sent many constituents would not have contemplated the detail of how the vulnerable will be attended to in this legislation. We are here to vote on detailed terms. The sorts of contributions made by members have given us some excellent evidence to discuss and debate the exact terms by which this bill will come to book. The vast majority of our constituents would not have contemplated the detail of how the vulnerable will be attended to in this legislation and the practical implementation of it. It is upon us, particularly in consideration in detail, to tease that out.

I will conclude on this: in my previous professional life I have been responsible for taking life. I have sent many into harm’s way. It is not ever of itself a decision taken lightly. I urge everyone to contemplate the professions and the professional people who surround themselves every day with those people who are dying—those people they have in their hands to care for. Do not underestimate the level of care, commitment, intention and professional approach they will take to each and every human. Life is not taken easily, regardless of who you are, particularly if you are a professional, and particularly if your entire professional life has been dedicated to the preservation of life. It is not a decision you take lightly. Some of the details around the actions in this bill and the consequences of some of its clauses need to be nested inside the professional conduct of an outstanding class of citizens in this country, and that is the healthcare workers—all of them. Please put some faith in them to understand the sorts of things they are doing every day.

Like many in this chamber, I have had a personal experience with this. My mother was a devout five-foot-four Catholic woman, who commanded eight children with a wooden spoon, a strap and a stern look. She died at our home in Kardinya surrounded by her family, weighing something like 30-odd kilos, ravaged by bone cancer and all the other attending cancers that come from a life of smoking. I am not sure that she would have chosen voluntary assisted dying in her final days, but I sure as hell know that, fierce woman that she was for individual choice, democracy and the sort of civil society she raised us all to belong to, she would have wanted that choice. She would not have wanted it denied to anyone else. That is why I support the intention of this bill and its smooth passage through this chamber. I thank you all for the opportunity.

Debate adjourned, on motion by Mr D.R. Michael.
MS M.J. DAVIES (Central Wheatbelt — Leader of the Nationals WA) [4.02 pm]: I stand this afternoon to speak to the Voluntary Assisted Dying Bill 2019. I admit that I do so with some level of anxiety. Surprisingly, I have a greater level of anxiety than when, as a newly minted member of Parliament, I spoke in the Legislative Council nine years ago, to Hon Robin Chapple’s Voluntary Euthanasia Bill 2010. That bill was debated only in the Legislative Council, and was not supported to proceed any further at that time. It was a private member’s bill, but every member in that place afforded it the due consideration deserved by such a serious subject. As a new member, and a young member—in fact the youngest in the house at that time—I approached that debate by conducting my own research and inquiries. I met with palliative care specialists, and with Marshall Perrin, from the Northern Territory who, by chance, is here in the Parliament today. I attended briefings and consulted with my electorate, Agricultural Region. It was a very different bill from the one we are considering today, and it had a vastly different pathway to the Parliament in comparison with the bill that is before us. However, I cannot say that the details or the parameters of that bill, or the way that it was developed, were the overriding reasons I chose to vote against it. In 2010 I did not support voluntary assisted dying. As a legislator, it was my view that the bill did not contain the appropriate safeguards, the legal clarity or the protections, but as an individual I could not or would not be convinced that we should legitimise a practice that would allow some people to choose to die with the aid of another. I was worried about the moral dilemmas that this would create for everyone surrounding the person making the request.

Now, nine years later, I find myself delving into this most complex issue for the second time as a member of Parliament, this time as the representative for the good people of the electorate of Central Wheatbelt. I have attended meetings convened by the Parliamentary Friends of Palliative Care. I have attended briefings with doctors and nurses from jurisdictions where this legislation has been introduced. I have met, albeit briefly, with Hon Malcolm McCusker and members of the ministerial expert panel. I have spoken to palliative care practitioners, nurses and doctors in my electorate. I have met with Mr Andrew Denton and representatives of Dying With Dignity. I have listened to all 17 hour-long podcasts from the series created by Mr Andrew Denton, titled Better Off Dead. As a country MP, I spend many hours in my car, and it was a good opportunity to listen to the sometimes harrowing stories that were recounted, in the privacy of my own space, along with the forensic manner in which Mr Denton scrutinised the arguments for and against voluntary assisted dying.

I note that members who have spoken prior to me have talked of town hall meetings as part of the consultation on the bill with their electorates. I have the privilege of representing an electorate that spans 100,000 square kilometres. It contains 27 local governments and twice as many towns and communities. I have done my very best to communicate with my electorate about the bill, and, before that, the work of the ministerial expert panel, and, before that, the inquiry and report of the parliamentary committee. I have invited comment and feedback and provided information directly to groups and individuals who have considered the matter. As result, I have received emails and letters into my office, contact via social media platforms, and communication with me directly at field days and local shows, mobile electorate visits, and events that I have attended, no doubt like every other member of this place.

Over the 10 years I have represented the electorate, first as the member for Agricultural Region, and now as the member for Central Wheatbelt, I have come to appreciate that the people who are the bedrock of these communities are both pragmatic and compassionate. I will not distil the electorate into one homogenous entity—it is far more complex than that—but it is true to say that many country people, particularly farming families, face the practicalities of death in some form far earlier than their city cousins. Whether it is humanely ending an animal’s suffering as a result of illness or injury, or slaughtering a chicken or sheep to put food on the table, the circle of life is very evident on a regular basis for many of my constituents. Indeed, I have lost count of the number of times that people have said to me that we do not allow animals to suffer unnecessarily, so why should we tolerate this for our family and our friends. I make a strong point here that this sentiment alone is not enough to warrant support for the bill, but this pragmatism that filtered through many of the conversations I have had over the past months in anticipation of this debate has rung true for me. I heard comments such as, “Why make them suffer when death is inevitable and near?”, “Why don’t you let me decide when I’ve had enough, Mia?”, and “I wouldn’t let one of my much-loved pets suffer a cruel and painful end.” Another said that the legislation does not mean that more people...
will die; the legislation only ensures that fewer of them will die suffering. Another said that we believe that if you are nearing the inevitable end of your life and suffering, the best option for the individual is to peacefully just go to sleep. I also received heart-wrenching correspondence from constituents who felt compelled to share some of their most private and painful moments. The experience of watching someone you love suffer is hard to bear in normal circumstances. To watch someone you love suffer when there can be no outcome other than death, knowing this is inevitable and the only release, is hard to bear. One constituent wrote —

The suffering he has and will continue to go through is ripping not only my heart out but also my mother’s and three sisters I can see the pain in his eyes and he has already communicated to us that he no longer wants to continue. He deserves so much more than an undignified death.

Another wrote —

Having to watch your mother disappear and her shell of a body left to wither away for years is something I don’t want my kids to go through as I did. My father had cancer and he too wanted only to die in peace, something that was not allowed to him and he died after 2 years in agony both emotionally and physical.

As we all began to talk about this in earnest after the parliamentary committee had reported, I was visiting the Northam Health Service to inspect the upgrades, which are almost complete. I was walking through the emergency department, which is really quite wonderful, and a lady and her daughter were in one of the treatment bays. The mother was in the bed, and she called me over, out of the blue, grasped my hand—I did not know her—looked me straight in the eye and said, “You must support this voluntary euthanasia bill, Mia.” Her daughter looked very upset and nodded, but when I asked her whether she would like the option, she simply said, “Yes, mum’s had enough; this body of hers is worn out, and she’s ready to go.” So many people are watching this debate. I do not know that woman personally, but the people who have reached out as part of this conversation have been quite remarkable to me, as a local member of Parliament, right across the state.

Sometimes my electorate is incorrectly characterised as conservative or resistant when it comes to social change. I am not altogether sure whether that label is correct, or whether it has ever been.

Pragmatic, a strong sense of self-determination and self-reliance, and compassionate—this is the wheatbelt that I know. You see this in the way these communities operate—volunteering and fundraising extraordinary amounts to make their towns a better place to live. We have aged-care facilities and independent living units for our senior citizens in towns with populations of sometimes fewer than 300 people. These existed well before the advent of royalties for regions and support from the state government in more recent years. They were built through donations, by hard graft and by everyone chipping in. As I speak about this, I would not like the Premier or the Minister for Health to get the impression that the demand for these facilities and services has been met—far from it. But I make the point that we in the wheatbelt have always been prepared to invest our own funds to look after the people who have built and contributed so much to our communities. Each generation is acutely aware that it has a responsibility to look after those who came before them, and leave it better for those who follow. For a number of towns, this burden is carried by a diminishing number of people, and yet that has not stopped them from wanting to provide the best care and support for those who are vulnerable in their old age, or facing a disease that may rob them of their quality of life. When death comes—as it does to everyone—in the wheatbelt, funerals are a whole-of-town affair, with generations of family, friends and neighbours returning to pay their respects. It is very literally the embodiment of the definition of compassion—a word that means “to suffer together”.

I have considered the notion of “compassion”, because I spent some time thinking about what this means in the context of providing the end-of-life option of voluntary assisted dying, and many have referenced that during the debate already. In 2010, during the debate on the Voluntary Euthanasia Bill 2010, I made the following statements about a compassionate society —

In my view, it is one that cares equally for the young, the elderly, the sick, the infirm and the vulnerable.

It is one that affords an individual dignity and respect in illness and health.

I used these statements to argue against voluntary assisted dying, saying more resources should be allocated to palliative care and support for those suffering at the end of their life. I now believe, with the benefit of the good work done by the parliamentary committee, and numerous discussions with those who have worked in this field, that this should not be an either/or debate.

In 2010, I spoke about my pop and my nan, and their passing. Since then, my grandad has passed away, and also my dad. Pop, nan and dad all had cancer, and my grandad—my mum’s dad—had Alzheimer’s. I do not know what their views were on voluntary assisted dying, and it is not my place to speculate. Had this legislation been in place, my pop, my nan and my dad would all very likely have been eligible for voluntary assisted dying. What I can do is reflect on their life and passing from my perspective. In my pop’s case, I remember him from my childhood as a strong man and a leader in his community, who had the respect and love of his family. I considered it a great privilege to be part of a family that drew in around him to care for him in his last months. In that time, a different relationship developed between him, his grandchildren, his daughters-in-law and his six sons. Where once he was robust, he was vulnerable. Where once he was thinking only of the next job to be done, he was reflective.
Pop received wonderful support, at one time being admitted to the Cottage Hospice in Shenton Park, stabilised, though wonderful palliative care, and then returned home, where his palliative care was provided until his death, surrounded by his family. So naive was I about how the system worked that at that time I thought that once you entered the hospice and were under a palliative care specialist, you would shortly be shuffling off this mortal coil. I was one of those people whom the parliamentary committee highlights at paragraph 3.28 of its report, and I quote —

Unfortunately, there remains a misconception that palliative care is just for the final days or weeks of life or only for people with cancer. Many patients and their families are reluctant to involve palliative care in their treatment out of the mistaken fear and misunderstanding of what it represents.

As we have heard from other members during the debate, palliative care can significantly improve and even extend a patient’s life. At least it can provide a quality of life that is comfortable for most patients.

There is a reason that much of the “My Life, My Choice” report completed by the parliamentary committee focuses on palliative care services, funding, staffing, education and awareness. Palliative care is, and will always be, an important service. Improving these services across Western Australia—overcoming the challenges of making sure every Western Australian can access appropriate palliative care—must remain a priority of this and future governments. This is of particular interest to me as the Leader of the Nationals because the delivery of these services into our vast and sparsely populated regional areas is truly a test for any government. But we can do this and also consider voluntary assisted dying. I know I am a better person, and my family are better people, for having known my nan, my pop, my grandad and my dad, these wonderful people in different stages of their lives, in both strength and vulnerability. I also know through their experience that the human body and mind can withstand much more than we ever think it can. There is an indomitable spirit and will to live, even in the grimmest of situations. It is a human condition to want to live.

My dad wanted to live. On days when he could barely breathe, he still wanted to be there to see his beloved grandkids, Harry and Ella. What I cannot gloss over is that when death is imminent, and the disease that our loved ones have fought so valiantly has got the better of their body, providing a choice to go gently and peacefully under their own terms is what I consider compassionate and just. I cannot say whether dad wanted that choice. I never discussed it with him, probably because in his mind he was never going to die! I can tell you that if I was faced with a diagnosis of lung cancer tomorrow, I would want the option of voluntary assisted dying. I would also want access to the support that palliative care can provide for the patient and family of someone with a terminal illness. If I was given the right to choose, and went through the process of applying, it would also be my right not to use the drugs provided. I do not agree that providing people with the option of voluntary assisted dying relieves us of our responsibility to look after our most vulnerable. I think it does exactly the opposite. In fact, there is strong evidence across the world that it does exactly the opposite.

Many people do not and will not consider death or dying until it arrives on their doorstep. They may not have had the experience of watching someone they love die a “bad death”. Many will likely not read the deeply personal accounts provided in the committee’s report, or have that firsthand knowledge that many medical staff will have about how death comes to patients with terminal disease. We are not a society that talks about death. But we should. This bill should mean that there will be more conversations, more checkpoints, and more access to support and advice.

It was with great interest that I listened to Andrew Denton interview a woman, Marjorie Vangansbeke, from Brussels, who had been suffering unbearably for many years with a mental illness. In that jurisdiction, she was eligible to access voluntary assisted dying. I know this is not being contemplated in Western Australia, and it is certainly not something to which I want to widen the debate, but the conclusion that Mr Denton arrived at, having discussed the process that applied to voluntary assisted dying, was interesting to me. Marjorie made the decision to apply for voluntary assisted dying, having suffered for many years. The first doctor she spoke to referred her to a specialist and she came to understand that the process was not in fact the free pass to death that she had been hoping for. She worked with a psychiatrist, and they diagnosed Asperger’s and developed a plan for living with the condition. Six months down the track, her thoughts had shifted from committing suicide violently, to living. Andrew Denton, at the conclusion of the interview, observes, “It is a paradox I had never considered before: how embracing the prospect of death can hold out, instead, the possibility of life.” Instead of suffering in silence, of believing that there is no option but for a violent death at your own hands, the option to discuss a gentle death in fact opens up opportunities for people that they may not previously have been aware of or considered. At the very least, there is a discussion about death and end of life in a supportive and reasonable environment.

I am convinced by the evidence provided to the parliamentary committee here in Western Australia and the evidence from across other jurisdictions that we would be failing our community if we allowed the status quo to remain. At this stage, I would like to refer to the comments of Andrew Denton in his final podcast of Better off Dead. I urge members who have not listened to this podcast to take the time, if they can, to listen to some of the work that was done as part of preparing this podcast. He states, according to my notes —

The point of changing these laws is not about forcing an outcome on anyone. It’s about giving them a choice—a level of control—when illness and suffering is robbing them of other choices and control.

Extracted from finalised Hansard
It’s about the comfort of having options. And it’s about respecting other people’s choices too. Those who disagree are free to live, and die, as they choose. Doctors and nurses who feel the same way have every right not to participate. A law for assisted dying is not about a right to die—as one Dutch doctor put it to me “death is not a right; death is a fact at the end of life”—but, instead, a right to ask for help should the suffering become unbearable and untreatable.

Ms M.J. DAVIES: There are still some questions for the government to answer in relation to this legislation and I hope that it will undertake to consider them all seriously. Firstly, I have already raised with the Premier the issues about the commonwealth legislation that has caused the Victorian government to restrict all discussions between a patient and doctor to face-to-face interaction. There will be logistical challenges for regional Western Australians to access voluntary assisted dying should it have passage through this Parliament. The use of technology, particularly telehealth, will play a vital role in access to both voluntary assisted dying and palliative care. If we are to limit discussions between doctors or healthcare professionals and patients to face-to-face interaction, we will immediately disenfranchise regional and remote Western Australians. We must have assurances from the minister that the concerns we have raised have been addressed. Secondly, there is little clarity at this stage on the implementation of the legislation, particularly from a regional perspective. Again, I point out that we have a shortage of general practitioners in regional Western Australia, and that shortage extends to allied health practitioners, including nurse practitioners. Will a person who accesses voluntary assisted dying have the same time line for the process as someone living in the metropolitan area? I suspect not, given the logistics and the size of our state. Certainly, if we rely on Australia Post for the delivery of the voluntary assisted dying substance, then I would say absolutely not, given that it takes me nearly three weeks to get a letter from one end of my electorate to the other. Is it fair that if a person has been approved to access the substance and is living in unbearable and insufferable pain, they will not have access to the drugs due to logistical reasons or implementation issues? I want to be clear in this debate that although there are those of us who agree with the principle of voluntary assisted dying, me being one of them, it is not a free pass for the government to gloss over the details, especially when we know from experience that any service delivery into our regional and remote areas comes with unique challenges. At all times we should strive for fairness and equality. There are too many examples of regional Western Australians being disenfranchised, marginalised or simply put in the too-hard basket for every government by trying to implement policy across a state the size of WA. A person’s geographical location in this state should not prevent them from accessing voluntary assisted dying if they are deemed eligible.

I would like to finish by commending the committee for the comprehensive report and work that was carried out as a precursor to this bill arriving in the house. It would be a fair observation to make that there would be few, if any, pieces of legislation that have had the same pathway to this Parliament. I would also like to thank those who provided evidence to the committee, and again to the ministerial expert panel. It was harrowing to read some of those very personal accounts, so I can only imagine just how difficult it was to present them in public. It would be awful to think that those people would have to return and do this again at some point in the future. To everyone who has contacted me about this bill, especially those from my electorate of Central Wheatbelt, I thank them. I realise that not everyone will agree with the position that I have taken, and I respect the views of those who do not support the bill and have taken the time to express those views to me in person or in writing. I am pleased to offer my support for the Voluntary Assisted Dying Bill 2019. I do so knowing that I have been on the public record opposing voluntary assisted dying in the past, particularly in the 2010 debate in the Legislative Council. However, I believe that my decision today reflects the wishes of the majority of my electorate and it is by their good grace and support that I stand here today. I commend the bill to the house.

MR W.R. MARMION (Nedlands — Deputy Leader of the Opposition) [4.23 pm]: The Voluntary Assisted Dying Bill 2019 that I rise to speak on today is certainly the most confronting and difficult piece of legislation I have had to consider in the 11 years I have served the people of Nedlands in this place. I have close friends with strong views and legitimate arguments for the case either for or against voluntary assisted dying. Like all members of Parliament, I have been lobbied by emails, letters and personally in the street and cafes, and, indeed, in most meetings over the past years, I have often sought the views of constituents whilst I had that opportunity. Before I outline the process I have been going through to determine which way I should vote on this landmark piece of legislation, which challenges a range of philosophical notions, including ethical, political, let alone cultural and religious, I note that this bill has been introduced coincidently with the recent death of my father. It has certainly been poignant to assess the bill given these circumstances. However, I have been able to integrate the merits of this bill in real time, having a father who passed away only on 14 August, and the funeral two weeks ago on 21 August. My father was nearly 93 and died peacefully in my presence. He leaves my mother, who turned 90 last Thursday, with dementia, which is another issue that is often raised in reference to this bill and was also raised by the Leader of the Nationals WA.

In terms of my personal thoughts on euthanasia, or, more appropriately, voluntary assisted dying, I have always been concerned about the morality of such a path and what impact legislation to legalise it could have on our
society as a whole, and the meaning we place on life. This has been an issue, I will admit, I pushed to the back of my mind for some time because it challenges my ability to intellectualise all the concepts it brings up. I have always sought the sanctity and structure of mathematics, science and engineering, which, for my brain, were much easier to analyse and determine with either factual answers or, at a minimum, risk-based options that are quantifiable. This confronting debate has forced my mind to explore areas I would much rather avoid. I have been very lucky to have been around death only in circumstances in which passing has not been painful. In fact, in all the cases, it was peaceful, although one instance was extremely distressing for all those, including me, who had to stand by and watch death occur. But even in this distressing event, I did not notice the young deceased suffer any pain, as I watched on with fellow workmates.

The one area of my life in which I have always been more than lucky has been that of a Wittenoom resident. As the lead speaker of the opposition when supporting the government’s Wittenoom closure bill, I recently mentioned that I lived in Wittenoom Gorge between 1956 and 1960, when the main asbestos mine was in full operation. Many miners and their families who lived in Wittenoom died from asbestosis or mesothelioma. I know that as the years go by my likelihood of getting mesothelioma diminishes, but when growing up it was always a possibility for all my family. To date, none of my family or I have had any signs of this terrible disease. I had the privilege of visiting the research laboratory of Professor Bruce Robinson, and his team, at QEII Medical Centre in 1994, who at the time was trying to come up with a cure for mesothelioma. I met patients who did not have long to live and were being given all sorts of experimental drugs, including interferon. It was distressing, shocking and heartbreaking to see the skinny frames of the mainly ex-Wittenoom residents, especially when some of them said they remembered me and my family. The thought of these residents having to experience a painful death just because they lived in Wittenoom still haunts me, as members can see.

In looking at the case against this bill, I received some very persuasive letters from people I know well. Floreat Medical practice is in my electorate and its principal, Dr Rosanna Capolingua, wrote to me following her presentation, along with Dr Michael Gannon, to the Parliamentary Friends of Palliative Care committee, of which I am a member. In a letter she made the following points. According to my notes, she states —

“Death may be an outcome of age, sickness or disability, but until now it has never been part of the treatment regime. This societal change fundamentally changes the goals or care for the patient and further empowers the doctor in the relationship as they have the power to offer and apply death as a treatment.”

In her letter Dr Capolingua goes on to say —

“When death becomes a treatment option, the patient may well miss out on treatment because the ability to end life prematurely is present.”

Perhaps her main concern is covered when she says —

“With increased longevity it has become more obvious in my general practice that apprehension of death of parents or elderly relatives where a benefit (financial or otherwise), will be realised, is a serious problem for our society. The elderly are often physically and emotionally dependent on offspring or relatives and are only held to ransom.

In her conclusion, Dr Capolingua summed up her position and the case against this bill by saying —

“This is more than being about the one individual’s right to choose. This is about the societal and cultural shift that will adversely affect the many.”

From what I have read, the most powerful intellectual position put for the case against the bill is probably that of former Prime Minister Paul Keating when he wrote —

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society... In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

For me, Paul Keating captures the essence of my concern about the path this bill takes our society and the very reason that it requires this Assembly and our Western Australian Parliament to give the matter and the wording of the bill our utmost and careful consideration.

I turn now to the case for supporting the bill. Again, I received many emails and letters and had conversations in my electorate with people urging me to support the bill. Most of these were respectfully worded, which is one aspect of this debate that I must recognise as this is not always the case with other issues of much less significance.

At this point I thank the members of the Ministerial Expert Panel on Voluntary Assisted Dying, led by Malcom McCusker, AC, most of whom were present to give me a personal briefing on their recommendations for the drafting of this bill. I must admit that until the government listed the names of the people on the expert panel, I was cynical, thinking that they were simply going through the motions and that the panel would be made up of...
people who were already strong advocates for voluntary assisted dying. I knew Malcolm for many years before I entered politics, and similarly Penny Flett. I have also met many of the other members over the years and recognise their professionalism and integrity. The panel’s report, “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report”, with its 31 recommendations, has formed the basis of the bill before us. No doubt during consideration in detail, aspects of those recommendations will be explored in the wording of the bill.

I received slightly more emails from people in my electorate who support voluntary assisted dying than from those who oppose it. However, in my casual meetings and at events when I asked people about their position, most seemed to be in favour. Like all members of Parliament, I received a letter from Doctors for Assisted Dying Choice urging me to support the bill. According to my notes, it states —

With overwhelming public support, your constituents are expecting this Bill to pass. It is stressed that under the proposed legislation, VAD will be voluntary—that is, a matter of choice. This bill is too important to too many people to allow it to fail.

I have known one of the signatories of this letter, Dr Roger Paterson, for many years from our school days. I know Roger to be an intelligent and objective person, and I respect his position on this matter. Likewise, I respect people such as Professor Michael Quinlan, who does not share Roger’s view on this bill. Michael is a former vice chancellor of Notre Dame University and, along with Roger, is also intelligent, objective and a person of immense integrity.

So how can two people of great intellect and integrity have opposite views on this bill? Therein lies the dilemma for the politician who is not the expert, trying to determine the best outcome for the people of Western Australia.

In the end, despite my “litmus paper” feel that over seventy per cent of my electorate—the people who voted for me to represent their views—were probably in favour of voluntary assisted dying, I still did not have a sound view of the actual numbers in Nedlands. Consequently, I commissioned an independent survey of my electorate and asked people the following questions. Question 1 was: do you know what voluntary assisted dying is? Question 2: do you think voluntary assisted dying should be legalised and available to a patient who desires a painless termination and where a doctor has confirmed they have only six to 12 months to live? Finally, question 3: would you like to see your local member of Parliament support or oppose voluntary assisted dying legislation for Western Australia?

This survey was undertaken just last week and carried on into the weekend. The data results were put together yesterday morning, so it is as current as possible. I would like to read the results. It covered many suburbs in my electorate. I have a breakdown of that but when we look at the breakdown, it becomes less significant. Question 1 was: do you know what assisted voluntary dying is? We do not often get a result like this. We found that 97.6 per cent knew what voluntary assisted dying is. Of those surveyed, 1.9 per cent had heard of it and only 0.5 per cent of people had never heard of it. That is a very strong indication that the public, certainly in my electorate, know what voluntary assisted dying is. Question 2: do you think voluntary assisted dying should be legalised and available to a patient who desires a painless termination and where a doctor has confirmed they have only six to 12 months to live? I might point out that it took a while to get that question right with the survey team to ensure that people were not led in any way. I did not think the first draft of the question was right. The results tie in with other polls; they were similar to the 50 per cent polling done by the member for Dawesville and also the poll in The West Australian. The percentage of people who said yes was 85.50. The percentage of people who did not know was 6.8, and 7.7 per cent said no. That was quite a surprise to me because my litmus test was about 70 per cent, so it was a lot more than that. The other question that I wanted to clarify as a local member was: would you like to see your local member of Parliament support or oppose voluntary assisted dying legislation for Western Australia? It went down a tiny bit. We found that 82.1 per cent wanted me to push for the yes vote. Interestingly, the percentage of people who did not know went up to 10.6 per cent. I do not know what that means. A total of 7.2 per cent said no. I am not sure what the researchers would make of that.

Before I conclude with my comments on the survey, I will talk about the demographic, which is important. A total of 207 people were polled. There are more females than males in my electorate—51.1 per cent females and 48.9 per cent males. The survey results skewed to females, which is probably because it was a phone survey and maybe females answer the phone more than men; I do not know. The survey sample profile was 62.3 per cent female and 37.7 per cent male. If we analyse the data, the survey was skewed to females. The age breakdown was also skewed to the over-65s. My electorate has roughly 40 per cent of people aged between 18 and 39, about 40 per cent aged between 40 and 64, and 20 per cent are aged over 65. The sample profile of the survey for 18 to 39-year-olds was only 20 per cent, unsurprisingly. Only 20 per cent of the sample were aged between 18 and 39; we were right on the money with those aged between 40 and 64, with 40 per cent; and 40 per cent of people surveyed were over the age of 65. What does that mean? By gender, 92.3 per cent of males were in support of voluntary assisted dying and 81.4 per cent of females were in favour. My results were skewed very conservatively. If we had more males in the sample, we would expect the figure of 85.5 per cent to have gone up.

The other area that we looked at was the breakdown of the age group. Again, the survey that I commissioned was 85.5 per cent, skewed with an older population. In the 18 to 39-year age group, 95.2 per cent were in favour of it and 4.8 per cent against. There were no “do not knows” in that group. In the 40 to 64-year age group, 86.6 per cent were in favour of it, 6.1 per cent were against, 7.3 per cent did not know and in my age group of 65 plus—I should

Extracted from finalised Hansard
not advertise that—79.5 per cent of people were in favour of it, 10.8 per cent were against and 9.6 per cent do not know. That is the result of my survey, and, being an engineer, I think it is quite useful from a quantified point of view. The result of my survey shows that no matter how we wish to break up the various demographics of my electorate, there is overwhelming support for voluntary assisted dying.

[Member’s time extended.]

Mr W.R. MARMION: Although this was not part of my survey, my constituency expects my support to be based on adequate controls and safeguards around the operation of the legislation. Some of the specific issues that need to be explored in consideration in detail and on which I will seek further advice from the minister include the rationale around the decision not to include the safeguard of the Victorian legislation that does not allow a doctor to initiate a conversation with a patient on an option for voluntary assisted dying. I think that was also mentioned by the Leader of the Nationals WA. Some other concerns were raised by many constituents on the protocols of how pharmacists will dispense the lethal medications and, once dispensed, how the process will be controlled, what safeguards there will be for storing the lethal medication before use and what will happen to the material subsequently. I also want to know what programs will be put in place to ensure that training of medical practitioners occurs. Will there be specific funding and how will this work in remote communities, where access to medical practitioners is limited? Finally, it is certainly my experience, although limited to family and friends, that palliative care is an essential component of the dying process, and that when it is put in place, it definitely improves quality of life for the dying person and reduces any pain. However, I agree with the member for Warren–Blackwood that the inadequacy of palliative care throughout our vast state is a serious issue, but that is a separate debate from the one we are having today. As mentioned in some of the papers I have read, although palliative care, properly provided, can reduce pain associated with death in the majority of instances, there are times when this is not the case. This bill is about providing those people who have a terminal disease or illness the choice to decide whether they wish to access voluntary assisted dying. It is clear that the people of the Nedlands electorate overwhelmingly support this bill. It is also clear that they expect me to represent their wishes in this house.

MR A. KRSTICIEVIC (Carine) [4.42 pm]: Today I rise to talk about an extremely confronting topic that has a strong possibility of impacting every Western Australian either directly or indirectly—the Voluntary Assisted Dying Bill 2019. I start by acknowledging the enormous task undertaken by the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying. I have no doubt that the process was confronting and emotionally draining for all the staff and members of the select committee. The committee report is 286 pages long, while the minority report has 248 pages. Both reports were very informative and definitely gave me a lot to think about as I worked through each section. It would be fair to say that very few people in the electorate of Carine have read this report or the current bill before the house. The ones who have contacted me and encouraged me to support the legislation will be bitterly disappointed that its narrow focus will not help them in the circumstances they discussed with me. To be eligible under the current bill, a person will need to have reached 18 years of age, have fewer than six months to live or 12 months for a neurodegenerative disease, have decision-making capacity and be suffering in a manner that cannot be relieved. Ultimately, a person needs to convince two independent doctors that they have met all the required criteria and that they support the request. Otherwise, they will not be eligible for voluntary assisted dying.

It is incumbent upon me, as a legislator, to act in the best interests of all of my constituents and the people of Western Australia during the course of this debate, which is why I attended a number of briefings and information sessions to get across this very complex area. I can honestly say that I initially struggled to come to a firm position on this issue; however, it became very easy once the legislation was introduced into the Parliament. It is interesting that a number of people have brought religion into the debate, both now and during the extensive select committee stage. I will not do that, as I have tried to approach this from a legislative, electorate and state perspective, bearing in mind that just over a dozen jurisdictions around the world have similar legislation and that, after Victoria, we will be only the second Australian state to have it. Victoria’s legislation was recently implemented, and the first person went through its process only a few weeks ago.

Before I go into the detail of the bill, I would first like to talk about its title and public presentation. The glossary of terms in the report of the Joint Select Committee on End of Life Choices defines “euthanasia” as —

…the intentional termination of the life of a person, by another person, in order to relieve the first person’s suffering.

“Euthanasia” is defined by the European Association for Palliative Care as follows —

A physician … intentionally killing a person by the administration of drugs, at that person’s voluntary and competent request.

The association defines “assisted suicide” as —

A physician intentionally helping a person to terminate his or her life by providing drugs for self-administration, at that person’s voluntary and competent request.

Extracted from finalised Hansard
The Voluntary Assisted Dying Bill 2019 allows both euthanasia and assisted suicide, and refers to both practices collectively as voluntary assisted dying. I understand why the committee did not want to label this bill more accurately with the terms “euthanasia” and “assisted suicide”, as the community’s view on suicide is clearly understood and no doubt the conversations would have been much more difficult. Having lived through a number of personal and distressing situations, I have a very strong view that we need to do everything in our power to take the thought of suicide out of people’s minds by providing the best possible health care. We need to urgently increase our investment in suicide prevention; otherwise, the current alarming trend upwards will continue unabated.

It is important to note that the Australian Medical Association does not support this legislation in its current form and believes that doctors need to improve the quality of people’s lives rather than end them. Unfortunately for doctors, the minister has put most of the responsibility and accountability squarely on to them, not to mention the penalties if they get it wrong or do not follow the process correctly. It was also noted in the minority report that suicides did not reduce in Oregon after its euthanasia bill was introduced, and as such I am very concerned about the mixed messages we are sending to the community, especially to our most vulnerable and young Western Australians, who suffer depression and other mental health issues in great numbers.

I see at least two very serious issues before us today. Firstly, people with terminal illness who cannot access euthanasia or high-quality palliative care will continue to commit suicide because their needs are being ignored. Secondly, if the state government legalises euthanasia and assisted suicide, we will be sending mixed messages to our young and vulnerable people. Will they understand and accept that it is okay to end one’s life only if one’s circumstances fit within the proposed legislation? During the course of this debate, many members have said that people should have choice and that these decisions are voluntary. Who is the government to tell people that they cannot end their lives in a dignified way? I understand the points people are making; however, such statements, if taken literally, make me concerned about the possibility of an increase in suicides once it is common knowledge that the government has allowed some people to make this choice while others are not allowed to. Numerous speakers have indicated that about 10 per cent of all suicides are because of terminal illness. If the minister is able to tell me, I would be interested to know whether this is true and how many of these people he thinks might qualify for euthanasia under the proposed legislation.

Many members have spoken about what people in their electorates have told them, and I can honestly say that I have not been inundated by emails or phone calls from people who strongly support one view over the other. Communications have been almost evenly split. When I did a mathematical calculation, approximately 40 per cent of respondents supported euthanasia. Surprisingly, 70 per cent of submissions were unique and not the usual template submissions we all regularly get on environmental issues. As I made my way around the electorate, one-on-one conversations on euthanasia were infrequent unless I directly raised the issue with people. When I held large community events with seniors, at the end of each session I asked people to give me a show of hands on their support for euthanasia, albeit that they knew nothing about the specifics of the legislation. On these occasions, a strong majority of people supported the concept as long as the legislation was well drafted and had guaranteed protections. I will say that 100 per cent of people agreed that people should not have to suffer during the last part of their lives and that, as a society, we have social and moral obligations to make sure that everyone has access to the highest level of care. It would not surprise many in the community that we have failed people in this respect.

Even without taking into account the future strong growth in number of our ageing population, it is evident that governments may never be willing to invest the required amount of money in palliative care or the health system generally. We must never forget that the price of not getting this investment right will be catastrophic for future generations. There are currently only 15 palliative care professionals in Western Australia. This equates to 0.57 palliative care professionals per 100 000 people, although we need more than two professionals per 100 000. We urgently need 52 palliative care professionals to meet current demand let alone future growth, not to mention all the necessary support services. We cannot forget the continued complexities in regional Western Australia. People who live in the regions should not be forced to move to the city for treatment. The state government’s supposed commitment to palliative care has only recently been increased to $206.2 million over the next four years. It is important to note that funding details provided by the member for Girrawheen during her speech show this investment will not all go to palliative care, and the government is being deliberately misleading with its announcement. Prior to this still woefully inadequate investment in palliative care, there had been negligible commitment in this area by successive governments; therefore, it is no wonder we are having this debate today.

I will quote some extracts from an article in WAtoday from 28 August 2019, titled “West Australians should not ponder euthanasia due to lack of care’: End of life specialists” and written by Nathan Hondros, which covers this area perfectly. It states —

WA’s most senior end-of-life care specialists have said they are worried the state’s most vulnerable people might consider euthanasia because of an alarming lack of resources available for palliative care, especially in the regions.

... palliative care specialists have said no Western Australian would die in pain if the state allocated adequate funding to specialist care.

Extracted from finalised Hansard
WA Palliative Medicines Specialist Group chairman Anil Tandon said only one in three Western Australians who needed specialist palliative care had access to it.

Royal Perth Hospital only provided specialist palliative care during office hours …

According to the doctors, WA has the lowest number of publicly funded care beds per capita in the nation. Dr Tandon said it was no coincidence that states with the worst palliative care were often the most supportive of euthanasia.

“If we join those two issues together, the current investment in palliative care and the current demand for euthanasia, what we see is that the two states with the lowest funding for palliative care are Victoria and Western Australia,” …

In the current budget year, the state government spent just $12 million on palliative care in regional WA, an increase from the year before of about $5 million.

According to information provided by the WA Palliative Medicines Specialist Group, there is only one visit a year to the Pilbara by a specialist.

There are six one-week visits each year to the Kimberley, 10 one-day visits to Geraldton and 12 a year to the Wheatbelt.

In the Goldfields, a palliative care specialist visits Kalgoorlie for one day a month and once every three months to Esperance.

Bunbury has two specialists who run a 10-bed hospice and an outpatient clinic.

In Albany, there is one palliative care physician funded for six hours a week, with only three hours a week to run an outpatient clinic.

The University of Notre Dame’s Chair of Palliative Medicine Research David Kissane said the state needed an extra $100 million a year spent on palliative care.

This is on top of the extra $40 million for palliative care over four years announced by the government in the state budget.

“And there are challenges for palliative care because this state needs another $100 million injected into it to deliver quality palliative care, so the government is choosing to finance assisted dying over really building up and developing better palliative care.”

Professor Kissane said palliative medicine could successfully treat people suffering from hopelessness and despair.

“They treat their depression, they restore their morale, they build them up again.”

Professor Bridge and Dr Tandon said specialist palliative care medicine could alleviate the kinds of suffering reported by some pro-euthanasia campaigners.

“The truth is that dying is hard … and unpleasant and causes grief, but that’s just normal dying,” …

Dr Tandon said the lack of specialist resources meant palliative medicine was sometimes only available when it was too late to make a meaningful difference.

“And there’s nothing that saddens us more than when we receive a referral to help someone, to provide palliative care and it’s almost too late in the course of that person’s illness to make an effective difference to the outcome,” …

The doctor said there was no need for a patient to die in intolerable pain, if palliative care was properly available.

“For us, around about 1 per cent of people have very severe and unremitting terrible distress and pain.

“In that situation what we have spoken to the McCusker expert panel and legislators about is that there is already a legal option and a legal treatment for these people and that’s the use of deep sedation at the end of life.

Extracted from finalised Hansard
“So we don’t leave people untreated; …

Professor Bridge was particularly critical of the state government’s euthanasia bill.

“The sad thing is that people who use this possible legislation I think will be very disappointed,” he said.

“They’ll find it is bureaucratic, difficult, complex [and] doesn’t achieve what they want.

“I think it’s just tragic that even with the best intentions, it’s chaos. The bill is disorganised, contradictory.”

Another area of concern is the possibility that telehealth services may conflict with commonwealth legislation and will, if allowed, have its own complications. It is difficult to reconcile the giant leap we are taking here today, when we are coming from a very low base, rather than taking an incremental approach by, firstly, identifying the gaps and closing them, and, secondly, identifying the best way forward once we have an understanding of the situation facing us and the options available with proper care and funding. One should acknowledge that continued advances in medicine will offer inevitable solutions. One hopes that these advances will occur quickly and banish the need for this solution to the pages of history.

People have referred to the 102 protections in the legislation. However, those of us in this place who have taken the time to look at them properly know that many are just eligibility criteria, and there are really very few substantial protections. Interestingly enough, the Victorian legislation has banned doctor steering, which means that a doctor cannot start a conversation around euthanasia if the patient has not raised it first. Unfortunately, our legislation does not provide this critical protection to vulnerable Western Australians. Alarmingly, allowing doctors to initiate conversations about euthanasia will put vulnerable patients at risk of undue influence. Inexperienced, incompetent or unscrupulous doctors could lead patients down an extremely dangerous and possibly unnecessary path. Ultimately, doctors could steer their patients towards euthanasia and assisted suicide as opposed to palliative care. It is even possible that a patient’s loved ones might ask a doctor to start the conversation. Loved ones might also be present during the first discussion and might encourage the patient to seriously consider the doctor’s advice, as the doctor knows best.

The Western Australian Ministerial Expert Panel on Voluntary Assisted Dying acknowledged that up to 60 per cent of Australians have low levels of individual health literacy, meaning that a large number of patients are completely reliant upon their doctors to provide guidance, support and advice about their health decisions. Unfortunately, the bill does not even require the doctor to be a specialist in the person’s illness or possible areas of treatment for them to make a decision about a patient’s request for euthanasia. During the brief life of the Northern Territory legislation, there was a valid requirement for everyone to undertake a psychiatric assessment. Again, our legislation does not have this critical requirement, which would protect people when they are at their most vulnerable.

I have serious concerns about the physical security of the medication once it is given to the patient, not to mention the possible pressure the person might get from family members to end their life sooner rather than later. There is also the possibility of this medication falling into the wrong hands.

Multicultural considerations need to be strongly taken into consideration. As we know, when people from non–English speaking backgrounds age, they generally revert to their native language and customs, and are thus more vulnerable than most to both coercion and confusion.

The principle of “suffering” is confusing to me, because it seems to not only reflect the principle of physical pain, but also include things like demoralisation, depression, stress, sadness, giving up, loneliness and numerous other possibilities, effectively meaning that anything can be categorised as “suffering”.

Doctor shopping and practices specialising in euthanasia also concern me. These behaviours have always and will always take place where this legislation exists. Doctor shopping is a well-entrenched practice in our society.

We know that doctors can get things wrong, let alone guessing the length of time someone has to live. My late godfather passed away from leukaemia. He was originally given less than six months to live. At the time, he spoke to his wife about ending his life. His wife convinced him to fight the disease, and he lasted 17 years before his body gave up. We were told at the time of his death that it was the second-longest battle for life in Australia. He was able to watch his grandchildren grow up, and spend quality time with his wife and kids. Imagine all those lost opportunities if euthanasia were available to him at that time.

Elder abuse is a serious issue in this state, with the current commonwealth inquiry indicating that there are as many as 75 000 victims in Western Australia, not to mention the fact that around 40 per cent of people in aged care never have a visitor. Some of these people could undoubtedly become victims of this legislation. This is something I am not willing to risk.

I am concerned with how it will be decided that someone has capacity, and why a thorough mental health assessment will not be undertaken in every situation to make sure that everything is aboveboard. It is well-documented that people can sometimes present as having capacity, even if they do not.

[Member’s time extended.]
Mr A. KRSTICEVIC: I wonder what the consequences will be if someone takes their life under this legislation and it is subsequently proven that they did not have capacity. Will people be prosecuted for murder in those situations? What will happen if you have a disease that can be managed but you cannot afford the treatment? Will the state government pay for the people who are not able to look after themselves, or will euthanasia be their only choice? The minister has presented a bill that I consider to be flawed in many respects. My responsibility as a legislator is to make sure that the interests of all Western Australians are protected and that they are not exploited by the government or others in our community. I cannot in all honesty support a bill that will end life while we continue to neglect our obligation to provide appropriate safeguards and healthcare solutions. If the minister was prepared to fund and fix all the problems I have mentioned, I would be willing to reconsider my position.

MR P.A. KATSAMBANIS (Hillarys) [5.00 pm]: I welcome the opportunity to debate the Voluntary Assisted Dying Bill 2019 and to exercise my conscience vote on the issue of assisted dying. The legislation before us proposes what is probably the most significant change to our laws and to the ethical framework of our society in my lifetime because it touches on the essential element of humanity—that of life itself. In exercising my conscience vote I have been guided by a number of important factors. I am guided by my faith as a Greek Orthodox Christian. I am guided by my experience in life as a son, brother, husband, and father. I am guided by my professional experience as a legal practitioner who has dealt with vulnerable people and assessed issues such as capacity and coercion in my daily work. I am guided by my experience as a legislator. I am also guided by the very public debate that has surrounded this legislation, and the views expressed to me by many Western Australians, including those in my electorate of Hillarys.

As a person of orthodox Christian faith, I recognise that life on earth is a precious gift from God that is to be cherished. However, I also do not fear death, as my faith comforts me that death is the essential pathway from earthly life to eternal life through a faithful God and through the resurrection of Christ.

In my own life, until the past few years, my family has been blessed with relatively good health, with the concept of death and dying being more an academic subject than something we needed to confront. My father is almost 90 years old and my mother is over 80 years old. They both remain in relatively good health, and long may that be the case. However, unlike many other families, it has been my parents’ children who have had to endure suffering and face up to their mortality over the past few years. These experiences have brought both the physical and the ethical concerns around death and dying into stark reality for my family and myself.

Many people know that in October 2017, less than two years ago, my heart stopped beating. It was not a heart attack; my heart just stopped without any warning signs. I was clinically dead on four separate occasions within a few short hours. It was only through resuscitation and an emergency operation to insert a pacemaker that I am able to still be here today to continue to enjoy life with my wife, my children, my family and my friends. What most people do not know is the aftermath of that life-changing event. My wonderful treating medical practitioners set out to find the underlying cause of what happened to me. I was eventually diagnosed with having a serious infection in my lungs called atypical tuberculosis, which found its way into my system through a still undiagnosed gap in my immune system.

The treatment for the atypical tuberculosis consisted of a cocktail of extremely potent antibiotics, which had severe side effects on me. These side effects were more magnified in the first few months of treatment, but remained throughout the entire treatment period. The severe pain in almost every part of my body, from my neck to my ankles, was excruciating and at times completely debilitating. There were nights when I was simply unable to lie down due to the sharp and severe burning sensations that were shooting through my body for hours on end. There were days when I literally felt like I was dragging a stranger’s body around behind me. There were times when I felt helpless and hopeless. Often I would say out loud, “I can’t stand this anymore” or, “I can’t live this way any longer.” Of course, for large parts of this period I was also unsure whether I would actually survive or whether I needed to prepare for the afterlife.

The good news is that I ceased the treatment in April this year and tests show that the atypical tuberculosis is gone. The lingering pain in my body is not gone and is worse on some days than others. Question marks remain around the reason my immune system is suppressed, and I am still highly prone to infection, which makes the debate about vaccination very pertinent and personal to me. Underlying issues with my lungs also need to be clarified. However, I can now approach life and the future with my beautiful family in the expectation of a longer life than I could contemplate less than two years ago. Every moment of every day is a blessing from God that I intend to enjoy for many years to come.

Sadly, my only sibling cannot say the same thing. My sister Ourania—or Rani as we call her—was diagnosed with late-stage kidney disease less than three years ago. That disease very quickly progressed to total kidney failure within a few months. At the time she was told her life expectancy would be two years at the most. Rani spent her fiftieth birthday in hospital, and soon after she was transferred to a nursing home, where she continues to receive long-term palliative care. She is bedridden and has lost total use of her legs. She is prone to both infection and wild fluctuations in her insulin levels, which lead to frequent ambulance trips from her nursing home to the hospital for urgent treatment. She is no longer the bubbly young girl full of life, the champion sprinter, the doting aunt or emotion—of death and dying being more an academic subject than something we needed to confront. My father is almost 90 years old and my mother is over 80 years old. They both remain in relatively good health, and long may that be the case. However, unlike many other families, it has been my parents’ children who have had to endure suffering and face up to their mortality over the past few years. These experiences have brought both the physical and the ethical concerns around death and dying into stark reality for my family and myself.

Many people know that in October 2017, less than two years ago, my heart stopped beating. It was not a heart attack; my heart just stopped without any warning signs. I was clinically dead on four separate occasions within a few short hours. It was only through resuscitation and an emergency operation to insert a pacemaker that I am able to still be here today to continue to enjoy life with my wife, my children, my family and my friends. What most people do not know is the aftermath of that life-changing event. My wonderful treating medical practitioners set out to find the underlying cause of what happened to me. I was eventually diagnosed with having a serious infection in my lungs called atypical tuberculosis, which found its way into my system through a still undiagnosed gap in my immune system.

The treatment for the atypical tuberculosis consisted of a cocktail of extremely potent antibiotics, which had severe side effects on me. These side effects were more magnified in the first few months of treatment, but remained throughout the entire treatment period. The severe pain in almost every part of my body, from my neck to my ankles, was excruciating and at times completely debilitating. There were nights when I was simply unable to lie down due to the sharp and severe burning sensations that were shooting through my body for hours on end. There were days when I literally felt like I was dragging a stranger’s body around behind me. There were times when I felt helpless and hopeless. Often I would say out loud, “I can’t stand this anymore” or, “I can’t live this way any longer.” Of course, for large parts of this period I was also unsure whether I would actually survive or whether I needed to prepare for the afterlife.

The good news is that I ceased the treatment in April this year and tests show that the atypical tuberculosis is gone. The lingering pain in my body is not gone and is worse on some days than others. Question marks remain around the reason my immune system is suppressed, and I am still highly prone to infection, which makes the debate about vaccination very pertinent and personal to me. Underlying issues with my lungs also need to be clarified. However, I can now approach life and the future with my beautiful family in the expectation of a longer life than I could contemplate less than two years ago. Every moment of every day is a blessing from God that I intend to enjoy for many years to come.

Sadly, my only sibling cannot say the same thing. My sister Ourania—or Rani as we call her—was diagnosed with late-stage kidney disease less than three years ago. That disease very quickly progressed to total kidney failure within a few months. At the time she was told her life expectancy would be two years at the most. Rani spent her fiftieth birthday in hospital, and soon after she was transferred to a nursing home, where she continues to receive long-term palliative care. She is bedridden and has lost total use of her legs. She is prone to both infection and wild fluctuations in her insulin levels, which lead to frequent ambulance trips from her nursing home to the hospital for urgent treatment. She is no longer the bubbly young girl full of life, the champion sprinter, the doting aunt or

Extracted from finalised Hansard
the person who always optimistically saw life as a glass half full. However, through the high-quality care she receives, she tells us that she is not in actual pain and, in fact, on many days she says that she feels quite well physically. But mentally there are days when she is depressed and other days when she is completely demoralised. Her ability or desire to speak or even to stay awake fluctuates with her mental state. On her better days, her old optimistic nature surfaces and she dreams of the day in the near future when rapid advances in medical science may cure her disease and help her to return to her previous life. We all pray that her dreams are realised. Through Rani’s ordeal over the past few years I have realised that although diagnosis of disease is excellent, predictions of length of life for those living with a terminal illness are simply guesses rather than scientific estimates. I have also learnt that good-quality palliative care is not just a last-few-days treatment option. In fact, if it is provided early and in conjunction with other treatment, it can both relieve pain and significantly enhance quality of life for extended lengths of time. The biggest barriers to good quality palliative care are cost and availability, which I will address later.

In my previous working life as a legal practitioner, I was exposed to the legal and ethical dilemmas around determining mental capacity of a client to execute important legal documents such as wills, enduring powers of attorney and documents relating to health directives that would be enforceable either after the person had lost capacity or, in the case of a will, after they had died. There was never a hard and fast test, and practitioners had to rely on a combination of guidance notes, court precedent and experience. Good file notes were absolutely critical in such situations. To avoid the potential for future challenges, there were a number of occasions when I asked a client to provide me with a medical certificate stating that they had the capacity to give instructions and execute a document. In these types of cases, the issue of capacity was usually mingled with a concern about coercion or undue influence. That was magnified when the client was sitting in my office and being assisted in providing instructions by a relative—usually an adult child. We know that in many cases the capacity of a person to execute the document at the time of execution or the voluntary nature of their actions have been questioned in court action either after the person has lost capacity or after they have died. Often in such contested cases, the eventual decision by the court has found that the person did not have the capacity to execute the document they made. As I stated earlier, the complex threshold issue of capacity is often intertwined with the even more complex issue of voluntariness, which involves the consideration of whether a person is acting under some form of coercion, duress or other external influence. Sometimes such influences are subtle, especially when the person is in a vulnerable stage of their life or when they are at the early, and often undiagnosed, stages of losing capacity for one reason or another. What to a legal or medical practitioner may be seen as a voluntary decision may not be seen as voluntary if the person’s full circumstances were known. As we find out more about elder abuse, we learn just how subtle but equally strong these pernicious outside influences can be in certain cases.

Since debate on this legislation commenced in earnest, like everyone else in this place, I have made sure that I take very seriously the views of the public, especially voters in my electorate. Amongst my constituents from the Hillarys electorate who have contacted me expressing their opinion on this issue, many have shared some very personal and very moving stories. I thank each and every one of those local people for sharing their stories and their views with me. A few constituents have simply wanted clarification about the legislation; however, the vast majority have been strong advocates on either one side or the other of the debate. Unlike some of the published figures and experiences of other members, my constituents are split absolutely 50–50 for and against this legislation.

As someone who takes their role as a legislator seriously, I have always had a strong sense of where the threshold lies between fair and appropriate legislation that promotes the common good of society and legislation that overreaches into areas that are not the appropriate realm of government. To that end, I have always drawn the line at legislation by which the state interferes with human life itself. It is why I have always opposed the death penalty for serious criminal offenders, despite proudly being someone who is tough on criminals and will always stand up for the rights of victims of crime. It is my belief that the state has no ethical or moral right to sanction the taking of a human life. I take this same ethical position in relation to the bill before us today.

I want to make it very clear that although I am a religious person, this is a position that I take not on religious grounds, but rather on my philosophical belief in the appropriate role of government and the appropriate limits of legislative power. As former Prime Minister Paul Keating put it so eloquently on similar legislation in the state of Victoria —

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society. The concerns I express are shared by people of any religion or no religion. In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

In my opinion, legislation to permit assisted dying crosses that threshold and goes beyond the norms and values of our society. It is not legislation that I can support.

However, I do recognise that others do not hold that view and that in our democratic society and in a democratic Parliament like ours, the majority view will prevail. That is why, as a legislator who takes my role in creating good, safe and ethical legislation seriously, I would like to take some time to point out what I consider to be serious

Extracted from finalised Hansard
and fundamental flaws with this bill. I do so in the spirit of cooperation, in the hope that the government will at
the very least accept that suggested improvements to the legislation will create a less dangerous framework than
the one contained in the bill before the house.

My first concern is a fundamental one about the protection of vulnerable people. I have concerns that there is no
adequate provision contained in the bill to unequivocally ensure that a person has the capacity to make any decision
to end their life.

The ACTING SPEAKER (Mr I.C. Blayney): Excuse me, member. Minsters, I am having trouble hearing the
speaker because of your conversation. Thank you.

Mr P.A. KATSAMBANIS: There are a number of protections that could be considered to ensure that people are
making a voluntary decision to end their life with full decision-making capacity and free of any coercion or other
pernicious external influence. The first such protection should be the need for some form of formal psychiatric
assessment of the person by a qualified professional. I spoke earlier of the type of demoralisation terminally ill
patients, including my own sister, can feel. This can cloud their judgment and often render them incapable of
having the capacity to make this type of decision. As the Chief Psychiatrist of Western Australia recommended in
his submission to the Joint Select Committee on End of Life Choices, any legislation regarding assisted suicide
must ensure an extremely robust assessment of capacity and screening for mental illness. The Chief Psychiatrist
further submitted that psychiatrists are the people who are appropriately qualified to assess such capacity. We need
to heed this advice from the state’s Chief Psychiatrist. Failure to do so runs the risk that people without the proper
capacity to make such a decision can be taken advantage of and killed. We have seen how capacity decisions made
in the context of the execution of wills and other legal documents have later been found to be wrong. Sadly, in
a jurisdiction such as the one we are contemplating, such findings after the event would be far too late.

After determining capacity and a voluntary decision, the next serious issue that presents itself is the issue of diagnosing
a terminal illness. There is no requirement in the legislation that the certifying doctor has any specialised knowledge
of the condition or illness that is being diagnosed. Nor is there any need for the doctor to have had any prior
knowledge of the medical history of the person concerned. One would think that these matters would be threshold
tests, but they are not covered in any way in the legislation. Apart from giving rise to concerns about doctor
shopping by vulnerable individuals, it raises concerns about ethical medical practice.

[Member’s time extended.]

Mr P.A. KATSAMBANIS: It may sound far-fetched to some that an orthopaedic surgeon could sign off that
someone has cancer. However, I was reliably informed at a briefing by Professor David Kissane that this actually
happened in the Northern Territory when it had similar legislation in place. Actual knowledge of the patient and
their medical history is also important in eliminating any risk of coercion or other undue influence. It is unfair and,
frankly, unconscionable to ask a doctor with no such prior knowledge of the patient and their history to make
a determination on someone’s capacity to decide to end their own life.

Unlike the Victorian legislation, the bill before this house does not prohibit a doctor from initiating the discussion
about the subject of assisted dying with a patient. I see this as another fundamental protection for vulnerable
people, many of whom, for cultural or other reasons, may be strongly influenced by any suggestion made to them
by a medical practitioner.

Another threshold issue that needs to be addressed is the lack of appropriate palliative care in Western Australia.
As I stated earlier, my sister has an ongoing need for such care. As a result, my family knows firsthand how good
palliative care can alleviate pain and significantly improve quality of life not just for a few days—as is the common
misconception—but also for an extended period of time. We also know how limited the availability of such care
is and how expensive it can be.

Palliative care is less than ideal in Western Australia. You do not have to ask me; you can ask anyone. It is of course
worse in the regions, but the availability of palliative care is in crisis even in the metropolitan area. Demand certainly
outstrips supply in the northern suburbs, including in the electorate of Hillarys. Yes, the government has provided
some additional funding, which is welcomed by all. However, as the Member for Girrawheen pointed out in her
contribution, the reality is that the claimed additional resources are only partly new funds and are partly repurposed
funds. Even then, not all the claimed funds are actually being allocated to palliative care. Palliative Care Australia
has determined that the appropriate ratio for palliative care specialists in our community is two per 100 000 people,
which means that we need around 50 such specialists to be in a position to provide appropriate palliative care
across this state. That is even before taking into account the extreme geographical and remoteness challenges that
we face here and that other states of Australia do not face. However, we currently have only 15 such palliative
care specialists in WA, across both the public and private systems. Unless and until we close the palliative care
gap we will simply not be providing appropriate care choices for people who are seeking to relieve excruciating
pain, especially towards the end of life. The sad reality is that without adequate funding and a proper commitment
to investing in palliative care, if this bill becomes law in our state, in many parts of Western Australia assisted
dying may sadly become the only available choice for relief of pain for terminally ill people. If it happened, that
would be a humanitarian travesty of the highest order.

Extracted from finalised Hansard
I share the concerns that have been expressed to me by many medical practitioners that the legislation as currently drafted would cause them significant ethical and moral issues, especially with regard to their adherence to medical ethics and the Hippocratic oath. Many doctors who do not want to participate in any regime of assisted dying would like to simply say to any patients who raise the subject, “This is not an area that I practise in”. In fact, in discussions with two very senior medical practitioners in the past week, I have discovered that many doctors are under the misapprehension that they would be able to do just this under the proposed legislation. After all, recommendation 20 of the report of the Joint Standing Committee on End of Life Choice clearly states —

The Minister for Health should ensure that health professionals are not compelled to participate if any voluntary assisted dying framework is developed for Western Australia.

Sadly, that is not the case with the legislation before us today. In fact, any doctor who does not want to address this issue with a patient and refuses a request for assisted dying is compelled to follow the proposed statutory framework and provide the patient with information that is approved by the CEO, in whatever form eventually gets approved, and we have not seen that as yet. A practitioner who fails to comply would be liable to a penalty of $10,000. Doctors who have a genuine conscientious or ethical objection to this regime should not be compelled to take any action at all beyond simply advising the patient that they do not engage in such practices. This would not only implement the recommendations of the joint standing committee, but would also alleviate the legitimate concerns and the ethical dilemma of many hardworking and committed medical practitioners.

The bill permits the use of audiovisual means of communicating requests for voluntary assisted dying. This brings the legislation into direct conflict with the provisions of section 474 of the commonwealth Criminal Code Act. This would potentially subject medical practitioners using audiovisual means to criminal penalties under commonwealth law. It may also make these specific provisions, or even the entire bill, subject to constitutional challenge. This is not an idle threat; this is real. Before the Victorian legislation came into operation earlier this year, Victoria’s health minister, Jenny Mikakos, issued a warning to doctors registered to discuss assisted dying with patients to meet all patients face-to-face to avoid potentially breaching commonwealth law. I know Jenny Mikakos—she is a good legal practitioner, prior to becoming a member of Parliament—and I know she would not issue such a warning without sound legal advice. It is something we should heed here in this state as well. This issue certainly needs to be properly addressed to ensure that medical practitioners are not inadvertently exposed to commonwealth criminal penalties. There are many other issues that need to be addressed to ensure better protection for both patients and practitioners. Time does not permit me to raise them all now but I am certain these issues will be covered in consideration in detail by many members on both sides of the house. I trust the government will address these issues in good faith.

In closing, I would like to add my own thanks to everyone who has participated in this debate both in the public realm and in this chamber. We are dealing with a very emotive issue of conscience and serious importance. Debate has been conducted respectfully and fair consideration has been given to divergent viewpoints. It is a testament to our maturity as a Parliament and as a society that we can hold these debates without recourse to threats, abuse, violence or marginalisation. As the debate progresses through the Parliament I trust that everyone will continue to remain respectful and tolerant of all points of view that are legitimately raised in debate. If this legislation does become law in Western Australia, I sincerely and honestly hope that it will give comfort to those who seek relief without unfairly impacting on vulnerable people and without it becoming a default pain relief option in the absence of appropriate palliative care. I also hope that the minister will accept the suggestions for stronger protections that have been made in good faith by me and by other members of the house, including many who support the principles of the bill. However, I affirm my support for the sanctity of human life and my conscientious belief that the legislation before us today crosses the threshold beyond which Parliament should not venture. Thank you.

MR V.A. CATANIA (North West Central) [5.26 pm]: I will not take long on this. Members have been approaching the Voluntary Assisted Dying Bill 2019 through their own personal experience, or through being members of Parliament. This legislation should not be supported just because, as reported in the newspaper, 88 per cent of Western Australians support voluntary assisted dying, or it is promoted as being popular. We should ensure that, as members of Parliament, we look at the legislation brought before this house and consider it in detail to ensure that it is as watertight as possible, and also consider all the unintended consequences, which a few members have brought up. That is our role in this house—not to do what is popular, but to make sure that legislation is as tight as possible.

The questions I have to ask myself about this bill are: Do we wish to give the terminally ill, who are in pain, the choice to end their suffering? Is it about life, or is it about death? Is it about how the death will occur? Is it about freedom of choice for individuals to make their own decisions about their own lives, and to have the decisions made for them? Last, but not least, I am a Catholic. Should I just say no, because of my religious belief? I have watched three grandparents pass away in pain, while receiving palliative care to make that pain go away to some degree, or, as far as we know, make that pain go away. This legislation would not protect them. It would not assist them in passing in an easier way. I have seen terminally ill people, and I have seen that with my mother-in-law, who suffered from pancreatic cancer, much like the husband of the Leader of the Opposition. She was diagnosed

Extracted from finalised Hansard
in 2014, and in her last days she obviously tried to do everything to prolong her life, even as far as me going out to the bush to collect bush medicine, to make that bush tea to assist in reducing the size of the cancer in the pancreas. Unfortunately, the illness got the better of her, and in the last seven days of her life she was lying in bed motionless, with the morphine being increased as each day went by.

In that instance, I asked my ex-wife what her mother would have liked to have done—would she have considered voluntary assisted dying if she had that choice? The answer was yes; if she had that choice, she would have considered it. My mother-in-law was in pain, and lying motionless. She knew that death was imminent—it was going to happen. That was difficult for not only my mother-in-law, but also for the people around her. Is that the way in which people with a terminal illness should die? That is the obvious question in my mind. All of us in this place have to decide whether voluntary assisted dying is a humane and safe way for a person to end their life, knowing that death is imminent. My father-in-law passed away from terminal lung cancer, and, although his death was quick, I saw the suffering that he went through. Unfortunately, the discussion about whether he would have signed up to voluntary assisted dying if he had been given that chance was never had.

On Father’s Day, we had a gathering with my father and other family members. After dinner, we had a debate about voluntary assisted dying. My father is a Catholic. His religious beliefs do not permit him to support the legislation. He strongly opposes the bill, as members on the other side would know. We had a debate about whether we should support the legislation, particularly given the fact that a few members of our family have had a terminal illness and we had seen the pain and suffering they went through. The debate started to get a bit heated, and I am smart enough not to take on my father in a debate, so I started to pull away and end the debate —

Mrs M.H. Roberts: Times have changed!

Mr V.A. CATANIA: Times have changed! That is right.

Mr P.A. Katsambanis: I think it’s called maturity!

Mr V.A. CATANIA: Maturity! That is right.

Another family member has a terminal illness—mesothelioma. That is not widely known, because they have not told many people. This person got involved in the debate and said, “I’ve got mesothelioma, and I would like to be able to make the decision to end my life when I believe it is necessary to do so.” It silenced pretty much everyone around the table to be faced with a family member who is going through that. The Leader of the Opposition clearly put forward the thoughts of individuals when they go through that process. I do not think anyone wants to die. Everyone wants to hang on. Everyone wants to see their kids grow up. Everyone wants to be with their family members for as long as they can, and that is what we should try to achieve. However, that becomes difficult, knowing that death is imminent and staring you in the face. Sometimes people have the will to live, but they know that time is against them.

No-one wants to see suffering occur. My wife is a veterinarian, and she sees death happen quite often. We put animals down, in a humane way, knowing that it is very difficult for animals to get around if they are in pain and are suffering. Obviously, my wife is a strong supporter of voluntary assisted dying. A photo of every animal she has had to put down is on the photo board of her vet clinic. Every time my wife has to put an animal down, it is hard.

I have had this discussion with many people around the electorate of North West Central. Can I say that the feedback from people who have approached me on this issue has not been that great. I have chosen to bring up voluntary assisted dying at every individual meeting and every group discussion I have, just to see what people’s thoughts are. I do not ask whether they support it. I let people tell me what their thoughts and concerns are. As I said at the start, I believe that a lot of people think that this bill will enable our seniors and grandparents to access voluntary assisted dying. The common feedback I get is that if a person is 92 years of age, bedridden, weighs only 30 kilograms and things are not looking too good for them, they would like to be able to end their life with a bit of dignity. That is taking it to the next level. I do not know that I could support legislation that would allow that to occur. Generally, in a group of 20 people, five are very vocal and very supportive of the legislation, and the rest have concerns or questions, because they do not know much about it. As has been said in this chamber during this debate, there is obviously a group of people who do not support voluntary assisted dying, for various reasons. However, all in all, there is strong support—to a degree—in the community of the north west. That may be because of the harshness of the environment. People in the north west go through a lot of hardship. Sometimes people take their own life with their own firearm. I am sure the member for Kalgoorlie came across a few situations during his time as a police officer when people just wanted to end their life. A lot of the suicides in regional Western Australia, particularly in the north west, occur because people in the bush often have access to weapons.

In my opinion, the support in my electorate for this legislation is close to 50–50. People are generally supportive. However, they want to ensure that safeguards are in place. The members for Girrawheen and Hillarys articulated some of those concerns that need to be addressed and will be fleshed out during the consideration in detail stage in this place. One thing that causes concern and has been highlighted—I think the member for Warren–Blackwood said it perfectly—is that we cannot have voluntary assisted dying and palliative care as one. They are two separate

Extracted from finalised Hansard
issues. The debate on voluntary assisted dying does highlight the need for greater services and funds in palliative care. Correct me if I am wrong, Minister for Health, but I do not think any palliative care exists in regional Western Australia, particularly in the north west of Western Australia. What concerns me, and I think the member for Girrawheen pointed this out, is that it is about old money and new money. One issue that has been close to me and my electorate has been that of Carnarvon aged care. When the Labor Party came to government in 2017, $5.5 million was taken out of the funds for building a 38-bed aged-care facility. But now that $5.5 million has been put back into the budget to complete the 38-bed aged care facility under the auspice of palliative care. In my mind, that is not new money. That money is there to complete the 38-bed aged-care facility for Carnarvon. I am glad it will have palliative care attached to it, because not having palliative care in places such as Carnarvon is becoming a growing issue. That is replicated pretty much throughout regional Western Australia. Palliative care needs to be addressed and funded to ensure that people have those options. As the member for Hillarys pointed out, we do not want voluntary assisted dying to become the norm. We do not want that becoming the only option—a default position. We do not want that becoming the only option that one has. We do not want people to have to move from the place that they were born and lived the majority of their life—that is, a regional town. I will use Carnarvon as an example. We have seen when seniors have to be moved out because there is no aged-care facility in Carnarvon, and they have to go to Perth or Geraldton. Unfortunately, their lives are shortened. Allowing people to die with dignity in their own home or town needs to be addressed by this government and future governments, because this is not an issue that will diminish over time.

In terms of this bill, I liked the words of the Premier, and I would like to quote him.

Mrs M.H. Roberts: That is a first!

Mr V.A. CATANIA: I will clarify it. Let me finish it off.

[Member’s time extended.]

Mr V.A. CATANIA: The Premier said —

It is a freedom of choice for individuals to make their own decisions about their own lives and to not have decisions made for them.

I agree. I hope that the Premier can look at other legislation for issues, such as organ donation as another example. People can choose to be an organ donor but when they unfortunately pass away in an accident, the family or relatives have the final say over the person’s wishes. I take it that the Premier’s words about the choice for individuals to make their own decisions should extend to organ donation. Let us make sure that we have legislation that not only assists people who are terminally ill to pass away with dignity to ensure that their pain and suffering is minimal, but also lets us give life to those people who need an organ to survive, whether it be a young kid who has cystic fibrosis or someone who needs a heart or kidney transplant. Let us give people their choice to assist others with organ donation, not a family member who will not adhere to their wishes and who will say no to organs being donated. Members, and Premier—if you are listening—I take the words that the Premier said about this bill and I hope that they can be replicated in a future bill in which we see opt-out legislation and organ donation being front and centre to make sure that those individual’s wishes are adhered to so that we can also assist people to live into the future.

During the consideration in detail stage, I will ensure that we try to tighten up this legislation, because there are some genuine concerns. Whether or not members agree with this legislation, this is our opportunity to tighten up this legislation so that we can do what I believe is right and support voluntary assisted dying for the terminally ill. I am sure that we all want that choice. Let us hope that we do not have to make that choice in the future, but I know that we have family members who will go through it, and I hope that this legislation is passed so that they may be able to make that decision or at least have that choice in the future. I have to support that person’s wishes to support this bill, even though we need to go through it in detail to make it as tight as possible. It is the right thing to do to make sure that when people are terminally ill, they have that choice to end their life with dignity, with less pain and suffering for not only them, but also their family members. I support voluntary assisted dying.

MR K.M. O’DONNELL (Kalgoorlie) [5.47 pm]: Greetings, Acting Speaker! I, too, wish to talk on the Voluntary Assisted Dying Bill 2019. In my very first speech, the very first comment I made to the Speaker was that I feel more comfortable in a pub brawl than standing here. Nothing has changed—fair dinkum. I would rather come up against bikies and violent members of our community than stand up and talk a lot. I have watched our other members. I was not here last week; I was in Dowerin, but I watched and listened to various members, and it has been a very heart-wrenching debate. The member for North West Central said that he is a Roman Catholic. I, too, am Roman Catholic, a proud Waverley College boy and Aquinian.

I have received numerous emails both for and against voluntary assisted dying. Some were based on religious reasons and others were cut and pasted. I say to people out there: do not cut and paste. That is my opinion. Tell me what you think. If people can keep it short and sharp, it makes it easier. Sometimes I have had emails that I have had to scroll through page after page after page. It would be very helpful if there were bullet points and it

Extracted from finalised Hansard
was not cut and pasted. I enjoyed reading various individual ones. Many who said that they were against voluntary assisted dying made comments about how their loved one died peacefully in palliative care. I thoroughly agreed. An example states —

1. My stepfather had a stroke … he was moved to a care institution … where he died peacefully some time later.

He died peacefully.

A mother was diagnosed with a quick-acting cancer and given a month or two to live. She was transferred to a nearby hospital with a palliative care facility and given the best of care and comfort until she died about a month later. The person commented that they had the greatest of respect for these institutions. Another person was diagnosed with liver cancer and given some months to live. She expressed the desire to remain at home, where she was looked after by family, who kept her comfortable and properly medicated until she died peacefully at home. What I noticed in a lot of the anti-voluntary assisted dying correspondence was the fact that people’s loved ones died peacefully. I did not get any correspondence from people saying that they were against voluntary assisted dying and that their partner or their loved one was in excruciating pain for months—that it was a debilitating disease and they were fading away, having to wear a nappy and suffering so much. We are all different, but I do not think I could stand by and watch a loved one in excruciating pain. If they had the option to take voluntary assisted dying to end the pain, I could understand them taking it. We talk about family pets. We take our dog, cat or horse to the vet and the vet says that the pet is in excruciating pain and will not have much time to live. Do we then say that we will take the pet home and keep it in excruciating pain? The vet gives an option and my belief is that everybody would take the option to put the pet out of its misery so that there is no pain, because most people regard a pet as a part of the family. Another lady was given 15 months to two years to live. She was given the choice of a risky operation, but she opted for palliative care. She was transferred to Murdoch hospital. She was looked after and spent time connecting with family until she died peacefully in her sleep a week later. Again, I say that every one of the emails I got that were anti-voluntary assisted dying said that the family member died peacefully; none of them said that the family member had pain or anything.

I attended a briefing with Andrew Denton. It was in the Legislative Assembly meeting room. I sat down there and looked around. The member for Morley was speaking and was about to introduce Andrew Denton. I kept looking around and I thought I had made a mistake and had the wrong time, date and place, because the other 30 people in the room were all Labor and there were no Liberals. I thought, “Oh!” I put my hand up to ask the member for Morley whether I could be excused, but I was informed that the briefing was open to every member of Parliament. I must admit that I was made to feel welcome, but I was surrounded by red. I was completely outnumbered, member for Baldivis! Andrew Denton made me feel welcome as well. I rated him after meeting him. I listened to what he said and it hit home with me, and I enjoyed it. On the flipside, I went to the anti-voluntary assisted dying member for Baldivis! Andrew Denton made me feel welcome as well. I rated him after meeting him.

Mr R.H. Cook: If she lived in our electorates, she would probably be taking our jobs. Be careful what you wish for!

Mr K.M. O’DONNELL: Yes!

Dr M.D. Nahan: She might go walkabout on you!

Mr K.M. O’DONNELL: Yes, she might go on the next expedition; we would have to control that!

I was very impressed with her. I listened to her story about her mother, who was a very strong, staunch Roman Catholic. We have heard the story, but her mother was in so much pain prior to her death. She was a staunch Roman Catholic against voluntary assisted dying, but she said that she could not take the pain any longer. We did not have this legislation, and Belinda’s mother went through all this pain and debilitation before she died. That is going to be etched in Belinda’s mind forever and a day. I felt sorry for Belinda when she told her story. However, I was very impressed with her. Belinda actually changed my thinking.

Members are not considering voluntary assisted dying instead of palliative care. As the member for North West Central said, they are two different things; however, they do go hand in hand. We should consider showing compassion to people for whom palliative care does not relieve suffering. Palliative care cannot relieve every person’s pain and suffering; however, it does a damn good job. The member for Carine mentioned an article by Nathan Hondros on WAtoday on 28 August 2019. It refers to an alarming lack of resources available for palliative care, especially in the regions. That was disappointing. The article says —

… palliative care specialists have said no Western Australian would die in pain if the state allocated adequate funding to specialist care.

Extracted from finalised Hansard
I thoroughly disagree with that comment. After listening to the debate on this bill, I have no doubt that in the years to come, whether the government is Labor or Liberal, palliative care will go ahead in leaps and bounds in order to ensure quality of life for people. I am not a university-trained person, but I cannot see how anybody could say —

Mrs M.H. Roberts: You have got police training; that is more important!

Mr K.M. O’DONNELL: I thank the minister. Correct, I do have training.

I am sorry, but I cannot wear that people say that no Western Australian would die in pain if more money was thrown at palliative care—but still keep throwing money at it, minister. It was disappointing to read that only one in three Western Australians who need specialist palliative care have access to it. That was a bit disappointing. The article referred to late referrals to voluntary assisted dying. Another doctor said that palliative care cannot relieve everyone’s distress, which is correct. The article said that around one per cent of people have severe and unremitting terrible distress and pain.

A lady named Angela Miller wrote a letter to the Kalgoorlie Miner. She was replying to one of our revered local reverends, Dr Elizabeth Smith, who had written an article against voluntary assisted dying. Angela said that her father had passed away. Palliative care uses drugs to take away the pain, but her father was allergic to morphine, and morphine is a popular drug used by doctors to assist in the relief of pain. The only option available was to keep him asleep. She was referring to the fact that if pain medicine does not work—in this case, the morphine could not have—something else will be tried, and if that does not work, a third option is tried. If that still does not work, deep sedation is used. In other words, the patient is placed into a drug-induced coma. The family and friends are around a loved one and the only way the person’s pain can be taken away is for them to be put into a drug-induced coma. When people come to visit, the person is unconscious. Some family members think that at least they have their loved one with them.

Sitting suspended from 6.00 to 7.00 pm

Mr K.M. O’DONNELL: Greetings, Acting Speaker. I will continue by saying that this bill is about providing assistance to someone who is dying—not euthanasia and not suicide. I agree with this. I attended plenty of suicides in my time as a police officer. I came across hangings, shotgun deaths, poisonings and drownings. People commit suicide for various reasons, such as financial issues, domestic arguments or ill-health. In my 34-odd years as a police officer, I also attended when people had died in hospital, and I had no doubt at different times, even when I was not the inquiring officer but simply attended the scene, that the person was helped along the way. I have no doubt and firmly believe that over years gone by, whether decades or centuries, we have had voluntary assisted dying. On one occasion, I asked whether the family member wanted to give me a statement. They said no, and I know why they said no: the doctor helped that person, alleviated their pain, and they passed on. I got no comment then. I dare say that many other police officers have come across the same thing, and I do not believe it is just here in Western Australia; I would say that it is worldwide.

There is a requirement in the bill for patients to make a written submission. I have a query about that. In my dealings with the mob from the desert, I have come across people who cannot read or write. I first came across that when I asked somebody to sign. I put an X where to sign, and they put an X. I said, “No, you’ve got to sign.” The X was their signature. I was quite young when I came across that. Even 10 or 20 years later, the same thing still happens—they put an X. I hope there is a provision to help or deal with the mob who cannot read or write. There might be some wetjala—white people—with the same problem. There could even be some Europeans, because a lot of elderly people move here with their family as refugees, so there may be an issue there; I do not know. Hopefully, that will be addressed.

I have a query about independent doctors.

[Member’s time extended.]

Mr K.M. O’DONNELL: The legislation states that assessments must be conducted by two independent registered practitioners. Both medical practitioners must independently come to the view that the patient satisfies all the eligibility criteria. My query is: if someone approaches a doctor and says, “I want to access voluntary assisted dying. Will you assist me?”, does that doctor then go back and ask for all the information from the general practitioner, or do they independently and separately do tests and make inquiries? I am curious about whether that makes it independent, rather than both practitioners getting the same information.

Moving along, it was disappointing to hear that the goldfields receives only 12 visits a year from palliative care specialists, with visits only once a month to Kalgoorlie. That is disappointing. Hopefully, in the years to come, that will be rectified. I took a tour of the Kalgoorlie Health Campus again the other day. I was walking through a ward. All of a sudden, I crossed over a line of vinyl on the floor to carpet. It had a completely different feel. They said, “We’re in the palliative care unit.” Kalgoorlie has a three-bedroom unit. Even though it is about nine or 10 years old, I was very impressed with the rooms. My idea of palliative care is that it is for the elderly—somebody like the member for Pilbara or the member for Bunbury!—older statesmen. It is for people who are ready to be moved on from their seat. I do not mean that in a derogatory way!

Extracted from finalised Hansard
Mr R.H. Cook: You are digging deeper, member!

Mr K.M. O’DONNELL: Yes, I apologise. While I was there, I fell over when they were talking about a four-year-old girl in the palliative care unit in Kalgoorlie recently. You could have blown me over with a feather. I have seen a lot of things and done a lot of things, but a four-year-old kid in palliative care was sad. They said that they would like to try to get a room done up to make it a kids’ room, because they do not have one in the children’s ward. They were also talking about Aboriginals in palliative care. Minister, I have a question; hopefully, I will not double up. I am hoping there has been consultation with the mobs from various communities out in the desert around payback. Payback in Aboriginal culture can be very strange to us. I came across a group of Aboriginals who had borrowed a car from a bloke out at Coonana. They drove it into town, rolled it, and one man was killed. We expected the person to get payback would be the driver who had borrowed the car. No, he did not get payed; the owner of the car got payed. He should not have lent the car in the first place. Sometimes we do not understand the thinking, but I have been told by people in the goldfields that there could be an issue with Aboriginals accessing voluntary assisted dying, in that somebody is helping that person to die rather than that person dying the natural way. More than likely, they will not go after the doctor or the nurse; it will be the family member and/or friend who has guided that person there. I am not saying that that will happen; I am just making members aware that that has been brought to my attention under the issue of Aboriginal payback. We can never stop payback—it has been in the Aboriginal culture for centuries—but that could be an issue down the track.

The other day I asked Amelda, the palliative care specialist at Kalgoorlie Health Campus, how many patients she sees. She said that she has 98 on her book. “No!”, I said. I congratulate the hospital on this; it allows Amelda to work with Bega Garnbirringu Health Service, the Aboriginal group, and to go to local nursing homes and other hospitals in the region, including in Esperance. The hospital pays for her, but she goes everywhere and deals with all these people. After finding out about it, I think she does a fantastic job.

I have a query about death certificates. In all my policing career, when police turned up to a death and a doctor said that they would issue a death certificate, half the time police would rub their hands with glee because the paperwork would stop and they would not be bogged for hours, days or weeks. I assume that the two independent doctors—if they are not one of the family GPs—will have sufficient information because they have agreed to the voluntary assisted dying and that would be sufficient to sign a death certificate.

Mr R.H. Cook: Yes.

Mr K.M. O’DONNELL: Yes. I have talked about clause 14(c).

I just want to say that I love life. For me, I would rather live through the suffering—it is easy to say—so that I can continue to see my loved ones, including my three fantastic grandchildren. The fourth grandchild is coming this month, when Precious has her first child. And I still want to keep watching Collingwood. They are the things that I love and I would rather push through the pain barrier, but I do understand that some people do not have a very good pain threshold. I can understand. I can stand here and say that I will do it, but I might not. For me, I do not want to go down the path of voluntary assisted dying. I do not. I want to stay alive as long as I can and see every day. That is what I want to do. I know I am not as suave looking as the member for Dawesville as I get older, but I want to stay alive. I do not want to participate in voluntary assisted dying, even though I support voluntary assisted dying. I can understand it for those who have a low threshold of pain. None of us wants to see people suffering.

May I ask a couple of questions in this debate?

Mr R.H. Cook: If you want me to interject and if I am in a position to answer them, sure.


Mr R.H. Cook: As you would know, the package that we have announced as part of the budget is predominantly focused on making sure that we have better palliative care services in the regions and that is one of the elements that the Department of Health is grappling with at the moment. I am not going to lie to you, though. We will never be able to make health services in the remote communities like they are for people in the metropolitan area, but I think we can do better.

Mr K.M. O’DONNELL: I appreciate that. I thank the minister. I raise that issue because we struggle to get doctors and nurses in remote areas. It is very hard. I am not sure how we can do it and I am not belittling this, but if we can try to get more police officers dating and marrying nurses, when the copper transfers, he will bring the nurse with him.

Mrs L.M. Harvey: It works with schoolteachers.
Mr K.M. O’DONNELL: A schoolteacher—yes.

Dr D.J. Honey: With him or her.

Mr K.M. O’DONNELL: Yes, it could be either.

Mr R.H. Cook: We have the rural clinical schools. They have been outstandingly successful. One of the elements of that is if we get young doctors out in the communities who invariably meet young members of that community, they stay in that community to both practise medicine and start a family.

Mr K.M. O’DONNELL: I just have to finish up. I refer to life insurance companies. I was not here last week. Someone might have touched on that, but, hopefully, there has been consultation with them so that people are not disadvantaged. There is nothing worse. They are not going to get paid out. They just have to put up with months of suffering. I will support this legislation. I am looking forward to the consideration in detail stage. There are probably some other aspects to clarify. Minister, I wish you good luck with it at the consideration in detail stage.

MRS A.K. HAYDEN (Darling Range) [7.15 pm]: I thank my colleague for a great contribution. We should have had him last week when we had a few full-on emotional speeches; it would have been a nice interlude.

I rise to oppose the Voluntary Assisted Dying Bill 2019. In doing so, I acknowledge that this is an extremely difficult and emotional debate and I have no doubt each member has spent many hours and days, if not weeks, contemplating the ramifications of this legislation. This bill will be one of the most important and challenging pieces of legislation that will ever be debated by many of us in this place and it has been reflected through every member having the right to vote as per their personal conscience rather than party aligned, although as a Liberal, I always have that ability. This legislation highlights the importance of this right. In our role, we are posed with many challenges, some far easier than others, and this debate would have been one of the hardest challenges I believe members will ever face. Even if members know their position, the time spent digging deeper into the decision is extremely emotional, personal and sometimes conflicting. The discussions we have with family, friends and people within our own electorate on this topic delve deeper than most conversations we usually have with one another, the most difficult being when opinions differ. After 10 years of experience as a member of Parliament, I have learnt the need to respect one another and even though our opinions might not align, it is important to let people voice their opinion without fear or favour so that members can rise and give their thoughts without unwanted interjection or adverse commentary. I acknowledge the many members who have shared their thoughts so openly and bravely. I know it has been tough for quite a few.

The community conversation is an important one. I know from the many conversations I have had on this bill that the original off-the-cuff position on this important subject by many often changed after we started discussing the reality of this legislation, especially when we discussed the possibility of error, influence or abuse that could occur. Another concern that swayed first impressions of this legislation was who would be responsible for administering the substance to take another’s life. This question had people admitting they could never do it. People understand that it is a difficult ask of our doctors, who have dedicated their career to protecting life. The option of self-administration was also raised as a concern, with the idea that people may be asked to aid, or need to have the aid of, a loved one, which I believe will occur in some circumstances regardless of it being legal. The idea of having to go through this experience was not warmly welcomed and it was agreed that it would have a long-lasting effect on those involved assisting in taking a life. The directions of the conversations I had changed the more that we discussed the reality of assisted dying. I have had many people finish the conversation with me by saying, “I would hate to be in your shoes” followed with comments along the lines of, “I haven’t really given it that much thought before. I am glad it’s you having to make this decision and not me.” After speaking with people who were adamantly supportive of euthanasia, I saw them shift. They now had doubts and concerns. It may be easy to get a poll to support assisted dying in principle, but when we ask questions and they understand the consequences and ramifications of this bill, doubt enters people’s minds. We do not have capital punishment in our country for the same reason. We cannot rule out the possibility that a person who has been sentenced to death and then killed may later be found to be not guilty. There is an element of doubt. I believe that there is an element of doubt in this legislation as well.

As members of Parliament, we are elected on the values and principles we advocate to our communities in the lead-up to election day. We are not elected on just the promises we make or the party that we represent. Many people take time to learn more about us as people to understand the principles that will underpin the decisions that we will make if elected. During the Darling Range by-election, I was questioned on this topic and others. Those discussions continued as I engaged with my community. All members of Parliament have a choice—a chance to stand on our convictions, to let them be known and to have the conversations. I choose to stand on my convictions. I believe that the Australian public look for that in their members of Parliament.

These principles guide our moral compass and determine who we are as individuals, what we will stand for, and what we will not tolerate. We need to show strength and leadership and not be sheep, but, rather, to stand up and be heard. We should not be afraid to ask the difficult questions or fear the ramifications that may follow if we do not follow suit. Unlike most members in this chamber, I have already had this debate and undergone the soul-searching process required to make such an important decision. In 2010, my second year in the upper house, Hon Robin Chapple tabled...
Palliative care is poorly understood by many in the community, including healthcare workers. We should not be surprised, because a conversation about dying is not one that we often have around dinner tables. It is not one of the top 10 topics with which to start a conversation. The reluctance to discuss death at any point has resulted in a misunderstanding of palliative care. A majority of people would say that it helps to ease pain in the last few hours of life; in fact, it is far more than that. Palliative care is available from the moment a person is diagnosed with an illness with no existing cure, and it is available while people undergo medical treatment. The service aims to provide people with the best quality of life, no matter how long their life is. It can be days, weeks, months or even years. There is a misconception that palliative care is only for the last few days, and that it occurs only in a hospice. Palliative care includes counselling and grief support for both the patient and their family members. The main service is to relieve pain and the other symptoms of the illness such as vomiting, shortness of breath and depression, but palliative care also provides access to resources such as equipment needed to aid care at home, improving the experience and quality of life, and extending a person’s life. It assists families to come together to talk and discuss sensitive issues. It connects the patient and the family to other services such as home help and financial support. It assists people with cultural needs and provides emotional, social and spiritual support for people who feel depressed, emotional or alone, which can often lead to some individuals believing they would rather go now than later. Pain is not always physical; it can also be emotional—a lack of sense of worth, embarrassment or a sense of being a burden. When assistance is provided, equipment obtained and emotional support given, life can be improved and, in fact, cherished. Without this help, some people may feel that their life is pointless.

However, 60 per cent of Western Australians are unable to access or are unaware of palliative care services that are or should be available to them. About 160 000 people die per annum in Australia, and about 40 000 of them receive palliative care. About 14 000 people die per annum in Western Australia, but it is unclear how many of them receive palliative care versus how many could benefit from it but are unable to access it. Professor Kathy Eager, director of the Australian Health Services Research Institute at the University of Wollongong, stated that 40 per cent of Western Australians who could benefit from palliative care are currently receiving it. That means that 60 per cent of Western Australians who could benefit from palliative care are not receiving it. By comparison, Palliative Care Victoria stated that one in four—10 000—Victorians miss out on palliative care.

I have been advised that across Western Australia, there are only 15 full-time palliative care specialists and that Royal Perth Hospital provides specialist palliative care only during office hours. Western Australia has the lowest number of publicly funded care beds per capita in the nation. In the current budget, the state government has spent $12 million on palliative care in regional WA. The University of Notre Dame’s chair of palliative medicine research, David Kissane, said that the state needs to spend an extra $100 million a year on palliative care on top of the additional $40 million that has been budgeted for the next four years.

I struggle to understand how we can be willing to legislate for euthanasia before first attempting to provide palliative care services to all. More than 80 per cent of deaths are due to five causes, which can generally be predicted, so those people can benefit from palliative care. Surely, we owe it to our community and the 80 per cent of people who would benefit from palliative care, and to the regional communities that either cannot access this care service or are simply unaware of it, to deliver that care service before we offer them a solution to end their lives.

In September 2018, the state government welcomed the report tabled by the Select Committee into Elder Abuse, titled “I never thought it would happen to me": When trust is broken”. I will not go through the entire report today, but the committee identified the very sad statistic that up to 75 000 older people are at risk of elder abuse in Western Australia and that previous data estimated that between two per cent and 10 per cent of older Australians will suffer from elder abuse. The report highlighted that most of this abuse comes from within the victim’s own family circle. This report uses the words and terms intimidation, bullying, coercion and threatening behaviour to describe the abuse that elders in our state are currently suffering. The media statement of 13 September 2018 by the Minister for Seniors and Ageing and the Attorney General states —

The State Government has welcomed the tabling of the Select Committee into Elder Abuse report as it continues to develop and progress policy in response to the emerging issue.

The statement continued with the Minister for Seniors and Ageing acknowledging —

Elder abuse is an emerging issue and the Select Committee report is an important resource …

Although the government acknowledged the recommendations of the committee and the need for legislation to be introduced to combat the growing incidence of elder abuse in WA, 12 months since its media release and the tabling of the committee report, we have not seen any new legislation addressing this extremely important concern. I understand that it takes time to get legislation of this importance correct, but I do not understand how we can be
discussing legislation that will end a life when we have not addressed the very concerns raised in the elder abuse report. The concern is that we could see the vulnerable within our community bullied and coerced or intimidated into a state in which they feel worthless, which could influence their decision to end their life. Legislation to combat elder abuse and to safeguard one of the most vulnerable groups within our community should have been in place before this legislation was introduced. Again, we are discussing the introduction of a bill that will take a life, yet we have not addressed the growing emergence of elder abuse and the lack of access to palliative care.

I refer to the poison that will be used. The Western Australian government has yet to outline what substance will be administered. I have concerns that we are debating legislation without all the details. Not knowing what substance will be used to kill another human being is a real issue and one that I am struggling with. Let us call it what it is; it is poison. The term “substance” is used throughout the bill. Why is it not simply referred to as per the description in the bill—that is, poison. The explanatory memorandum states —

Clause 7  Voluntary assisted dying substance

This clause defines voluntary assisted dying substance to mean a Schedule 4 or Schedule 8 poison, approved by the CEO under the Voluntary Assisted Dying Act, in order to cause a person’s death.

The terms Schedule 4 poison and Schedule 8 poison are defined in section 3 of the Medicines and Poisons Act 2014.

How can we be expected to support legislation that will take another human’s life without knowing what the poison will be or how it will work? What guarantee do we have that it will work effectively and without pain? We cannot, and just guessing and assuming is simply not good enough. I understand that authorities in Victoria have refused to release the details of the poison, or drug, used in its voluntary assisted dying program to avoid copycats, but it is believed to be similar to pentobarbitone, also known by the brand name Nembutal. It is a short-acting barbiturate that causes death by respiratory arrest. It is used in veterinary clinics in small doses as a sedative and in high doses to euthanise animals. An oral dosage of the drug is used for assisted death in Oregon, Washington, Vermont and California. A solution of pentobarbital sodium and sugar syrup in a 20 per cent ethanol solution is used in the Netherlands. The same drug was adopted by some states of the US to execute criminals following reports of failed executions. However, some lethal injections using pentobarbital have also been reported to have failed. A local US paper reported on failed executions on three occasions. Without going into the detail, because I do not believe it is necessary for us to do so, I think it is vitally important for us to understand this reality—it cannot be ignored. The failed attempts were not pleasant and were referred to as alarming, with the victims in distress. How can we be expected to support legislation that could deliver the opposite of the intent of its supporters in this chamber? We cannot be confident or guarantee that this legislation will provide a dignified and peaceful death, yet most speakers have used those words in support of this bill. There are cases in which this drug has not delivered a peaceful, painless death. Not knowing the substance the government will decide on using is simply not good enough.

What has become obvious over recent years is that the people of Australia, and particularly Western Australia, are seeking, as I said earlier, conviction, honesty and strength from their members of Parliament. I have replied to all within my electorate who wrote to me on this issue, and I thank them for sharing their views with me. I outlined my position to them. I have to say that the number of inquiries to my office was extremely small.

During this debate, statements have been made that it is not a euthanasia bill and that it is not assisted suicide; however, the definition of “euthanasia” is the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma. The definition of “assisted suicide” is suicide effected with the assistance of another person, especially the taking of lethal drugs, provided by a doctor for the purpose, by a patient suffering from a terminal illness or incurable condition. The definition of “assisted dying”, which is the term used in this bill, is that it is a practice whereby a person suffering from a terminal illness or incurable condition is helped to take their own life, especially by means of lethal drugs provided by a doctor for the purpose. Again, I do not understand the arguments that have been put during this debate that this is not a euthanasia bill, nor is this assisted suicide. This bill will enable someone to take their life and to allow another to assist. No matter what the title of this bill, it is suicide and it is euthanasia, so why are we denying that, why is it not being discussed and why is it being hidden?

(Member’s time extended.)

Mrs A.K. HAYDEN: As I have outlined, the argument that this bill will provide for a peaceful and dignified death is an argument that I really struggle with. As a reminder, our parliamentary role is to review, debate and pass legislation to form law. In doing this, we are to ensure that the legislation passed is the best it possibly can be or not pass it at all. In order to do this, we need to understand the detail and investigate every clause of the bill to ensure that there are no unintended consequences and that no-one is left vulnerable or at risk as a result of the legislation passing. Along with the concerns I have raised about palliative care and elder abuse is my concern about the lack of information on the substance that will be used to act out this assisted dying, as I have already outlined. This is where I would like the minister’s response. If the information is not available to us, how can we know or ensure that death will be painless and with dignity, and how can we possibly know how death will take
MR R.S. LOVE (Moore) [7.40 pm]: In starting my contribution tonight, I understand that this is an extremely sensitive issue and, for some people, a traumatic one. No person’s life is the same and no person’s death is the same. People’s experiences of this are different. There are many different points of view about the Voluntary Assisted Dying Bill 2019 and its nuances. I appreciate that. I stand very reluctantly to talk about this issue. It is not an issue that I approach without a sense of trepidation.

I go back to the concern that I and many others have raised during the debate around the lack of access to our palliative care services. Remote and vulnerable members of our community already struggle to access palliative care because the state is unable to allocate sufficient funds to extend the service and people cannot afford to travel to receive it. I am interested to hear from the minister: if the government is funding people to access euthanasia, why has this been made a priority over extending palliative care and protecting our elders against abuse? At best, whether or not you support euthanasia, this legislation is premature. It is inappropriate for WA to be contemplating voluntary assisted dying when the report of the Select Committee into Elder Abuse unanimously found that we have a serious elder abuse problem in WA, and this is also waiting to be addressed. It is also inappropriate for WA to contemplate voluntary assisted dying when the report of the Select Committee into Elder Abuse unanimously found that we have a serious elder abuse problem in WA, and this is also waiting to be addressed. It is also inappropriate for Western Australia to be contemplating voluntary assisted dying when it is far too early for us to assess whether the new Victorian legislation is safe. To me, it seems silly not to wait and see how it plays out in Victoria, before we make the same mistakes. It takes only one life to be lost in error, one life to be lost as a result of abuse or one attempt to fail or to be taken in extreme discomfort—it does not matter how many safeguards we put in place, they will not be sufficient. For that and the other reasons, I have outlined, I will not be supporting this bill. I will seek the minister’s answers to some of the questions I have raised during this speech during the consideration in detail stage.

I want to walk members through scenarios that have been keeping me awake at night—scenarios that could easily play out with the passing of this legislation. For example, an eligible patient is granted the right to take their life and they choose to self-administer and to die at home. A number of paths could be taken and a number of paths could occur. The first is that they follow the instructions and succeed in taking their life. The second is that, for a number of reasons, including medical, they cannot swallow or their digestive system is not working and they are unable to digest the entire contents of the drug and do not succeed. The third is that they share the drug with their loving partner, who wishes to pass with them. Let us talk through that third scenario. What if I were diagnosed with a terminal illness and I wished to take my life, so I choose to take the substance home and die at home. My husband chooses to go with me—he does not want to continue life without me and wants us to leave together. Now, a number of paths could follow. Sadly, both could pass—one healthy, one not healthy. A second path is that neither could be successful, because they have shared the poison they have been given and it is not enough to take both their lives. The third is that the dying partner passes but the loving partner survives. Going through all that trauma—I cannot imagine it. The fourth is more unlikely but still possible: a dying patient survives, because they simply cannot swallow or digest the drug, but the loving partner does not. I simply cannot vote for this legislation knowing that that is a possibility. It is on us to make sure there is no possibility that scenarios such as this could ever happen. We are here to protect our community. I am confident to say that I do not believe anyone involved in this debate would view any of these scenarios as acceptable. I am also confident to say that these scenarios are not the intent of this bill. However, the real issue is that these four scenarios could happen on the passing of this bill, and that is what scares me.

One other issue I wish to raise is the cost, which is also not outlined in the bill. Who will be paying for this? Will there be a government subsidy? Will it be listed on the pharmaceutical benefits scheme? If not, I go back to: how much will it cost? I have heard figures of around $5 000. I have also been told that in the US, the cost ranges from $8 000 to $11 000. If this is a rough estimate of what it will cost to access assisted suicide, I suspect that it will be out of reach for many in our community. Again, we have no detail on this matter, nor could I find it addressed in any of the reports that were the basis for this legislation. I hope the minister will be able to answer these questions. What will it cost to access euthanasia? Who will pay for it? If it is the government, how much will it cost the state? Is funding allocated; and, if so, where and under which portfolio? If it is to be funded by the individual, how much will it be and who will be paid?

In beginning this contribution, I recognise the efforts of all those involved in the extensive consideration of these issues. First, there are the people involved in the Joint Select Committee on End of Life Choices, including the committee staff, who are the unsung heroes in these types of deliberations. They sit through the same evidence that members sit through but they then have to sift through that in some detail and so they live it much more deeply than we do.
do members. The members of the committee that was formed to investigate this matter performed their task diligently. I know that many of them were personally affected by some of the stories they heard. I recognise the efforts of the chair, the member for Morley; the deputy chair, Hon Colin Holt, who is a member of my party; the member for South Perth, who I think I saw in the gallery a little while ago; the member for Mount Lawley; the member for Baldwins; Hon Robin Chapple; Hon Dr Sally Talbot; and Hon Nick Goiran, who delivered a minority report, “The safe approach to End of Life Choices: License to Care not Licence to Kill”. It was a detailed contribution from that single member and is testament to his mental and intellectual acumen. I also acknowledge the contribution of the Ministerial Expert Panel on Voluntary Assisted Dying: the chair, Mr Malcolm McCusker, AC, QC, an eminent Western Australian who, I think, has the respect of everybody in the chamber; the deputy chair, Dr Penny Flett, AO; and all the other panel members. I acknowledge the community members who contributed to the investigations and consultations of both the committee and the expert panel. I respect and recognise the good intent and integrity of all those involved.

There is little doubt that the weight of public opinion—and, I think, the overwhelming number of members in this house—is firmly in support of the introduction of a form of voluntary assisted dying in Western Australia. That being said, it is the duty of every member, no matter how popular an issue, to carefully weigh the issues relating to all legislation. I have done that. I have consulted with my community but not, I might add, as extensively as did the member for Dawesville, who personally contacted 6 500 people and asked them their views, but within the limited ability that I have as a member of Parliament. I have come to the view that most people with whom I have spoken are in favour of voluntary assisted dying. Some of them had very passionate views because of their personal experience. I say to all those people that none of their views are discounted in anything that I will say from now on. I had to weigh up not only their views, but also what I think is right. That onerous decision and duty has been placed on all of us. Having done that, I have come to the view that I do not support the bill. In doing so, I do not cast a negative view on any member of this house who supports the bill or has a contrary view on this matter because all of us have done our best to weigh up community representation, our personal experiences and the experiences that others have relayed to us in coming to decisions on this matter. I expect that, given the number of those members in the house who have expressed support for the bill, it will quite easily pass in this house. Although I will not vote in favour of the bill, I will attempt to contribute thoughtfully to the consideration in detail and point out any improvements that I think can be made. I was told by government members last week that the government will not entertain any amendments during consideration in detail. If that is so, that is disappointing. It should be recognised that no legislation is necessarily perfect when it comes to this place and improvements should be considered when they are pointed out. Fortunately, we have a two-chamber Parliament and I can only hope and assume that more consideration will be given to improvements to the bill in the Legislative Council, our house of review. I am sure that the Council will discharge its duties thoroughly, with the possibility perhaps of a committee examining the legislation thoroughly.

I know the government has to organise its business throughout its term, but one of the things I find a little hard to understand is the tight timetable of all of this, including the scope with which the ministerial expert panel was allowed to examine issues. I know, having spoken to people involved in health, that drafts of the bill were circulated early on, well before the select committee had met. I think there is a level of pressure to get this done within a certain timetable and that is disappointing because it is a hugely important bill. If any bill needs and deserves the full examination of both chambers, it is this bill. It should not in any way be short-circuited. I hope that the Council looks at this bill thoroughly.

Having had discussions with community members and, indeed, at the ministerial expert panel consultation round table that I attended in Joondalup—unfortunately, I missed the one in Geraldton, which is close to my electorate, because I had to attend another event, but I went to Joondalup with the view that some people in the south of my electorate may well be in that area and I did recognise a couple of people—there is a strong view that voluntary assisted dying is required. Having had discussions about many circumstances, it seems that palliative care is felt not to be sufficient to relieve the suffering of a portion of those who are dying from a terminal illness. That may or may not be so. It appears to be at odds with some of the palliative care practitioners with whom I have had the occasion to discuss these matters. It appears that often palliative care is sought far too late, when there are just weeks left of a person’s life. In briefings and discussions, palliative care specialists have expressed the view that palliative care should be more deeply embedded in the medical system and that part of the problem is the view amongst some of the, shall we say, go-getters in the medical world, the active can-do guys who are doing the surgery, that they do not need to involve palliative care until they run out of options. From what I understand, that is not the way it should be run and it is not the way to get the best outcomes for patients. In fact, I think that was borne out in finding 12 of the Joint Select Committee on End of Life Choices’ majority report, “My Life, My Choice”. It states —

Access to specialist palliative care in the early stages of a diagnosis might improve remaining quality of life, mood, resilience, symptom management and allow for death in the patient’s preferred location. These benefits would be more readily available to patients if difficult discussions about death and dying took place earlier.

I think that is the core of it. Some of the medical professionals are not ready to accept that the patient is terminal or that death is inevitable—well, death is always inevitable, but that death is inevitable at a predictable rate and the patient is beyond the point where treatment will be effective in prolonging life. It is a matter of trying to embed

Extracted from finalised Hansard
much more deeply in the medical profession the idea that, even if a disease inevitably claims a patient’s life, if we can extend their life and their quality of life, that is a desirable outcome, so the two things work hand-in-hand. I think there is a bit of, shall we say, tension between those two aspects.

This is particularly concerning for regional people, which is borne out in findings 19 and 20 of the report, which spell out something of a warning for regional people. Finding 19 states —

There is limited access to palliative care medical specialists in regional Western Australia.

Finding 20 states —

There is limited medical oversight, coordination or governance of medical palliative care services across WA Country Health Services.

As a regional member of Parliament, I find that particularly concerning. I have said in this house before that I would not like to see people accepting voluntary assisted dying simply because they are unable to access proper palliative care in their own region or community. I have said that on a number of occasions and other members of the Nationals WA have also highlighted that as an issue. Although this is a matter of conscience for National Party members and we have different views on these things, I also think there are some commonalities in that we all recognise that regional people should not be disadvantaged in their access to palliative care, and even though I do not support voluntary assisted dying, if it is going to be available, it should be available to everybody equally. The Leader of the National Party earlier outlined some of the issues around the ability to access all sorts of medical services as part of this legislation, and that needs to be addressed. Both the minority report by Hon Nick Goiran and the majority report pointed out those deficiencies.

I refer to a media release this month by Dr Anil Tandon, chair of the Western Australian Palliative Medicine Specialist Group, in which he points out that —

“WA has the fewest number of palliative care specialists per capita, —

Presumably in Australia —

the lowest number of publicly-funded palliative care beds, and only one-in-three people who could benefit from specialist palliative care has access to the services they need.

That points out that there is a very big gap in the whole system. This is also borne out in an article by Nathan Hondros from 28 August, “‘West Australians should not ponder euthanasia due to lack of care’: End of life specialists”, which again points out the lack of palliative care as an issue in Western Australia generally. The member for Scarborough, the Leader of the Opposition, also pointed out that there were issues in the metropolitan area. We are concerned that regional areas are a focus for improvement, but in fact, as the Leader of the Opposition has pointed out, there are gaps in the metropolitan area as well. We should not be blinded to the fact that this is a statewide problem.

Mrs L.M. Harvey: It’s a significant issue.

Mr R.S. Love: There is a significant gap, and in fact the same article states —

The University of Notre Dame’s Chair of Palliative Medicine Research David Kissane said the state needed an extra $100 million a year spent on palliative care.

This is on top of the extra $40 million for palliative care over four years announced by the government in the state budget.

It is easy to pluck figures; the government has plucked a figure of $40 million and applied it to palliative care; it might fix it up, but Dr Kissane is saying, “Well, another $100 million might fix it up”. I think we need some proper planning, to set out some parameters, work out just how much it will cost, and then action that as quickly as possible. Just plucking a few figures out of air sounds good; $40 million sounds like a lot of money. It might be a drop in the ocean compared with what is required, or it might be more than sufficient. I do not know, but I do not think there are any real parameters around any of this at the moment, and that in itself is very concerning.

The member for North West Central made his contribution just before the dinner break and he pointed out the need for aged care in Carnarvon. He understands that the $5 million that went towards that is not really going to address the statewide need for palliative care. Good on him for his advocacy, and I applaud him for the effort he went through on behalf of the Carnarvon community to get that aged care facility and to make palliative care available in his town, but a lot of other towns need to be addressed as well, and they cannot all have facilities unless we are going to put a lot more than $40 million into them. It is time for the government to take this very seriously. I know that statements were made by the Minister for Health and the member for Morley during the matter of public interest, but we certainly need to take this very seriously. I reiterate what I have said before on this matter: I do not want voluntary assisted dying to become the default choice for regional people simply because they have no access to decent palliative care. I see the member for Kimberley; I am sure that in the Kimberley there are many examples of people being unable to access that level of care.

[Member’s time extended.]
Mr R.S. LOVE: I do not believe that we should be considering the introduction of voluntary assisted dying until our palliative care is brought up to scratch. Others might disagree with me, and that is fine; we are all entitled to an opinion.

I turn now to the whole idea of the slippery slope argument, and it is real. We are told that the Voluntary Assisted Dying Bill 2019 has adequate and extensive safeguards—one hundred and something has been quoted—and some of them are not so much safeguards as procedural matters, but nonetheless, there are a number of safeguards in this bill. If we examine the Victorian legislation closely we see that there are some differences, and the differences seem to be a freeing-up of some of the Victorian safeguards. An analysis in *The Australian* of last weekend, 31 August, points this out, as well as discussing the draft Queensland bill, which has been floating around and which widens even further some of those processes. For example, the Western Australian bill allows doctors to suggest voluntary assisted dying, whereas the Victorian legislation does not; in fact, it precludes it. The Victorian legislation requires a medical specialist to be involved in the assessment of a patient; the Western Australian bill does not. The Western Australian bill will allow more active participation by medical people in actually administering the lethal drugs. In Victoria, a doctor who is unwilling to participate in the process can simply refuse to; in Western Australia, they are required to pass on general information, which will actually involve them in the process. Whichever way we look at it, they will actually become involved in the process of that person moving towards voluntary assisted dying.

When we have six states all bringing in different legislation and all looking at the legislation that the other states have brought in, and they all bring in legislation just a bit more liberal than the previous legislation, we are going to end up with a far more liberal outcome at the end than what Victoria first envisaged. That is because there are no absolute lines in any of this. Once we cross that line and allow voluntary assisted dying, everything else is pretty much subjective. Once upon a time we used to have absolutes in our society such as, “I believe in God and the principle that was outlined in a document handed down to Moses 5 000 years ago”, but now most people do not hold that central to their belief systems. When we move from that into a system in which people determine their own measures, it is much easier to see how this “creep” of scope of something like voluntary assisted dying will occur. That is something Paul Keating pointed out in his opinion piece that was published in 2017, when he said —

Beyond that, once termination of life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law.

I fear that, in the future, pressure will come on more and more to broaden the scope and the eligibility of voluntary assisted dying in areas such as its availability to people with mental health problems, its availability to people who have an illness without a predictable life expectancy, its availability to children, and its availability to people suffering from dementia, perhaps using advance medical directives. We should note that the Attorney General here in this house proclaimed last week that the Western Australian government will not be accepting recommendation 23 of the final report of the Ministerial Expert Panel on Advance Health Directives. Recommendation 23 stated —

If, at a future point, voluntary assisted dying legislation is implemented in Western Australia, the State Government could consider establishing an Expert Panel to provide advice and recommendations on how to provide people with a neurodegenerative condition access to choice regarding voluntary assisted dying, in particular through the potential application of advance directives.

The Attorney General and the Western Australian government will not accept this, but in fact the ministerial expert panel has put it on public notice as an issue. It will be a live issue.

A week or so ago, *The West Australian* published a survey that showed 88 per cent of people support voluntary assisted dying. That strong level of support has been cited by a number of people as a reason for them changing their views on this issue. Public pressure and public opinion makes a difference. I suggest that the people I have spoken to would support the use of voluntary assisted dying in the case of dementia. A lot of them support it. How many of the 88 per cent would actually support that? Does anyone in this house seriously believe that the public does not support voluntary assisted dying following an advance health directive? I do not believe that for a minute. The same people who came to me and said, “We believe voluntary assisted dying should be available”, want that for the people who end up with dementia. Many of us live in fear of dementia. In fact, representatives from Dementia Australia were here in Parliament a week or so ago. The member for Girrawheen and others were at their presentation. I have here with me a copy of a fact sheet that was spoken about. It says the leading cause of death in women in Australia now are conditions related to dementia. The second leading cause of death in Australian men are conditions related to dementia. Given the recognition of the ministerial expert panel and given the disappointment my constituents feel when I tell them that dementia will not be covered by the Voluntary Assisted Dying Bill—because it is assumed there is a lack of capacity for people to access it—I am sure at some point the push will be on to extend the eligibility. Bear in mind Paul Keating’s words, “Once the threshold is crossed, it will be much easier to liberalise.”

On the question of capacity, we have to imagine the capacity of a 40-year-old person in full health who is sitting around talking to his wife and kids and everyone else, or the husband and kids and whomever it is, about their future, who has a greater mental capacity to make those decisions than a person who is suffering from a terminal illness, who is receiving medications and treatments that are grossly affecting their ability to function, and they are facing an existential threat to their existence. In those circumstances, I believe that person is not in exactly as

Extracted from finalised Hansard
good a position mentally to make those decisions as we are right now to make decisions about what should happen to us in 40 years’ time, should we have dementia. I believe that the 88 per cent of people who support voluntary assisted dying would also support that proposition. Once these things are added, the list will only continue to grow.

What about the availability to children? Why is the suffering of a 14-year-old not considered as important or any less real or less distressing than the suffering of a 40-year-old? There was a case in the UK—the member for Hillarys would have heard of it—the Gillick case, in which the House of Lords established a principle that young people have a right to determine their medical treatment. That has been supported in cases in the High Court of Australia. Those principles were outlined and accepted in Marion’s case. Why does this bill not reflect that legal principle? Why are the rights of a child to seek that same sort of medical intervention not being respected in this case when they are in other cases? I go back to the point: why is the suffering of a 14-year-old or a four-year-old any less real than the suffering of a 40-year-old? This bill has been written by adults about adults, but what about the kids? Kids also die from horrible diseases.

As soon as we accept this legislation, these very difficult issues will have to be addressed. It is all very well to look at the examples. I know adults who have suffered terribly—I have great sympathy for them; I would not like anyone to suffer—but we have to accept that once we move into this field, a whole range of other parameters need to be addressed. Constant pressure will be on to address each and every one of them if we move into that field. That was examined somewhat by the Joint Select Committee on End of Life Choices. I will read from Hon Nick Goiran’s minority report. In doing so, I pay tribute to the work that he did in this area. He was talking to Philip Nitschke, who is a bit of a doyen amongst those people who believe in voluntary assisted dying. I will read a few examples. According to page 230 of the report, Dr Nitschke stated —

> What has happened where we have seen laws change… such as places like Holland, where I am now a resident, is that over the years people realised that the onerous restrictions cause difficulty and, of course, there is an erosion or a change to those requirements. We have seen changes here, first of all, to the age of eligibility, and then the nature of the condition and the nature of suffering that entitles a victim to make use of these laws.

Dr Nitschke went on to say —

> ... the question is now: is it a right or not for an elderly person to simply say, “If I want these drugs, I should be provided with them?” In other words, we are seeing a change from it being considered not just as a medical privilege for the seriously ill who qualify, but as a basic human right.

> …

> I want to see a debate held about a “tired of life” argument such as we are seeing here in the Netherlands. Should every person over a certain age be issued with those drugs? That is where the debate will go. I am predicting that. It will happen even in Western Australia and other Australian states, because that is where the debate around the world is heading.

Again, these things have a habit of changing. The pressure comes on for the whole gamut of the legislation to grow.

I will finish by reading once again from the minority report. I refer to a quote from Fabian Stahle’s “Moral Disengagement — Mechanisms Propelling the Euthanasia/PAS Movement” published in the Journal of Ethics in Mental Health. The quote in the report states —

> Voltaire has said that those who can make you believe absurdities, can make you commit atrocities. The first absurdity may be to claim, against better knowledge, that it is possible to construct a safe system for the medical termination of people’s lives. Once that absurdity has been elevated to truth status, you and those you have seduced into agreeing, can actually end up supporting an activity that you initially felt was abhorrent—now with hardly any regrets at all. The abominable thing has thus been normalized or even glorified. Black has become white.

MR P. PAPALIA (Warnbro — Minister for Tourism) [8.09 pm]: At the outset, I would like to acknowledge the Minister for Health and the member for Morley for their roles in leading this debate in many respects and in leading the consultation across the state of Western Australia. While I am acknowledging people who have made a contribution, I would like to acknowledge the Ministerial Expert Panel on Voluntary Assisted Dying and its magnificent chair, who is a great Western Australian and has made a significant contribution here and throughout his entire life. Malcolm McCusker, AC, QC, should be acknowledged at this time. Whether or not people agree with the Voluntary Assisted Dying Bill 2019 and the concept of voluntary assisted dying, it is undeniable that a huge effort was made to consult with the community to seek out differing views and to ensure that those views were represented on the panel and that experts from the entire spectrum of views were given the opportunity to contribute to the discussion around the development of this legislation. That is undeniable. It was led by one of the greatest Western Australians of all time. I think that is a magnificent contribution, regardless of people’s views.

With regard to my contribution, I do not intend to delay the debate too long. I believe it is my obligation, noting that it is a conscience vote, to place on the record for the benefit of my constituents how I intend to vote. I intend

Extracted from finalised Hansard
to support this legislation. In making that statement, I acknowledge that a significant proportion of people within my electorate would not agree with this legislation and would prefer that I vote against it. To them I say: I cannot say that I understand your views, but I acknowledge them; I do not agree with your views, but I appreciate those of you who have made the effort to contact my office and notify me of your views. Invariably, those people who have contacted me who oppose the legislation do so because of religious conviction. In response to that I would say that they benefit from living in a secular state where the rule of law dictates people’s freedoms. We are fortunate to live in a nation where we have separation of church and state. Religious zealots do not dictate what government should do. We have the opportunity for democracy to be exercised and, as a consequence, the right to practise religion is recognised and defended, and I will defend that right any day. I am proud to say that I have served the nation in a lot of different fields and I am proud that this nation is essentially secular. That means that every religion is defended and every religious person is given the opportunity to practise that religion, but it does not mean that religion can dictate what others must do. It does not enable adherents of a particular faith to deem others less worthy, it does not enable those who have a belief in God to suggest that those who do not believe in God are any less worthy as citizens, and it does not enable those people to dictate how anyone else should live their lives. The rule of law does that. The rule of law protects us all. I thank you.

I recognise that many people will be disappointed by my intention to vote in support of this bill, but I believe it is about choice. This legislation will provide some people with a choice, but not as many as the community would prefer. It has nowhere near the extent of reach that many people in the community would believe is reasonable. Nevertheless, it will provide some people with the option to choose the nature and time of their death, noting that they are facing impending death in the near term anyway.

The reason I support the bill, apart from my belief that it is the right thing to do, has been dictated by personal experience in recent times. In the first of two cases, both of which were very close to our family, within the last year, our family witnessed someone in palliative care. Despite those who oppose this bill and suggest that palliative care is an alternative to a death that does not have dignity and is painful—in some cases it may be—the experience I witnessed was that palliative care essentially deprives somebody of nutrients and fluids until such time as they weaken, their organs fail and, as that process carries on towards death, they are sedated so that they hopefully do not feel pain, and then subsequently pass when they are probably unconscious at a time essentially chosen, in many cases, by the doctor administering palliative care. That is what I witnessed in the delivery of palliative care.

Mr J.E. McGrath: That would be at a very late stage.

Mr P. Papalia: Correct. It is not an alternative to that process. It is not about someone’s choice of the time of a pain-free and comfortable death to avoid the consequences of the body breaking down over time and, ultimately, the likelihood of not making a conscious decision about the time of their passing.

The other thing that occurred in recent months was the loss of a very close family friend to motor neurone disease. Palliative care does not make that disease a less horrible death. If people assume that it is a choice between palliative care and having a potentially very painful, frightening death that is lacking in dignity, it is not in all cases. It does not matter whether there is palliative care, confronting a death from motor neurone disease is not a nice prospect. The person is gradually deprived of their ability to conduct themselves in a normal fashion and to have any form of dignity. They know it is coming. They know what the symptoms are. They know that their capacity will be diminished over time. They know that they will lose the ability to control their movements and any form of bodily function and to conduct any of their own care over time towards an inevitable, pretty bad death. I can only say that providing someone in that situation with a choice is absolutely the right thing to do. This bill does not compel anyone to take the choice; it provides them with the alternative. While they are still capable, and despite knowing that they are confronting imminent death, they can choose the time. It is not a time chosen by the doctor who is administering the drugs and who is caring for someone who may be unconscious by the time they confront that end-of-life period, but a time they choose. We are enabling them that one decision while they are still strong enough to do it, while they are still coherent and have the cognitive capacity to do it, and while they are still able to say goodbye to their family and friends in a dignified fashion. I think that is the right thing to do.

Again, I commend those who have led this debate and those who have crafted the advice to government. I absolutely commend the legislation.

MRS M.H. ROBERTS (Midland — Minister for Police) [8.19 pm]: Euthanasia—this is not an easy subject. It has been an emotional debate for many. Many have related deeply personal experiences. There has been consideration of the death of loved ones and contemplation of one’s own mortality; heartfelt emotions have been brought to the fore. I have received hundreds of pieces of correspondence, some for, others against this legislation. Each has been heartfelt and contains many very intimate accounts of the death of a loved one and many impassioned pleas about the consequences of the proposed legislation. I acknowledge those who have implored me to support the legislation; those who view euthanasia as a merciful compassionate choice—one each individual should be able to make for themselves. They ask: why should they not be able to make a voluntary choice to ask a doctor to end their life rather than endure the pain and suffering before an inevitable and relatively imminent death? I have thought long and hard about whether it would be right to support legislation to give them that choice. Some have

Extracted from finalised Hansard
been through incredibly harrowing experiences, and I am not immune from feeling the pain in their words or understanding their genuine plea. I have also read the equally impassioned pleas from those who see this as the thin edge of the wedge, or the slippery slope, as destroying the sanctity of human life, and who view the legislation as neither right nor good.

Most of what we do in this place is to affirm and support life. I have two portfolios—police and road safety—both of which are grounded in the common principle of safeguarding life. Indeed, the primacy of life is so important in the police portfolio that we no longer use death as a punishment, even for the most heinous of crimes. Instead, we feed, clothe and shelter them in line with international conventions. We do not have the death penalty, as has been mentioned by others. One reason we do not have the death penalty is that for some it is just a matter of the sanctity of human life; for others it is because they believe that it is far worse for one innocent person to be punished or to lose their life than it is for others to be set free. I find it interesting that people can have that consideration at that point in time: they would rather let people who have committed heinous crimes live than see a single innocent person face the death penalty—that finality—because mistakes can be and are made. Indeed, through the Innocence Project here and in the USA, in the UK and right around the world, DNA evidence has found that a lot of people who had been convicted of murder right around the world have subsequently been found to be not guilty. Therefore, we act with caution when it comes to people accused of crimes of that nature.

What this legislation is asking the Parliament to do is to reverse the common duty—to safeguard life. Some see this debate as being about the circumstances in which we can affirm death rather than the principle of whether we do so at all. This is illustrated by two key things—one, the elaborate mechanisms envisaged in the legislation to safeguard the process from coercion or abuse; and, two, the attitude of the medical profession. Much has been said already about the so-called safeguards, and I am sure much more will be said in the consideration in detail stage. The real point here is that we need them at all. The intention is to distance us from the reality of what we are doing. Their effect will be to legitimise and bureaucratise what is intended to be a pastoral process. The fact that we need safeguards means that there is something inherently worrying about the principle—there exists the very real opportunity for abuse. If we look to those safeguards, we will see the safeguards proposed in Western Australia are less than those in place in Victoria. A handy summary appeared in an article in The Weekend Australian dated 31 August, on page 18. It highlights a few of those differences and I itemise them here—

- Doctor can raise VAD with patient, reversing onus.
- VAD medication can be administered in some circumstances by a nurse practitioner.
- Self-administration remains preferred, but if the approving doctors agree this is inappropriate, physician-administered VAD allowed.
- No requirement for doctors to apply for a government permit in each case. No requirement for a specialist to be involved.
- If a doctor declines to participate on conscientious grounds, they must immediately inform patient and provide standardised information on accessing VAD.

These are all differences from Victoria’s legislation. I acknowledge that not all doctors oppose this bill. However, the Australian Medical Association remains opposed. This should ring alarm bells for everyone. They are the very people who are closest to the issue on a daily basis. They are the best informed and they are the ones we expect to deliver the legislation. The fact that they are against it, or at the very least heavily divided, should concern us all. They are the ones who have the most experience in diagnosing terminal illness and conveying that diagnosis to patients. I fully understand that any doctor who opposes the legislation can opt out and will not be required to assist in euthanasing a patient, but that does not quell their legitimate and valid concerns—concerns that go well beyond the quality and availability of palliative care. They are concerned about the sanctity and preservation of human life; the potential for undue influence, no matter how subtle; and they are also concerned about the finality of any decision.

I have been there at the end of life for close relatives whose quality of life has deteriorated and who have been in their final days on earth. It is hard, but it is important. Indeed, it is a privilege to be there for those people. It can bring people together. It is about family, it is about relationships and it is important. I would not have had that experience any other way. None of us likes the thought of our children or their children suffering through seeing a parent wasting away or in pain, but in my view the alternative is worse. I am limited for time in these remarks and will not elaborate, suffice to say that this has been more than eloquently explained by the member for Scarborough when dealing with her own personal experience. I am in no doubt that it was unbelievably difficult to see their husband and father waste away, but I am also in absolutely no doubt that it was much better than the alternative—and, in particular, so much better for the children both in the short term and the long term.

I am going to relate a situation that I was very closely involved in quite some years ago now. It is about someone who is known to people in this chamber. Batong Pham is a friend of mine. Just after his fortieth birthday, I think it was, one Sunday morning, he had a stroke. He had a wife, a child of about 18 months of age, and his wife was three or four months pregnant with their second child. Batong was taken to hospital—I think first to Joondalup

Extracted from finalised Hansard
and then to Royal Perth Hospital. He remained in an induced coma in Royal Perth Hospital in the intensive care unit for the remainder of that week. His was a Catholic Vietnamese family. They had come across perilous seas and settled in Perth, so they had already survived a lot. Here they were faced with this situation.

The doctors at Royal Perth Hospital told the family that Batong was effectively brain dead and that nothing was happening up there. By the Friday, his family were told that they should turn off the respirator and there was no hope for Batong because there was no brain activity whatsoever. The doctors showed them the various pieces of equipment and pointed out the normal range to indicate brain activity and a viable life. They showed that he was well below that; there was no activity and, therefore, no hope. Batong’s family, being Catholic–Vietnamese, found it very difficult to deal with the concept of turning off the respirator and ending his life. His wife, who had gone up to the hospital on the Sunday, had collapsed in distress. She had had difficulty in earlier pregnancies and there was a lot of worry for her. She had been admitted to another area of the hospital for care and attention. Extended family of about 20 people or more remained outside the ICU praying the rosary and praying for Batong day and night for that whole week. But by the Friday, they said all hope was gone—no brain activity, no action—and that they should, on the advice of doctors, turn off the respirator.

As members will recall, the late John D’Orazio was a pharmacist. He was also a close and trusted friend of Batong and his family. John was also a Catholic. The family said to John, “The doctors are saying we must do this. We don’t want to do it.” Batong’s parents did not understand it and his brothers and sisters and extended family did not support it. They trusted John to talk to the doctors on their behalf. They understood that he was someone with some medical expertise via his pharmacy degree. They knew that John understood these things and they trusted him. John talked to the doctors with the family about whether there was another way, because John said that if any healthy person were on the amount of drugs that Batong was on, they would not be able to breathe unassisted. They would need a respirator. John said that if the respirator was turned off, it was certain that Batong would die, because with the medication that he was on, he could not possibly sustain himself to breathe. John put a different proposal to the doctors. He said that perhaps they could accommodate the family’s belief and our beliefs by reducing his medication and giving him the opportunity to sustain life himself, however unlikely that was. The family went along with that. They said, “Well, we will give that a go.”

The doctors agreed to gradually withdraw the medication and said that in all likelihood he would pass away that evening or the next day—certainly within 24 hours or so. The family had a priest come and do the last rites. The family were all involved and said their goodbyes. John D’Orazio called me and explained what had occurred. I was at a function on the Friday night and had something to do on the Saturday morning, and he said, “Michelle, if you want to see him before he passes, you will need to come tonight.” After I had been to the function, my husband and I went to Royal Perth ICU and Batong was lying there with his bare chest going up and down with the respirator. Two relatives remained there, one of whom was his brother. His brother sought the permission for us to go in and see Batong. I held his hand and I spoke to him for a very long time. After about half an hour, I felt that I was getting a response. I felt that he was responding to me talking to him.

My husband was sitting well over to one side, wondering how I could maintain a one-way conversation for half an hour with someone who for all intents and purposes looked as though they were already dead. Nonetheless, I did so. I held his hand and I talked to him about his wife Thuy, the young child Alban and the baby they were expecting. I talked to him about a lot of the good times we had had. Part of the reason I did this was that I had also had the experience of another friend of mine having Guillain-Barre syndrome—a locked-in syndrome—some years earlier and he told me that he had been laying in hospital unable to do anything or talk for months on end with his family visiting every day, initially talking to him and then talking across him. He said that was not too bad because he got to catch up on the family news. He fully recovered from his Guillain-Barre syndrome. It occurred to me that there might be a minuscule chance that Batong could hear what I was saying, so I was giving it a go. I felt that he was squeezing my hand at key moments. I asked him whether he could open his eyes. I saw his eyelashes move. He could not open his eyes, but I could see that he was trying to. I was starting to wonder whether it was my hope, rather than reality. His brother came over and looked at the equipment; he could see that there might be a minuscule chance that Batong could hear what I was saying. I felt that he was responding to me talking to him.

[Member’s time extended.]

Mrs M.H. ROBERTS: Before long, we had about half a dozen medical staff there who instructed me to keep talking to him. Batong had a tracheotomy so he had no opportunity to speak, but, to cut to the chase, within two or three days he was in a regular ward in Royal Perth Hospital. The doctors were unable to tell us whether he would be able to speak but it was clear that his brain function was there because he could hear and understand what we were saying to him. No-one should tell me that doctors do not make mistakes or that they know everything. If we had taken the doctors’ advice and this family had not had the faith and made the choice to turn off his respirator, Batong would not have lived to see his second child born and his boys grow up. I know that in many other circumstances people get wrong diagnoses or medical advice.

Many in this debate have acknowledged the woefully inadequate availability of palliative care in this state, which our government is now seeking to address with a significant cash injection. There is still a long way to go before there

Extracted from finalised Hansard
are appropriate options for people in all different circumstances and areas of WA. Some have noted that the two states with the smallest per capita investment in palliative care are the same two states that have the highest percentage of community support for euthanasia, clearly implying that if more people and families had exposure to early and good palliative care, they would be less likely to see euthanasia as the solution. Some have said that they have polled their electorate and found a clear majority in favour. Some have looked to published polls that indicate a very high level of support for euthanasia. They have cited these as reasons that they will support the legislation. If those same MPs polled their electorates on capital or corporal punishment, I wonder whether they would feel the same obligation to go with the flow.

Some have risen in this debate to say that there is no right or wrong here, implying that it is just a difference of opinion, but then some have gone on to say that if we are compassionate and merciful, the only choice that we can make is to help people end their pain and suffering. I am not without compassion, nor do I want to see people suffer, but I really care about what is right and wrong. If this legislation passes, many people may well suffer tragic consequences—people who feel pressurised and vulnerable people who may have their lives cut short despite the repeated catchcry of “it’s voluntary” or “it’s their choice”.

The very concern that I raise is countenanced in the bill. The so-called safeguards are testimony to that. They are there to mitigate against the prospect of someone being pressured. The question is: do they mitigate enough?

I read quite an informed article written by Peter Quinlan, who at the time was a barrister at Francis Burt Chambers, and published in Brief in November 2009. He set out the legal case for assisted dying. This article is opposed to the bill that was proposed in 2009. The arguments that he proselytises are just as valid today. The article is titled “Haggling Over Price: Euthanasia, Reason and Purpose of Law”. As people know, Peter Quinlan is an eminent solicitor. His introduction states —

“Would you sleep with me for $1 million?”, Groucho asked the attractive young woman seated next to him at dinner.

Pretty woman, laughing: “Of course”.

Groucho: “How about for $10?”

Pretty woman, aghast: “Mr Marx, what kind of girl do you think I am?”

Groucho: “We’ve already established what you are. Now we’re just haggling over price.”

I will get back to that point in a moment. This is an eight-page article. I certainly do not have time to go through it all but I want to highlight some of the very salient legal points that Peter Quinlan has made. He states —

Firstly, the proponents of voluntary euthanasia clearly see their goal as directed towards a “Good”, in the classical philosophical sense of the term. Voluntary euthanasia legislation is, in this view, to be enacted because the right to euthanasia is a “good” or “right” thing properly to be desired. There is, accordingly, implicit in the voluntary euthanasia cause something objectively good, which goes beyond merely the desire of the particular applicant for euthanasia. What that “Good” is, remains to be explored.

The second way in which “natural law” concepts find their expression by the proponents of voluntary euthanasia is in the use of the concept of “rights”. Clearly, those who would legislate for voluntary euthanasia regard the applicant for euthanasia as having a “right” to intentionally terminate his or her life. I would also go further and posit that such proponents regard that “right” as being a “basic”, “fundamental” or “human” right. By this I mean that the proponent of euthanasia regards the “right to die” as inhering in human beings by reason of their status as human beings prior to those rights creation or recognition by the institutions of the state.

I will miss a few paragraphs and go on to read some other valid parts of the argument. He lists some of the criteria for euthanasia, stating —

Without each of these criteria voluntary euthanasia is not to be permitted, even if it is desired (no matter how strongly or sincerely).

I note that his comments pertain to the 2009 legislation, not the current bill. He continues —

On what grounds is euthanasia to be made available to a person suffering pain as a result of an illness that will result in their death within …

More importantly, why should the right to die be denied to a person who will never die of their illness or medical condition?

…

Clearly in relation to such persons, the “right to die” or their individual “autonomy” to determine the time, place and manner of their death is not to be accorded recognition (or respect) by the state. For those persons some other, unstated, consideration overrides their right to self-determination.
Effectively, he is saying that in some circumstances, people have a right. In some circumstances—specialised circumstances outlined in the legislation—people have a right to choose the time and place of their death but other people who do not meet that criteria do not have that right. That is the contradiction that he pointed to. He went on to say —

Necessarily then, something else is being “taught” by this law. And what is being “taught” and made abundantly clear, by this law is that, in some circumstances (that is, those contemplated by the objective criteria of the Bill) the Parliament (the expression of the community) agrees that “It is right and proper and reasonable, to regard nonexistence as preferable to this human life”. In other cases, however (those outside the objective criteria of the Bill), Parliament (the community) says, “No, this life has intrinsic value. It is worth living, regardless of whether the person who is living that life agrees”. Immediately it is clear that what this law is teaching us is not something about “autonomy” or “individual rights” but something about the “value” or “worth” of the life in question. This is because these objective criteria apply, regardless of the desire or “will” of the person in question. As a matter of the operation of the law, they are what are called, in legal terms, conditions precedent to the exercise of the decision by the applicant for euthanasia. They are assessments of “value” (or “value judgements”) which logically precede the question of the individual’s desire.

The law then, explicitly and objectively, concludes that one human life has an intrinsic value that another does not.

I would recommend that article to those who are really interested. Peter Quinlan goes through some subjective and objective criteria. He refers to the right that already exists in law for people to refuse medical treatment and also the rights that people have to drugs such as morphine and matters that people have already spoken about during this debate.

My learned colleague the member for Armadale raised his concerns about the safeguards. He also raised the question of whether any amount of palliative care would be enough to quell the concerns of those who oppose the principle of euthanasia. That certainly gave me pause for thought. Ultimately, for me, this is a matter of principle. It is about what is right and what is wrong. It is about the sanctity of human life. It is about protecting the most vulnerable, the elderly, those with disabilities and the sick. It is about not putting a price on human life.

Can we give some people the choice without effectively infringing on the choices of others? I do not think so because in giving some people this choice, there will be consequences for others in our community, potentially those people who are vulnerable, who are disadvantaged, who are not so well off or who do not have the choices in life that we have in this place. Many people may well make the choice voluntarily, as those who support the legislation would like, but can we be assured that others will not feel subtly or less than subtly effectively persuaded to make a choice that others believe is best for them? The choice argument does not stand. It assumes that all choices are freely exercised without external, social or economic constraints. This is a nonsense, especially when speaking of the severing of human relationships. In this concept, we are all inextricably part of one another and the neoliberal atomism of our community into individuals exercising free and rational choices is shown to be a devastating and alienating model for living our lives.

I would like to close by quoting one of my favourite metaphysical poets, John Donne, from “Meditation XVII”, which reads —

No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend’s or of thine own were: any man’s death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bells toll; it tolls for thee.

MR D.R. MICHAEL (Balcatta) [8.49 pm]: Madam Acting Speaker, thank you for the opportunity to contribute to this debate on the Voluntary Assisted Dying Bill 2019, especially given that I am the last speaker before the Minister for Health replies. After hearing the many life experiences recounted by members in this debate so far, I consider myself lucky that in my life I have not had the experience of a close friend or family member dying after prolonged disease or suffering. Thankfully, my fiancée, parents, uncles and aunts are well and truly alive. The thought of a loved one dying brings me to think of my grandparents, who have all passed away. Although when they got older they had various illnesses and diseases, from what I observed none of them suffered greatly in their last months, weeks, days and hours. All had a relatively quick death without the prolonged suffering, loss of dignity and pain that this bill aims to address and alleviate. Two of my grandparents died very quickly at the hand of morphine. In an almost unspoken understanding or covenant with family members, discussion of this was somewhat swept under the carpet at the time. However, I know that the morphine alleviated their suffering. In assessing this bill, I have to rely on the findings of and the stories and experiences related to the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying, as well as those from my constituents and from this debate. I have received many letters, calls and emails from constituents about

Extracted from finalised Hansard
the Voluntary Assisted Dying Bill and I appreciate the time they took to put their views to me. I received a large amount of correspondence urging me to vote in favour of the bill and, of course, I also received correspondence from people who do not support the legislation. The constituents who wrote to me and are opposed to the bill had three major concerns—the coercion of vulnerable people, the legislation being used for non-terminal patients and the lack of access to palliative care. I will quote some of the correspondence that I received. According to my notes, one person wrote —

Taking one’s own life, whether assisted or not, is “suicide” by definition ... When the Government spends so much on mental health care, but then takes steps to introduce a system that not only enables suicide, but actively promotes it as an appropriate response to physical or existential suffering, it says to the community: That suicide is okay; —

The ACTING SPEAKER (Ms M.M. Quirk): Member for Morley, you just walked in front of the speaker. Please continue.

Mr D.R. MICHAEL: It continues —

that people’s daily battles to live aren’t important; and, that people’s work to prevent suicide is worth nothing. We don’t prevent suicide by assisting suicide."

According to my notes, another constituent wrote —

The solution for improving end of life care is highly accessible palliative care during a time of great emotional distress, not killing patients. Wrongful deaths are guaranteed by this bill, which has even less safeguards than Victoria. No permit will be required to ensure a legal and robust process. There is no requirement for expert assessment of patient capacity.

I thank and respect these constituents for sharing their views with me, but after seeing the legislation, I believe that these concerns have been alleviated. The Voluntary Assisted Dying Bill 2019 was drafted following extensive community consultation undertaken by the Ministerial Expert Panel on Voluntary Assisted Dying. It includes strict eligibility conditions as well as 102 safeguards, with stringent measures to assess a person’s capacity and to ensure the protection of vulnerable people. This bill is more conservative and narrower in its possible application and has more safeguards than does the Victorian legislation and the legislation in most other jurisdictions with this type of legislation enacted. I do not believe that this bill is a slippery slope. The debate in this house, with a conscience vote, shows that we are more than capable of dealing with legislation on its merits and the Voluntary Assisted Dying Bill is what we are dealing with.

This bill will set up a very rigorous process in which two independent medical practitioners will be required to assess the eligibility of people seeking to access voluntary assisted dying. They must be over 18 years and an Australian citizen or permanent resident who has resided in Western Australia for at least a year. They will also be assessed as to whether their disease, illness or medical condition is advanced, progressive and will, on the balance of probabilities, cause their death within six months, or 12 months if it is a neurodegenerative condition. The patient will also be assessed as to whether the condition is causing suffering that cannot be relieved in a manner that the patient considers tolerable. Throughout this process, independent medical practitioners will assess whether a patient has decision-making capacity while also investigating any signs of coercion or pressure on vulnerable patients to end their lives. There is a requirement in the bill for practitioners who are making these assessments to also ensure that they have discussions about palliative care and other treatment options. There are 102 safeguards in the bill that strike the right balance between providing the stringent safeguards necessary to protect vulnerable people while ensuring that eligible people who genuinely wish to access voluntary assisted dying to relieve their suffering are not prevented from doing so. I am satisfied that this bill contains sufficient protections. There are those strict eligibility conditions and an assessment that the person who is seeking access to voluntary assisted dying has decision-making capacity free from coercion. They must be dying and in the final weeks and months of life and they must make the request themselves on three separate occasions—twice verbally, and once in writing and witnessed by two independent people who will not benefit financially in any way from the death of the applicant.

The ACTING SPEAKER: Members, there are three or four conversations going on, which makes it hard for the member for Balcatta.

Mr D.R. MICHAEL: Only qualified and suitably experienced and trained medical practitioners may assess a person’s eligibility, and they must submit all relevant information to the Voluntary Assisted Dying Review Board, which will supervise the entire process. There is a strict management regime for the voluntary assisted dying substance, including the requirement of the appointment of a responsible contact person and the introduction of several significant new criminal offences for those who act outside the legislation.

I commend the McGowan government for its commitment to bring the palliative care choice to many more Western Australians, with a $41 million commitment in the most recent state budget and over $200 million allocated over the forward estimates. I can imagine, as has been mentioned by many members, that there will continue to be a demand for these services into the future. I encourage the state government and all future state governments to continue to expand the availability of this service should someone choose palliative care in the last
stages of their life, no matter their postcode or bank balance. I hope to see palliative care beds at Osborne Park Hospital one day soon and I will continue to advocate for this given that the Morrison government did not match federal Labor’s commitment to fund this proposal in the most recent federal election.

The bill’s safeguards, the increased access to palliative care for Western Australians and the regulations around who may apply for voluntary assisted dying give me confidence that this is a conservative bill that will protect the vulnerable and is worthy of support.

I have received many letters and emails from people in Balcatta whose loved ones have been terminally ill and they have had to witness that person suffer an agonising death due to illness. In every case these constituents have encouraged me to vote in favour of voluntary assisted dying legislation. I will put on record some of the moving stories from people in Balcatta. According to my notes, one story reads —

I watched my mother die horribly of emphysema. Every breath became a struggle for her, every moment was agony. She had been a long-term supporter of the right to assisted dying, but due to the current laws she was unable to end her torment in the way she wished. I would not wish her death on anybody—it was long and hard, and intensely traumatising for her and for all who knew and loved her. When life becomes intolerable due to a medical condition, people deserve to have their wish to end the agony.

Some members may have read the story on the front page of The West Australian recently in which Joondanna resident Kate Law shared her story. She wrote —

I watched my 73-year-old mother die in distress after a long battle with breast cancer that had spread to her bones, causing many of them to break and never properly heal.

I have seen firsthand that palliative care cannot alleviate all forms of pain, leaving the patient and their family in a horrifyingly helpless situation representative of a Third World predicament.

The memory of my mum writhing in pain and begging me not to let her die like this continues to haunt me.

Passing voluntary assisted dying legislation in WA and giving people a choice to end their lives peacefully is the essence of humanity.

Another constituent shared her story in which, despite the great care given to her ill mother, the last two weeks of her life were unbearable. According to my notes, she wrote —

It was fortunate that mother was extremely well cared for and for that I am grateful indeed. Tears dried up, requiring regular eye drops, saliva failed, so her mouth had to be swabbed regularly to prevent ulcers, her body turned regularly to prevent bed sores and regularly checked for bowel and urine action. The last two weeks of her life resulted in her not accepting food but fluids were possible. Her weight dropped markedly to the point her skin was draped over her bones. Some weeks prior to the end, I pleaded with the doctor to put an end to her life. The gutless blighter was too concerned due to the possible repercussions. That legally his hands were tied. My poor old mother finally died of starvation and certainly no dignity.

I have had other constituents speak of lonely suicides or the suicide attempts of loved ones who have had enough of their suffering or, in the case of healthcare workers and emergency service personnel, who have had to experience attending such events and deal with the emotional impacts.

I will be voting in support of this bill because I am satisfied that it delivers the safeguards and protections that are appropriate to protect vulnerable people in our community.

I will be voting in support of this bill because relying on a person to starve themselves to death or to attempt suicide in another fashion is neither dignified nor humane. These personal stories have moved me. I cannot reconcile the ways in which some people are dying when we have it within our power to do something about improving their situation. Let us be clear: voluntary assisted dying is not a choice everyone will take, but let us give those who want it, or who want the peace of mind of knowing it is there if they need it and are eligible for it, a safe, compassionate and transparent framework to access.

In conclusion, I have made my mind up on this legislation based on three things: commitments I made in the lead-up to the 2017 election; the views and experiences of my constituents; and my personal values and views. In the lead-up to 2017 election, as I doorknocked just over 7 000 doors in Balcatta and received hundreds of emails, I was regularly asked about my views on voluntary assisted dying. Most of the time I did not know the views of the person asking the question so, as a candidate, I always answered with some trepidation. My email reply to the large number of emails I received on this issue was that should such a bill come to Parliament, whilst I had no moral objections on the issue, I would base my vote on the views of my electorate and ensure that any such bill would be well drafted and have adequate protections for the most vulnerable in our community.

This is the commitment I am following through on today. Given the protections I have already alluded to and the large number of other safeguards contained in the bill, some of which have been spoken about already in this debate, I am confident that the bill will protect the most vulnerable in our community. With regard to the views of
my community, I have outlined the main concerns that have been raised with me and how the bill, in my eyes, addresses those concerns. I have also tried to give the house an insight into the lived experience of some of the supporters of this legislation who live in the Balcatta electorate. Some people with terminal illnesses are killing themselves; some are refusing treatment or starving themselves; and some are dying horrible deaths. People who are suffering terribly at the end of their lives should have the right to choose.

I support this legislation because I agree with the majority of views expressed to me by the people in my electorate. My decision was not based solely on community support of voluntary assisted dying; this issue is far too important to be just a popularity contest. However, it is important to mention that every published poll on this issue has shown that an overwhelming number of Western Australians support voluntary assisted dying. Of the constituents in the electorate of Balcatta that I have had contact with, the vast majority I have spoken to or who have written, called or emailed me, support this legislation. In choosing to support this bill, I know that I will however disappoint those in my community who have deeply held views in opposition to the bill. Please be assured that I respect your views and acknowledge what this debate means to you.

Finally, my personal views. Those who know me, know that I strongly value fairness, kindness and compassion. My moral code is that all sentient beings should be free from fear, pain and suffering. I am absolutely convinced that some humans, as sentient beings, are being subjected to unnecessary fear, pain and suffering at the end of their life, and that there is no level of pain relief, sedation or other palliative care that can remedy that. That is why I support this legislation, and that is why I commend it to the house.

MR R.H. COOK (Kwinana — Minister for Health) [9.03 pm] — in reply: I take great pleasure in concluding the second reading debate on the Voluntary Assisted Dying Bill 2019. I begin by thanking all members for their contributions. The leaders on both sides of the chamber called for civil, respectful, compassionate contributions from all members, and I think we have done ourselves proud; we have done a particularly good job. I particularly acknowledge those members who have shared difficult personal stories: the member for Scarborough, the member for Central Wheatbelt, the member for Murray–Wellington, the member for Kalamunda, the member for Fremantle and others who shared firsthand accounts of the death of loved ones, including both good and bad deaths. This has not been a particularly easy debate for many members, and I want to acknowledge the efforts made by everyone in bringing those stories to bear in this debate.

I also want to acknowledge Belinda Teh and Noreen Fynn. Their suffering has become emblematic of the many families across the community who have borne witness to the harrowing last days of their loved ones. Both Noreen and Belinda have demonstrated great courage during the community debate, and I commend them for the way in which they have conducted themselves.

The evidence is clear: complete relief of suffering is not always possible without optimal palliative care. To argue that palliative care achieves complete relief is to deny the reality of those who have shared with us their personal experiences. Palliative care is the solution for nearly everyone; I think that has been accepted and acknowledged, but it is not the solution for all people when it comes to end-of-life experiences. It is also clear from the evidence that compassionate assistance is already rendered to those for whom death is imminent, but such assistance is reliant on the decision-making of a medical practitioner, with no safeguards and no consent.

When suffering cannot be relieved, this bill will provide a safe and compassionate way to access voluntary assisted dying, and it will do so in a way that provides a choice—a choice based on enduring consent, and a choice that, if faced with such suffering at the end of their life, the vast majority of Western Australians have indicated they want such patients to be able to consider.

Friedrich Nietzsche said —

One should die proudly when it is no longer possible to live proudly.

I paraphrase the member for Vasse—and I apologise if I massacre the line—who said we need to have a right to die with dignity because living with dignity is no longer an option.

This bill would not have been possible without the diligence and thoughtful deliberations of the cross-party Joint Select Committee on End of Life Choices, chaired by the member for Morley, with significant inputs from others, including the member for South Perth. I would also like to acknowledge the remarkable work of the Ministerial Expert Panel on Voluntary Assisted Dying led by chair, Malcolm McCusker. I might observe that, contrary to some commentary, it is not correct to say that the panel did not invite comment from those opposed to this bill. The panel welcomed and indeed heard contributions from those who are opposed to voluntary assisted dying in relation to the specific elements that informed workable legislation.

I might also say that the member for Cottesloe’s comments—that the common and unequivocal view of palliative care experts is that there is never a clinical reason for a person to experience pain when dying and that pain at the end of life comes about through a lack of palliative care specialists—are not borne out by the evidence. Australian data from the Palliative Care Outcomes Collaboration shows that a small percentage of people, even those being cared for in specialist palliative care services, experience pain at the end of life. It is also clear that people are motivated to

Extracted from finalised Hansard
request voluntary assisted dying for a range of complex reasons, which are not specific to pain management only. Professor Kathy Eagar told the ABC that when it came to choosing euthanasia, pain did not make it into even the top five reasons; the most common reason is the person not wanting to lose their independence and autonomy.

The premise of this bill is not, as one member stated, that an ideal version of death is a controlled death. The purpose of the bill is to provide choice, for an expected small number of people already nearing the end of their life, over the timing and manner of death. Voluntary assisted dying does not preclude or prevent palliative care; these are not either/or choices. We are considering the compassion we show to those people for whom palliative care does not relieve suffering. The provision of voluntary assisted dying in Western Australia will be part of a continuum of end-of-life care choices available to the Western Australian public; it is not instead of palliative care. People need to bear in mind that there is always more we can do in palliative care and there is always more we can do in health, and we must endeavour to do so.

A number of members commented that we need to do more for palliative care, especially in the regions. The government is doing more and providing record levels of funding. Across the forward estimates, $206.2 million has been invested in palliative care. Of this, a total of $58.9 million will be provided to regional services. The total funding for community palliative care in 2019–20 is $47.2 million, up from $38.7 million in 2016–17. This level of funding stands in stark contrast with previous investments in palliative care services in Western Australia and represents a significant uplift in our efforts. This bill is not about voluntary assisted dying instead of palliative care. As the member for Morley noted, Palliative Care Australia’s own survey of international jurisdictions demonstrates that in those jurisdictions where assisted dying is lawful, palliative care services have been significantly boosted.

Some members referred to WA having a low number of inpatient palliative care beds. I simply want to put on the record that this fails to take into consideration the unique service arrangements we have in Western Australia. Western Australia is the only jurisdiction in the nation to fund the Silver Chain hospice care service in the way that we do to provide specialist palliative care services in the community. It is a model that other states are looking to replicate. The Silver Chain hospice care service in Western Australia provides community and consultation services along with specialist palliative care in-home services across the Perth metropolitan area and is extending into the regions. The Silver Chain hospice care service has demonstrated reductions in hospital-based care, reductions in length of stay, and increased likelihood of dying out of hospital. As all members would have seen in their research, the overwhelming preference for people facing their end-of-life situation is that they die at home surrounded by loved ones.

In the 2019–20 budget, total funding allocated to Silver Chain for palliative care was $22.5 million. The state government is currently considering funding for Silver Chain in accordance with the joint select committee’s recommendations in its “My Life, My Choice” report. Members, particularly the member for Kimberley and the member for Kalgoorlie, raised the point that some Aboriginal communities experience a lack of access to culturally appropriate local palliative care and that it is important for Aboriginal people to be given the opportunity to die on country, and for the configuration of those services to take into account collective decision-making. I want to familiarise members with the work done by the ministerial expert panel in its quite extensive consultations with the Aboriginal community. Advice was sought from the Aboriginal health policy directorate in the Department of Health and the Aboriginal Health Council of Western Australia regarding the approach to consulting Aboriginal stakeholders. The information was provided to participants at the AHCWA state conference in March this year. An information session was held with the AHCWA CEO network in April this year. As members would know, the network of Aboriginal-controlled community health organisations is extensive. AHCWA also provided a written submission to the Ministerial Expert Panel on Voluntary Assisted Dying. I spoke this week with the chair of AHCWA who, once again, committed the council’s support for this legislation.

Improving access to culturally appropriate palliative care provided in the person’s place of choice forms part of priority 1 of the “WA End-Of-Life and Palliative Care Strategy 2018–2028”. The government accepts that it is important to consider the needs of people from diverse backgrounds who may be from cultures that have a collective approach to decision-making. I thank the member for Kimberley for reminding us of the need to improve communications with people for whom English is not their first language. The expert panel paid particular attention to the needs of culturally and linguistically diverse people, Aboriginal people and members of vulnerable population groups, as well as those living in rural and remote areas. I anticipate that the implementation will establish a care navigator service to ensure that the needs of Aboriginal people are identified and provided for in the operation of the bill. The Department of Health is already considering the development of a care navigator model similar to that used in Victoria, with a focus on enabling access to voluntary assisted dying for people living in rural and remote areas.

The issue of coercion was raised by a number of members in this place. Some members contended that the bill does not go far enough to protect the vulnerable; that one of the practitioners should have a prior relationship with the person; and that we cannot be sure that a patient takes medication at the time of their own choice and not after coercion by a family member. It is important for members to consider these facts: repeated, independent and exhaustive reviews have shown no evidence of abuse of the vulnerable in overseas jurisdictions. Evidence from

Extracted from finalised Hansard
both Oregon and the Netherlands demonstrates that members of vulnerable groups are no more likely to receive assistance in dying, and that the demographic profile was typically people with comparative social, economic, educational and professional advantage. This regime does not of itself prey upon the disadvantaged and the vulnerable.

The member for Warren–Blackwood referred the house to the 2016 Australian Human Rights Commission report that stated —

Well drafted ‘proactive’ legislation permitting and regulating active voluntary euthanasia can deliver certainty, transparency and above all, protection to all who may be involved in these practices.

The member for Morley reminded us that this bill will protect vulnerable people in ways that do not exist now and that opponents are actually arguing for the substandard status quo to remain.

An assessment to determine whether the decision was made voluntarily and to detect coercion will form an explicit component of the mandatory training that a coordinating or consulting practitioner would be required to undertake. Medical practitioners will have experience in determining that a person has not been unduly influenced by health professionals, friends or family, via longstanding application of consent to treatment processes. A requirement for a person to have a prior relationship with one of the practitioners could unfairly exclude someone whose usual practitioner refuses, conscientiously objects, is ineligible or has not undertaken the training. This would be a significant access and equity issue for people in regional and remote parts of Western Australia.

The bill includes safeguards to ensure a person is acting freely. Clause 15(1)(d) provides that the eligibility criteria for voluntary assisted dying include the requirement that a person has acted voluntarily and without coercion. Clauses 23 and 34 provide that a person is required to be assessed against eligibility criteria by two independent medical practitioners. Clauses 27(2)(a) and 38(2) provide that if the medical practitioner is not satisfied that the person is acting voluntarily and without coercion, they must assess the person as ineligible. Clauses 25(3) and 36(3) provide that if the medical practitioner is unable to make a determination on this matter, they must make a referral to a person with the appropriate skills and training to make that determination. Clause 54 requires that the medical practitioner must be satisfied the patient is not being coerced prior to the issuing of a prescription. Clause 58(5) also requires this prior to administration in the case of practitioner administration. The bill provides that an application may be made to the State Administrative Tribunal for a review of a decision that the person is acting voluntarily and without coercion. The process is suspended whilst the review application is determined. The SAT has indicated that it would attempt to resolve the matter in an expeditious manner.

Express offence provisions reflect that coercion will not be tolerated in relation to voluntary assisted dying. Severe penalties, ranging from a summary conviction of three years’ imprisonment to life imprisonment, have been drafted. The bill makes it clear that the parens patriae jurisdiction of the Supreme Court is not excluded. The Supreme Court may, in the exercise of its parens patriae jurisdiction, make orders for the protection of vulnerable people, such as children, the mentally ill and the elderly.

Some in this chamber have made the suggestion that voluntary assisted dying will be seen as a solution to dealing with the complex issues of ageing and dying and that there could be a temptation to avoid costs and complexity by encouraging people down this path. The member for Girrawheen raised concerns that these laws will be seen as a way out for those who have outlived their usefulness. This bill does not address the concerns related to aged care or quality of life in older Western Australians. It sets out to provide choice for a small number of people who have a life-ending illness and are nearing the end of their life in the timing and manner of their death. A review of the aged care sector in Australia is currently the focus of the Royal Commission into Aged Care Quality and Safety. The Western Australian government is committed to preventing and addressing elder abuse. One of the four priority areas outlined in the “Draft WA Strategy to Respond to the Abuse of Older People (Elder Abuse)” is to support older people to remain socially connected and to provide avenues to seek help. A further priority area is to safeguard and support older people with accessible support and justice responses. The government also funds an elder abuse helpline, which provides confidential advice and information to protect themselves and others from elder abuse. The Alliance for the Prevention of Elder Abuse: Western Australia, a collaboration between the departments of health, local government and communities, has a 2013 elder abuse protocol that includes guidelines for action and sets out emergency and non-urgent referral pathways. The mandatory training provided under the Voluntary Assisted Dying Bill will include the identification of risk factors for abuse.

In relation to safeguards, some members have incorrectly asserted that there are fewer protections than in the Victorian law. I can assure members that this is just not true. As an example, the permit system in Victoria, which a number of members have referred to, does not offer any further protections. It is a bureaucratic layer that already exists in the health system for medicines and poisons. The WA bill reflects practices consistent with how medicines and poisons are issued in this state. We already have our own permit and authorisation system. There is no need to replicate it in this bill. Furthermore, the bill applies tighter restrictions to the voluntary assisted dying substance. Whereas the Victorian legislation uses the permit system to authorise particular acts, the WA bill expressly authorises them in legislation. The Voluntary Assisted Dying Bill 2019 is amongst the most conservative and restrictive in the world. It is important to remember that safeguarding is about doing everything possible to keep people safe, without diminishing their human rights.

Extracted from finalised Hansard
I acknowledge the comments of the member for Moore about patients who are suffering from dementia or other cognitive degenerative disorders. I think it is fair to say that we could not, in all conscience, satisfy ourselves that that person could meet the decision-making capacity criteria.

The member for Morley rightly reminded us all that terminal sedation may be undertaken without consent and that the 10 per cent of suicides related to chronic or terminal conditions are the current wrongful deaths that members are keen to avoid. Neither of these outcomes should be acceptable to members.

A number of members, and in particular the member for Armadale, raised the issue that a medical practitioner should not be allowed to raise voluntary assisted dying as part of the patient care options. I think it is fair to say that the panel carefully weighed the outcomes of the consultation on this issue. In fact, I will quote from the panel’s report —

The Panel carefully weighed the outcomes of the consultation and knowledge of other jurisdictions, with the unique cultural circumstances of Western Australia in its deliberations on this matter.

The Panel believes that health practitioners have a professional obligation to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying.

The Panel acknowledges the position of the Joint Select Committee and agrees that health practitioners should not be restricted in their ability to have comprehensive end of life discussions with patients, including that there be no prohibition on health practitioners appropriately raising the subject of voluntary assisted dying.

In short, we do not believe that it is appropriate that we should second-guess the conversation between a patient and their doctor.

Concern was also expressed by the member for Cottesloe that there may be an expansion of the bill in future to give a wider range of people access to voluntary assisted dying—for example, those with dementia. As I said, the member for Moore also raised those concerns. However, as the Attorney General has already explicitly stated, this government does not, and will not in the future, support the proposal to include voluntary assisted dying in an advance request for those with dementia. Belgium and the Netherlands are often cited as examples where scope creep has occurred. Access to voluntary assisted dying in these countries has never been limited to people with a life-limiting illness; a person needs only to be suffering. In jurisdictions with more restrictive eligibility criteria and more rigorous processes, such as those in the United States, there is no evidence that the scope has been informally expanded. In the 22 years that the Oregon Death with Dignity Act has been in place, there has been a single amendment to allow the 15-day waiting period to be waived if death is likely to occur before expiry of the waiting period. The ability to waive the waiting period in some circumstances is consistent with legislation in Victoria and Canada and the proposed WA bill. However, no further amendments have been made to the Oregon legislation since it was legislated for 22 years ago.

The bill provides for the ethical, moral and professional objections to voluntary assisted dying held by some medical practitioners, but balances this with the need to facilitate timely and appropriate access to people who request voluntary assisted dying. Practitioners are not obliged to refer persons seeking voluntary assisted dying directly on, but they are required to inform the patient of their refusal and give the person information about voluntary assisted dying. Faith-based hospitals are able to object to participating in the voluntary assisted dying process for any reason, including, but not limited to, conscientious objection. A person seeking to access voluntary assisted dying may be required to transfer to a particular hospital or care facility. Practitioners at those facilities remain bound by ethical and professional obligations to ensure proper care and timely transfer. However, evidence from overseas shows that most people wish to die at home.

It is incorrect to say that clause 10 of the bill has the effect that a medical practitioner cannot tell a patient that there is a better way to be treated than to access assisted dying. This clause does not prevent a medical practitioner from informing a patient about treatment options. A medical practitioner is able to raise and discuss assisted dying with a patient. Indeed, under clauses 26 and 37, medical practitioners are required to inform the patient of all the treatment options, including palliative care. Clause 10 provides that when a registered health practitioner contravenes a provision of the legislation, that contravention is capable of constituting professional misconduct or unprofessional conduct. Professional misconduct or unprofessional conduct will be ascertained pursuant to the Health Practitioner Regulation National Law (WA) Act. The act creates a suite of offences so that a contravention of a particular provision attracts criminal liability.

With regard to mental health, a person is not eligible to access voluntary assisted dying only because the person has a mental health issue. However, having a mental health issue does not preclude a person from accessing voluntary assisted dying when they otherwise meet all the other eligibility criteria to do so. Decision-making capacity is obviously an important element and is required at every step of the voluntary assisted dying process. Determining whether a person is able to make a treatment decision is part of current professional health practice. Doctors routinely assess decision-making capacity now—decisions made by their patients to consent to or refuse dialysis, to consent to or refuse chemotherapy, to consent to or refuse surgical interventions or to forgo treatment that may result in the patient’s death. Under the bill the coordinating consulting practitioners must refer to a relevant health
practitioner, such as a psychiatrist, geriatrician or psychologist, if they are unable to determine capacity. This is the approach that was endorsed by the Royal Australian and New Zealand College of Psychiatrists in its submission to the Joint Select Committee on End of Life Choices, and I quote —

Where there is some question regarding capacity or the potential of treatable mental illness then the RANZCP WA Branch would support a framework in which it is mandatory to consider psychiatric assessment.

The bill does not overturn the fundamental legal principle that an adult is presumed to have decision-making capacity, but where there is a question, where there is doubt, the practitioner must refer for a specialist assessment.

The coordinating practitioner must also complete a final review that certifies by way of signed statement that the practitioner is satisfied that the person has decision-making capacity, is acting voluntarily and without coercion, and that the person’s request is enduring. Practitioners are required to undertake mandatory training that will emphasise the importance of referral for specialist opinion when there is any concern that a mental health issue may be adversely impacting the decision a person is making to access voluntary assisted dying. GPs already conduct detailed mental health assessments of their patients for the purposes of mental health care plans. These are not undertaken during short consultations, but require long appointments to enable GPs to properly assess the mental health needs of their patients.

The training package in WA will be developed in consultation with the Department of Health; key medical nursing and allied health stakeholders and experts; palliative care and end-of-life stakeholders; and cultural stakeholders and advisers and consumer community representatives. Training will be informed by the mandatory training program in place in Victoria, noting that there will be different and additional requirements in Western Australia. The Royal Australian College of General Practitioners will be involved in the development and accreditation of training to ensure that it is effective and meets required standards. In addition, in its submission to the Joint Select Committee on End of Life Choices, the WA branch of the Royal Australian and New Zealand College of Psychiatrists noted, and I quote, “psychiatrists are well placed to support upskilling colleagues” in relation to capacity assessment. The training will contain competency assessments and a successful pass is required for the training requirements to be met.

Mentoring programs and support networks will be vital for providing support not only to medical practitioners but all health professionals involved in the voluntary assisted dying process, including those who decide not to participate. Frameworks for establishing and encouraging growth of these support systems across the state will be developed during the implementation phase in consultation with key medical, nursing and allied health stakeholders. As in Victoria, it is likely that mandatory training will include advice on self-care for medical practitioners, as well as information on where to access support services.

All of us in this chamber are aware of the challenges in delivering world-class health care across the single largest jurisdiction in the world. The bill has been drafted in full awareness of the challenges faced by regional Western Australians and seeks to enhance accessibility through the inclusion of nurse practitioners and provision of the appropriate use of technology. Although we acknowledge the challenge of service access equity across rural and remote WA, it is not the purpose of the Voluntary Assisted Dying Bill to address underlying issues related to access to health services. During the implementation, the government will work closely with regional stakeholders such as the WA Country Health Services, the WA Primary Health Alliance, the Australian College of Rural and Remote Medicine, the Australian College of Nurse Practitioners and other relevant stakeholders to facilitate access for rural and remote Western Australians.

Members have sought clarification regarding the use of telecommunications in the request and assessment process given the commonwealth legislation that is in place. The Department of Health is aware of the provisions of the commonwealth Criminal Code Act 1995 about the use of carriage services for suicide-related material and the instruction given to medical practitioners in Victoria. The commonwealth provisions were introduced to deal with the phenomena of cyber-suicide and pro-suicide websites. Section 474.29A prohibits a person from using a carriage service for suicide-related material, including material capable of constituting a communication which directly or indirectly counsels or incites committing or attempting to commit suicide. Section 474.29B prohibits a person from possessing, controlling, producing, supplying or obtaining suicide-related materials for use through a carriage service. State legislation cannot override commonwealth legislation. The Department of Health has taken the view that voluntary assisted dying is not suicide. Clause 11 of the bill states as such. This view is supported by the Department of Justice. Furthermore, the Department of Health has taken the view that the commonwealth provisions were not intended to include circumstances related to voluntary assisted dying. This view is supported by the Department of Justice.

There has been some preliminary communication between the Department of Health and the commonwealth Attorney General’s department. The Western Australian Attorney General has written to the commonwealth Attorney General to ascertain the commonwealth government’s position with a view to seeking an undertaking that the commonwealth will not prosecute or that it will take steps to amend the Criminal Code Act 1995 to

Extracted from finalised Hansard
Some members of this house who are opposed to the bill contend that prognosis cannot be predicted—that there is uncertainty on when a person will die when they are in the final stages of a terminal illness. The member for Cottesloe asserts that scientific literatures supports the overestimation of life expectancy; however, there are a large number of occasions when the prognosis is overly pessimistic, and, further, that safeguards on prognosis will be eroded over time. The truth is that studies show that in most instances doctors are overly optimistic about survival following those who make accurate predictions, and a doctor is shown to be overly pessimistic in only the minority of instances. This is made clear in the 1 December 2016 volume of the Journal of Palliative Care & Medicine.

The Voluntary Assisted Dying Bill 2019 specifies that a person will be eligible for voluntary assisted dying only if two medical practitioners have completed the approved voluntary assisted dying training, independently determined along with other criteria that the person is diagnosed with a disease, illness or medical condition that will cause death, and that it will on the balance of probabilities cause death within six months or within a period of 12 months in the case of neurodegenerative conditions. There is no evidence to suggest that the safeguards on eligibility will be eroded over time. In jurisdictions with more restrictive eligibility criteria and more rigorous processes such as those in the US, there is no evidence that the prognosis requirement has been formally or informally expanded.

The member for Dawesville asked how the person will be identified and satisfy the demographic requirements. It is a requirement of the bill that the coordinating consulting practitioners must be satisfied as to the residency status of the patient as part of the assessment against the eligibility criteria. In practical terms, this may include review of the Western Australian driver’s licence or other such documentation that establishes the person’s identity and residency.

The member for Vasse asked how voluntary assisted dying will be funded and what are the expected costs. As outlined in the bill, a range of medical practitioners will be eligible to provide services—clause 16—as well as limited scope for nurse practitioners to provide services, outlined in clause 53.

Funding for individual services will need to be compliant with current Medicare billing guidelines. Although some standard consultation items may be applicable, it is recognised that the time invested by practitioners may exceed that which is usually provided for and will need to be further addressed during implementation planning. I anticipate that patients will be subject to the usual Medicare billing arrangements as would normally apply when seeing a doctor.

During the implementation phase, a clinical expert panel will be convened to determine the appropriate schedule 4 and 8 substances and protocols for voluntary assisted dying, as raised by the member for Darling Range. The pharmaceutical benefits scheme is a commonwealth scheme that lists medications available to all Australian residents who hold a Medicare card at a government-subsidised price. It is expected that the voluntary assisted dying medications would not be on the PBS, and I anticipate that the cost of voluntary assisted dying medications will be covered by WA taxpayers, as is occurring in Victoria. Until such time as the specified medications are determined by the clinical expert panel, the cost to the state cannot be confirmed.

The member for Dawesville also raised a question about the level of coordinating consulting commerciality that may exist with practitioners. Based on overseas evidence, the rate of people accessing voluntary assisted dying ranges from 0.4 per cent in Oregon to four per cent in the Netherlands. Given that this bill is reflective of the Oregon framework—that is, a person must be dying and their death will probably occur within six months—it is more likely that our rates of voluntary assisted dying deaths will be closer to Oregon’s rates. Given those very low rates, voluntary assisted dying will not be a commercial prospect for any health practitioner.

Members have raised the issue of handling and safety of voluntary assisted dying substances. For medication, the bill includes requirements that are consistent with the Medicines and Poisons Act 2014 and also specifies additional requirements. The Medicines and Poisons Act 2014 and regulations specify the requirements for the safe transport, storage and disposal of medications. The Voluntary Assisted Dying Bill 2019 includes additional requirements to ensure the safe and secure management of voluntary assisted dying medications in a way that can be appropriately tailored to a patient’s appropriate situation. Before prescribing the voluntary assisted dying substance, the prescriber must provide the patient with information on appropriate storage, preparation, how to self-administer and, if necessary, disposal of any unused or remaining substance. Clause 71 provides that when supplying a prescribed substance, the authorised supplier must also provide the same storage, preparation, administration and disposal information to the recipient. Clause 73 provides that medication supply be notified.

Extracted from finalised Hansard
to the Voluntary Assisted Dying Board as well as registered according to the existing requirements of the Medicines and Poisons Act 2014 and regulations. Provisions of this act have been included in the bill to provide a high level of safety and ensure compliance. A police officer or an investigator appointed by the CEO can investigate noncompliance.

In WA, schedule 4 and 8 poisons, which will make up the voluntary assisted dying substances, are already dispensed to people without the legislative requirement of a locked box. All medications should be stored securely. The requirement for medications to be dispensed in locked boxes may introduce problems for patients with poor manual dexterity. Patients who are often confined to bed may be able to self-administer medications, but may not be able to locate and open a box. Furthermore, governance and locations of the key to the locked box potentially misplacing confidence in the integrity of the security offered by the locked cash box, as used in Victoria, may be an issue.

I will provide further detail on the medication processes at the consideration in detail stage. A number of members have raised the issue of pharmacy dispense and control. We anticipate that we will operate a hub-and-spoke model for the prescription of medications and dispense and disposal of any unused medications for regional and remote patients.

The member for Cottesloe indicated his concern about the nine-day time frame for a reflection period. The length of the reflection period is intended to strike a balance between minimising the time a person is suffering and ensuring sufficient time has passed to demonstrate that the request is enduring. The addition of a qualification period may unnecessarily extend a person’s suffering.

A number of members raised the issue of what is on the death certificate, including the member for Kalgoorlie. The intent of this provision is that the voluntary assisted death will not be listed on the medical certificate or the public death certificate as the cause of death.

I will go to other points at the consideration in detail stage. However, I reiterate to members that this is a watershed moment for the chamber and it is within our power to be courageous, compassionate, decent and fair. The bill offers a beacon of hope for those in our community who experience unnecessary suffering at the end of life. It is an exemplar of safety, freedom and individual autonomy. I reflect on the comments by the member for Midland who commented that no man is an island and that economic, legal and social constraints constrain us all, and we do not have unlimited liberties as individuals. However, through carefully crafted legislation, we can provide this liberty. We can provide someone whose death is imminent and whose pain and suffering is unbearable with a dignified end-of-life choice.

Those who satisfy all the eligibility criteria and who undergo a stringent assessment process will be free to choose. Those who are already dying will be free to end their life in a humane and dignified manner. Freedom is one of the deepest and noblest aspirations of the human spirit. Members, we must have the courage and the confidence to uphold these freedoms for the most vulnerable amongst us. Let us resolve that we as members of this Parliament will not abuse the trust of the community, the trust of more than 88 per cent of Western Australians. Many members have said that we have not done enough and that it is too early, but I put the question to all of you: if not us, then who; and, if not now, when?

I commend the bill to the house.

**Division**

Question put and a division taken with the following result —

**Ayes (44)**

| Ms L.L. Baker | Mr T.J. Healy | Mr K.J.J. Michel | Ms C.M. Rowe |
| Dr A.D. Buti | Mr M. Hughes | Mr S.A. Millman | Ms R. Saffioti |
| Mr J.N. Carey | Mr D.J. Kelly | Mr Y. Mubarakai | Ms J.J. Shaw |
| Mrs V.A. Catania | Mr Z.R.F. Kirkup | Mr M.P. Murray | Mrs J.M.C. Stojkovski |
| Mrs R.M.J. Clarke | Mr F.M. Logan | Mr K. O’Donnell | Mr C.I. Tallentire |
| Mr R.H. Cook | Mr W.R. Marmion | Mrs L.M. O’Malley | Mr D.A. Templeman |
| Ms M.J. Davies | Mr M. McGowan | Mr P. Papalia | Mr P.C. Tinley |
| Ms J. Farrer | Mr J.E. McGrath | Mr S.J. Price | Mr R.R. Whitby |
| Mr M.J. Folkard | Ms S.F. McGeek | Mr D.T. Punch | Ms S.E. Winton |
| Ms J.M. Freeman | Ms L. Mettam | Mr J.R. Quigley | Mr B.S. Wyatt |
| Ms E.L. Hamilton | Mr D.R. Michael | Mr D.T. Redman | Ms A. Sanderson *(Teller)* |

**Noes (12)**

| Mrs L.M. Harvey | Mr P.A. Katsambanis | Mr R.S. Love | Ms M.M. Quirk |
| Dr D.J. Honey | Mr A. Krsticevic | Dr M.D. Nahan | Mrs M.H. Roberts |
| Mr W.J. Johnston | Mr S.K. L’Estrange | Mr D.C. Nalder | Mrs A.K. Hayden *(Teller)* |

Question thus passed.

Bill read a second time.

*Extracted from finalised Hansard*
The ACTING SPEAKER (Ms S.E. Winton): Members of the public gallery, I would like to remind you that photographs are not permitted.

Leave denied to proceed forthwith to third reading.

Consideration in Detail

Clause 1: Short title —

Dr M.D. NAHAN: I do not want to hold up consideration; this is not a stalling scheme. I would like some background from the minister about the title of the bill. Why was this title chosen? In this debate through history we have evolved various terms such as “euthanasia” and “assisted suicide”. Other bills have been brought to the upper house that had the word “euthanasia” in them. During their second reading contributions, many members raised the issue of the definition of “euthanasia”. A comment from one of the minister’s expert advisers was that the words “voluntary assisted dying” were chosen because of the pejorative nature of the definitions “euthanasia” and “assisted suicide”. Could the minister give us some reasons for “assisted dying” being used in the title? “Assisted dying” could mean many things. Palliative care is sometimes used to assist in the dying process. It is used to help address the pain caused by a disease that will lead to death, as is psychiatric treatment and a whole raft of other activities that, by the way, the government is quite rightly pursuing outside this bill. During my second reading contribution, I applauded the minister for doing that. It is a very good idea. Could the minister give us a rundown on why this title was chosen?

Mr R.H. COOK: It is a very important question. We are reflecting the language that has been used in Victoria. In some respects, that has become the modern nomenclature, for want of a better reason. I am advised that euthanasia, as I think the member pointed out in his speech, is a situation in which death is induced to relieve suffering. I have often said to folk that in modern times the word “euthanase” has become the transitive verb; that is, to euthanise is to do something unto someone else. It has had significant connotations. Historically, it has reflected the abuse of involuntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value; that is, they are doing the relieving, if you like.

More recently, most people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. It is commonly used nowadays in that field as something that we do to a pet to relieve it of its suffering, whereas voluntary assisted dying is explicitly a process during which someone acts of their own free will in their own suffering. When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient. By contrast, voluntary assisted dying, as I said, is a process that is requested and led entirely by the person involved.

The member mentioned suicide. Obviously, we make a very strong distinction with suicide. Suicide connotes loss of life of a person who is typically not dying or in circumstances that are often tragic and when the person feels socially or emotionally isolated. Voluntary assisted dying involves a person’s choice about their mode of death, not about whether they will die. Their death is imminent and inevitable. From that perspective, we are making a very firm distinction that this is not an exercise in suicide or of euthanasing someone; it is about someone exercising voluntary assisted dying in their own regard.

Dr M.D. NAHAN: There are two operative actions under this bill. The primary one is to give a terminally ill person facing imminent death the tools—the poison, if you wish—to end their life. In certain conditions specified in the bill, the bill also allows a physician, a doctor, or perhaps under rare circumstances a nurse, to give the poison to the patient. I am not going to push this but I strongly believe and want to make the point that we are dealing with something important and the title should precisely describe what we are dealing with. That is my point. In the former, it is to assist someone to die voluntarily in their own time and to commit suicide. I am not using that in a pejorative sense. The other one is to have a physician effectively end a person’s life under the common definition of the word “euthanasia”. Other people have pointed out that there are quite a few definitions of euthanasia. It is very broad. In its Greek translation, I think it would be suitable, but who translates Greek?

Several members interjected.

Dr M.D. NAHAN: The member for Hillarys does—Ancient Greek!

The language has changed over the centuries, though not in this case. Is it more precise to use “euthanasia” and “assisted suicide”, which are commonly used? During my review of the literature in recent times, when this issue has been debated around the world, those were the terms used. “Assisted dying” is not precise. “Assisted dying” has a whole raft of tools, including palliative care, that are not the focus of this legislation.

Mr R.H. COOK: I appreciate the technically descriptive way in which the member has approached the title. As I said, for the reasons I just outlined, we do not believe that this is euthanasia and it is certainly not suicide. In this context, we are trying to describe it in a more respectful and contemporary way. As I said, in the modern context of euthanasia, it is primarily described as something that someone does to something else and most commonly something that people do to a family pet, whereas this is not reflective of that. It certainly cannot be characterised in...
[ASSEMBLY — Voluntary Assisted Dying Bill 2019]

that way. This is not suicide. Suicide is when someone takes their life for reasons beyond their medical condition—
they have simply lost the will to continue living. It is not because they have a life-determining condition. From
that perspective, suicide is certainly not appropriate. Voluntary assisted dying is the most thoughtful and respectful
title, and we want respect and dignity to be a central value of this bill.

Mr P.A. KATSAMBANIS: I was not intending to speak on clause 1 because I accept the proposition that the
minister made in his first set of remarks; namely, that over time language can change. The word “euthanasia”
proves that. The member for Riverton referred to Ancient Greek. In Ancient Greek, it was “eu thanasia”. “Eu” means
good, kind or graceful and “thanasia” is the extension of the Greek word “thanatos”, which means death. It is meant
in its original use as a good or graceful death. It had nothing to do with a death that was induced. It simply means
someone who died well, for want of a better word, and they could have died well at the expiry of their own life. It
has come 2 400 years later to mean as it was defined on page 20 of the Joint Select Committee on End of Life
Choices report, which states that the definition of “euthanasia” is given as meaning the intentional termination of
the life of the person by another person to relieve the first person’s suffering. That is when I join forces with the
member for Riverton in the sense that I think that is a well-established and well-accepted term.

Euthanasia is considered to be the intentional termination of a life of a person by another person to relieve the first
person’s suffering. People can say that that has become pejorative and that they would like a less pejorative term,
and other people would say that the government should use the term that is in common use. I will not get into a debate
about that. I was concerned that in the minister’s first contribution on this point, he suggested—I am paraphrasing
and the minister will correct me if I am wrong—that suicide is someone taking their life when they were not going
to die anyway. If that is the case, that is a serious misrepresentation of suicide. Suicide is someone taking their
own life—full stop. Period. That is suicide—someone taking their own life. It is not someone taking their own life
when they are not dying or might not be dying. It is someone taking their own life—full stop. Period. Let us stop
playing with, and twisting, words. We have had a pretty respectful debate. We have our different views. However,
I do not think there is any use at all in trying to play around with words. If the minister said that colloquially and
did not mean it, I would welcome him correcting the record, because it is not a statement that should stand on the
record. If I misheard or misinterpreted him, again, I apologise for that.

Since we have come to this debate, given that it was the Joint Select Committee on End of Life Choices that
defined “euthanasia” as meaning the intentional termination of the life of a person by another person to relieve the
first person’s suffering, and given that there is a clear understanding of that term, why has the government chosen
to not use the term? Obviously using the word “voluntary” distinguishes it from involuntary or any other type of
euthanasia. It is a deliberate choice. Why has the government chosen to go away from the Joint Select Committee
on End of Life Choices’ own position on this? I do not like us somehow or other trying to hide what will really
happen. As the member for Riverton said in his contribution, under this legislation, people will be able to die in
two specific ways. One way will be to request a poison that they will ingest. They may self-administer it or take it
home. They may request the assistance of someone they know in the comfort of their own home. As has been
proven in jurisdictions in other parts of the world, the other way is for them to request a physician to administer
the poison to them. That is not anything other than the intentional termination of a life of a person by another
person in order to relieve the first person’s suffering. That is euthanasia. Why are we shying away from that term?

The ACTING SPEAKER (Mr R.S. Love): Minister, before you speak, Attorney General and Minister for
Emergency Services, if you want to have an animated discussion, could you take it outside?

Mr R.H. COOK: Thank you, member for Hillarys. I do not necessarily disagree with what the member is saying,
and I take note of his learned response about the origins of euthanasia. As I said to the member for Riverton, the
modern usage of the concept of euthanasia is that it involves an involuntary act. I accept the member’s advice on
the origins of the term. Modern usage of the term euthanasia often connotes an involuntary exercise—that is, the
doing of one thing to another person. From that perspective, the debate in this area has moved away from the
language of euthanasia. I do not doubt that the member can find reports, and I think I have quoted from reports
from just a few years ago, that still use the term “euthanasia”. I am sure we can all find such reports, but, ultimately,
I think that the community has moved on in terms of that language because of the way I said it was described. As
I said, suicide connotes the loss of life of a person who is typically not dying and in circumstances that are often
tragic and the person feels socially or emotionally isolated. The phrase “voluntary assisted dying” emphasises the
personal volition and decision-making of the individual involved. Ultimately, the term is consistent with the
language used in the Victorian legislation, and the language used by the joint select committee and the ministerial
expert panel. From that perspective, we are continuing that approach.

Dr M.D. NAHAN: This will be my last comment on this issue. We heard many contributions from members on both
sides who said that one of the reasons for this legislation is that people who are in great pain and are facing terminal
illnesses commit suicide to end their lives. They do so because of pain and the terminal nature of their diseases. We
all heard many members describe as suicide. I think it is incorrect, in the context of this debate, to define suicide
as one person taking their own life not because of terminal illness. The member for Hillarys made it quite clear that
suicide is defined as one taking their own life—full stop—for whatever reason. We heard many statements in which
members gave statistics and said that one of the reasons for this bill is for people not to have to take their own lives

Extracted from finalised Hansard
under painful or long and drawn out processes, such as starving themselves or the use of firearms. I do not think it is accurate to say that the definition of the word “suicide” is restricted to those who take their lives but do not have a terminal illness. Again, words are precise; the English language is the most intricate language on earth and we are dealing with an issue that I think requires precision. One of the criticisms or concerns about the bill is its lack of precision and the need to be precise and restrictive on its application. If we use words to sell it rather than words to define it precisely, we could very easily get lost. I think, with all due respect, the minister is not defining “suicide” properly, and I think “euthanasia” fits this bill quite precisely. Nonetheless, I will sit down now and move on.

Mrs A.K. Hayden: I want to go back to the term “involuntary euthanasia” and ask the minister where he got the information to make him believe that the community has moved on from the term “euthanasia”. Everyone in this place has been out there talking to their communities, their constituents, family and friends. When I talked to them about voluntary assisted dying, they looked at me in puzzlement. When I told them what it is, they said, “Oh, you’re talking about euthanasia.” People in general in the community understand what the word “euthanasia” means, and I do not necessarily agree with the minister when he says that the community has moved on from that language and that they now call euthanasia “involuntary euthanasia”. I do not know where that has come from; I do not know which community is telling the minister that, but I can tell him that the community I speak to understands the word “euthanasia”. Voluntary assisted dying is a new term that is being put out there. As the Joint Select Committee on End of Life Choices said, and the member for Hillarys outlined, they even have the meaning of euthanasia as being exactly what this bill intends to do, which is the termination of the life of a person by another person in order to relieve the first person’s suffering. I am really confused and concerned, because this is legislation that everyday citizens are going to have to understand and get their heads around. This will affect people who do not have access to palliative care or the internet, especially in regional and remote areas. They are going to be confused. Why are we confusing the language and making it even more difficult for vulnerable people by not letting them know up-front the intention of this legislation?

Mr R.H. Cook: I thank the member. As I said in an earlier response, we are informed by the work of the Joint Select Committee on End of Life Choices, which held more than 81 hearings, and we are informed by the Ministerial Expert Panel on Voluntary Assisted Dying, which undertook the most extensive consultation process ever conducted by WA Health in relation to all facets of this bill. In that regard, “voluntary assisted dying” is clearly the language that has been used throughout all those processes. Victoria, as I mentioned to the member for Riverton, also uses “voluntary assisted dying”.

I was listening to a sports report the other day and there was a racehorse that broke down in a race. At the end of the report, they said that the horse had been euthanased. That is essentially what has become the common usage of the term, so I simply make that observation. With regard to what gives me the confidence to use the term “voluntary assisted dying”, it was the joint select committee, which undertook an extensive process, and the ministerial expert panel, which undertook an even more extensive process of consultation with the community. In that sense, “voluntary assisted dying” is very much the modern language that is used to describe this process.

Mr J.E. McGrath: I might be able to help the minister because I know a lot of people refer to it as euthanasia, but I recall the member for Nedlands’ speech today. He undertook a survey of his electorate and I think the first question was: do you understand what voluntary assisted dying is? I think 98 per cent of those very wise people from Nedlands said yes. We are going into semantics a bit here. I was a member of the select committee and we discussed this at length. Voluntary assisted dying is the best title for the bill. It is used in other jurisdictions, including Victoria.

This is not suicide. If I wanted to commit suicide, I would just walk outside and throw myself in front of a car. That would be suicide. If I want to participate in voluntary assisted dying, I have to go through a process. No-one who commits suicide goes through a process and says to the wife, “You go off to the shop and when you come back, I will be hanging in the garage.” It does not happen. People just make a decision, for all sorts of reasons, to end their life by suicide. People will have to make a conscious decision to go through that process in a proper way. There is no way that this could be referred to as suicide.

Euthanasia is a little different. As the minister said, an animal is put down when it is in great pain. That is euthanasia. If a person who wants to end their life goes through the process and they are deemed to have full capacity and they are in fact dying—it is not that they are not dying; they have to be dying within six months—it is certainly not euthanasia. It is something that they choose to do. Very strict guidelines have to be adhered to. In some circumstances—there will not be many—they will be able to get some assistance if they cannot actually take the substance themselves. We have to move on from this. People understand what voluntary assisted dying is about. They cannot be under any misapprehension about what we are talking about. When someone is asked whether they support voluntary assisted dying, they never say, “What do you mean?” They say “Yes” or “No”.

Mr S.K. L’Estrange: “Euthanasia” is defined on page 20 of the Joint Select Committee on End of Life Choices report. It states, in part —

Euthanasia means the intentional termination of the life of a person, by another person, in order to relieve the first person’s suffering.

Extracted from finalised Hansard
That is the definition. The minister agrees with that definition because he just said that the joint select committee and the ministerial expert panel went to a lot of trouble to define it. They have defined it—it is clear. The issue here is the aspect of “voluntary”. Euthanasia is euthanasia; it is defined. “Voluntary” means the person saying they want euthanasia. That is the distinguishing point here. That is not in dispute. In answer to an earlier question by the member for Darling Range, the minister made the point that the joint select committee and the ministerial expert panel had liaised with a lot of people. The minister said they had moved on from the term “euthanasia”. I asked how many people were communicated or liaised with through all of the processes that led to the bill being formed. How many people who opposed the bill agreed with the short title of the bill?

Mr R.H. COOK: I will ask the member to get back to his feet in a second just to clarify his last question. The member is quite right: we have a passion to ensure that members of the public understand that this is an entirely voluntary process. It underscores the technical nature of the bill and it underscores the principles and the value of the bill. In that context, the title reflects the approach and the outcome that we all aspire to.

In relation to the use of the term “voluntary assisted dying”, it is a term that is in common usage. It accurately describes what we are trying to do through this bill. In terms of people understanding what this is achieving in the context of other bills around the country. Victoria has the Voluntary Assisted Dying Act. The Western Australian bill has many similarities, so it is a perfectly appropriate title to use in that context. Could the member ask his final point again? I was not quite sure what the member meant.

Mr S.K. L’ESTRANGE: The point I am making is that the minister is making a lot about how this title is more appropriate. That is really what the minister is saying. The minister is saying that, in his view, this title is more appropriate than, for example, the title “Voluntary Euthanasia Bill”. The minister has defined euthanasia as being what it is. He is then saying this is voluntary, because obviously if it were not voluntary euthanasia, that would be akin to murder. “Voluntary” means that the patient has given their authorisation to participate in euthanasia. We get that. When the minister consulted the community prior to coming up with the short title of the bill, what term were the people who were opposed to the concept of euthanasia most comfortable with?

Mr R.H. COOK: Throughout this process, people have used a range of language. Voluntary assisted dying is the language that has been used most effectively to communicate with both those who support and those who oppose the bill.

Mr S.K. L’ESTRANGE: I will not labour this much longer, suffice to say that definitions are important. I do not think we should just assume that all the populace understands this term. That is particularly the case for people from multicultural and different language backgrounds. We have a set word such as “euthanasia”, which, as we have just heard from the member for Hillarys, has links to Ancient Greek times, and is defined as the intentional termination of the life of a person in order to relieve the person’s suffering. We understand the genesis of the word “euthanasia”. I do not understand why we should be frightened of that word. I think we should be positive about that word. If people choose “voluntary euthanasia”, that is their choice. That is what this Parliament has been debating for the last few years. That has not changed. I worry about the fact that the title may be picked up by a person who does not understand language as clearly as the minister does. As has been pointed out by some members, voluntary assisted dying for those at the end of life, in palliative care, is assisted dying. We know that. They are being assisted by expert staff to be cared for and made as comfortable as possible, and then they die. What we are providing in this bill is different from that. We are providing the opportunity for someone to take a lethal injection to end their life. That is very different from a palliative care approach. There seems to be a merging of what is assisted dying with what is euthanasia. That merging in itself may create confusion for people who might not be as well-read as the minister.

Mr R.H. COOK: I thank the member. I now understand what the member is saying. Certainly in our consultation process, the phrase “voluntary assisted dying” was in common usage and was readily understood by all the communities that we discussed it with. I understand the point the member is making, as indeed has also been made by the member for Riverton and the member for Hillarys. Voluntary assisted dying is a modern-day description of the process that is prescribed in the legislation, and I think it is entirely appropriate.

Mr A. KRSTICEVIC: I know that this legislation is currently in place in roughly a dozen jurisdictions. As the minister has said, Victoria is one of them. This sort of legislation around the world is pretty new. It has been around in some places for longer than it has been in others; however, it is relatively new in modern history. The minister is saying that this language is modern language. Can the minister tell me which of those 12 jurisdictions have the same title for their legislation; and, if they do not have the same title, what titles do those other 12 jurisdictions have for their pieces of legislation?

Mr R.H. COOK: No, I cannot, but I can assure the member that the Victorian legislation is titled in a similar way.

Mr A. KRSTICEVIC: The minister is saying that although we are the second state in Australia to debate this modern piece of legislation, he is not aware of the titles of the legislation in the other 10 jurisdictions in the world. I find it amazing that he does not know what the other legislation around the world is called or how it is referenced, yet he is saying that this is modern terminology. If this is modern terminology, one would assume that every other piece

Extracted from finalised Hansard
of legislation around the world that deals with this issue also refers to “voluntary assisted dying” and would not be called something that is antiquated or that people do not understand. I would expect the minister to know the titles of some of this other legislation. It is not good enough to refer to just the Victorian one, which has been introduced only recently. He should know the title of at least one other piece of legislation in the world, if there are so few of them, and why the title of our legislation is either the same or different. What makes us think that we have created this modern language?

Mr R.H. COOK: I thank the member for his long question, because it enabled me to locate the information that he is chasing. Victoria has the Voluntary Assisted Dying Act 2017. In Belgium, an act struck in 2002 is called the Act on Euthanasia. The provinces and territories of Canada have an “Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)”. Quebec has the Act Respecting End-of-Life Care 2015. The detail on Colombia is not here, but I think its regime is found in common law. I will go through a couple of others that are more straightforward. Luxembourg has the Law of 16 March 2009 on euthanasia and assisted suicide. The Netherlands has the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001. In Switzerland, there is no legislation that decriminalises assisted dying; it is a criminal offence to assist suicide only when the assister has a selfish motive, which is captured under its Criminal Code. In the United States, California has the End of Life Option Act; Colorado has the End-of-life Options Act; Columbia has the District of Columbia Death with Dignity Act; Hawaii has the Our Care, Our Choice Act; and Maine has the Death with Dignity Act. In Montana, it is done on the basis of common law. New Jersey has the Aid in Dying for the Terminally Ill Act; Oregon has the Oregon Death with Dignity Act; Vermont has the Patient Choice and Control at End of Life Act; and Washington has the Washington Death with Dignity Act. Just to summarise, only two of those jurisdictions refer to the word “euthanasia” and I think one of them was the Luxembourg legislation, which was struck in 2002. It is consistent with what I was saying. Modern acts tend not to rely upon the term “euthanasia” because, as I said, it has a range of meanings in a range of different jurisdictions nowadays.

Mr A. KRSTICEVIC: Of all the titles that the minister read out, a couple referred to “euthanasia” and some referred to “assisted suicide”; otherwise, the titles were generally all over the place. When the minister says that “voluntary assisted dying” is a modern term, is he saying that it is modern in the context of us making it modern in Western Australia and in Australia as opposed to modern on a world basis? I am trying to work out how he has come to the determination that this is modern terminology that has now taken over the world as the focus, as opposed to something that we have created in Australia.

Mr R.H. COOK: The point I am making is that it can be described in a range of ways to meet the needs of the community for which it is struck. In Australia, we have the Voluntary Assisted Dying Act in Victoria. It is the language we have used in the context of Western Australia, and I think it really aligns with the community’s expectations and views about these things.

Mr A. KRSTICEVIC: I will make just one last point and then I will leave it there. When the minister talks about the community’s expectations and views, again, like the member for Darling Range and, I am sure, many other members here, when people talk about this in my community, in my electorate, they talk about euthanasia. Nobody comes up to me and says, “Look, I want to talk to you about voluntary assisted dying”; they come up and say, “Look, I want to talk to you about euthanasia” or “I want to talk to you about assisted suicide.” The term “assisted suicide” would be used less often, obviously, but “euthanasia” is certainly used. I think the bill’s title is misleading. Yes, the ministerial expert panel and the people in the know may use this terminology, but it is not the community’s terminology. Yes, people may understand what voluntary assisted dying means because it is pretty obvious, but it is not the language that people I come across would normally use. I am trying to work out where the minister has got the view that this is the community’s language, beyond the expert panel and the people who were inside the tent who were using that language. What makes the minister assume that that is the case?

Mr R.H. COOK: I think it is language that everyone recognises. I commend the member for Carine to the second reading contribution of the member for Nedlands in terms of the outcomes of his community consultation. The term “voluntary assisted dying” also reflects the intent of the bill; that is, it is voluntary in nature and the patient has the right not to participate at any point. I understand that the member may have views that it is one thing but not the other, and he is right: people do come to this debate with a range of experiences and a range of ways of describing or naming it. I think “voluntary assisted dying” accurately reflects the intent of the bill and the framework that it prescribes.

Mrs A.K. HAYDEN: I do not want to push this any further than we have, except to say that I find it a little disappointing, because the community I represent in Darling Range—the people out there—do not refer to this as “assisted dying”; they call it “euthanasia”. I take offence at being told that this is modern terminology and this is what modern-day people, the people who are up to date with everything, use. I am telling the minister right now that people in Darling Range do not use that terminology. This legislation is meant to represent every single Western Australian, and particularly those who are vulnerable, not just those who are well-educated and learned and who live in Nedlands, with all due respect to the member for Nedlands. It is also about the people who live outside the western suburbs—who live in the eastern suburbs and regional WA. We need to make sure that when
we are delivering legislation that is this important, people do not have any doubt about what it is about. How often are we blamed by the community for talking bureaucratic—I will not say the word—rubbish nonstop, yet here we are with a very important bill with a name that sugar-coats it, because for some reason, the minister is afraid to say the words “suicide” and “euthanasia”? Call it for what it is.

Mr R.H. COOK: I thank the member for that plea with regard to her local constituents. Obviously, I think it is important that we use language that is meaningful for people. Ultimately, I think people understand that voluntary assisted dying is just that; it is voluntary assisted dying. From that perspective, with the use of that particular descriptor, I think the member’s constituents would have a very clear idea of the intent and nature of the bill. I note that Palliative Care Australia now uses the term “voluntary assisted dying”. It is simply the language used to describe the modern context in which this legislation is struck and the intent of the legislation. As we have emphasised to the chamber time and again, this is an issue around a voluntary process—that someone voluntarily seeks to have control over the manner and timing of their death in the context of an inevitable, imminent and painful terminal condition. From that perspective, I think that people understand what we are trying to communicate when we say “voluntary assisted dying”. Even with all due respect to the member for Nedlands’ constituents, I think people understand very clearly what we are describing here.

Ms M.M. QUIRK: The minister referred to the consultations that took place. It is true, is it not, that a number of questions were put to participants, but at that stage the decision to call it “voluntary assisted dying” had already been made, so it was not the subject of this community consultation that the minister referred to?

Mr R.H. COOK: As the member would be aware, the ministerial expert panel undertook a very extensive consultation process. I attended some of the consultations. People at those forums knew exactly what we were talking about when we used the language of voluntary assisted dying. I think it was very clear. We were also informed by the work of the Joint Select Committee on End of Life Choices. In that respect, I think the language in the title of the bill is absolutely appropriate.

Ms M.M. QUIRK: I am trying to confirm that at some stage between when the joint select committee met and when the consultation occurred, a decision was made that that is what the term would be. It was not the subject of any of the questions of the consultation panel, a number of questions of which are included in “Appendix 4: Consultation summary” of the expert panel’s report. There are no questions about what is the appropriate term. It is not a complicated question. I am just asking: is that the case? There was no debate on this; it was effectively decided already.

Mr R.H. COOK: I cannot vouch for whether it was already decided, but it is certainly true that we could not characterise the consultation process as a debate around the language about whether it was called one thing or the other.

Mr S.K. L’ESTRANGE: The member for Girrawheen has reinforced the point I made earlier—that is, when we are talking about the language of the short title of this bill, the minister made out that there was wide consultation. We have now discovered from the appendix included within the report that there was in actual fact no consultation on what the short title of the bill should read. It was called “voluntary assisted dying” and the government then went out and did its consultation on how voluntary assisted dying should look. It did not go out and consult the community on how voluntary euthanasia should look. That is a very important point to make. I think that the minister should show a little more respect to the people who suggest that the use of words is important in such a serious bill, and just say, “You are correct. We didn’t consult on the name. We came up with the name and then we went out and consulted.” That would at least satisfy the record that that is what the government actually did. If I am wrong, the minister needs to provide some evidence to support his case that the government actually consulted on what the short title of this bill should be.

Mr R.H. COOK: As the member knows, the consultation process is not one of, “What do you think the short title of the bill should be?” The consultation process is informed by many conversations that are had over a period of time. We, as members of Parliament, are then informed by the reports that are informed by that consultation process. For instance, recommendation 24 of the joint select committee states—

The Western Australian Government develop and introduce legislation for voluntary assisted dying having regard to the recommended framework and following consultation with the Panel established under Recommendation 21.

The genesis of the use of the language “voluntary assisted dying” took place some time back in that long consultation process. We would not have done justice to the consultation process had we asked the question: did we poll people whom we consulted?

Mr S.K. L’ESTRANGE: I did not ask the minister whether anybody was polled, we are simply making the point that the short title of the bill does not reflect the correct use of language, which is what the bill is all about. That is the point we are making. In his answer earlier, the minister tried to make out that it is because of consultation that the short title of the bill was formed. We are saying that there is no evidence of that. The minister has decided it will be called “voluntary assisted dying” and then consulted with the community. Earlier I asked, “What about the
people who oppose euthanasia? How do they feel about the title? Do they want euthanasia put in it?” I have not had that answered. Other members have asked different questions around the same topic, that there was not a consultation on the title of this bill. The government has created the title, which is a soft title, because it does not accurately reflect what the bill is about. We know perfectly well that when we use terms such as “voluntary assisted dying” it can be construed any number of ways, which is different from euthanasia, yet this bill is about euthanasia. The people who ask the question, “Why is that term not used in the short title of the bill?” I think have every right to ask it, because it accurately reflects what the bill is about—that is, voluntary assisted euthanasia.

Mr R.H. COOK: Member, we are informed by the consultation process, which made very clear the direction and the nature of this legislation. They want it to be voluntary and they want it to be issues around voluntary assisted dying. I am informed by the Lifeline WA position of 2013, which states —

Words can cause harm. Any linkage between euthanasia and suicide has the potential to cause harm.

We recommend that any public debate surrounding euthanasia refrains from making the link to suicide as this can provoke suicidal ideation

That is consistent with all the consultation processes that have gone on. The member says that he wants me to come up with a specific title that has been tested. The member knows that the process is not like that; it is one of a range of concepts, values and processes being consulted across the system. From that point of view, the ministerial expert panel was there to consult about safe and compassionate legislation and it recommended, amongst other things, this sort of language. It is the same language that is used in Victoria and it reflects much of what goes on in Victoria. I am not sure why people, regardless of their views about the legislation, would believe that it does anything other than just that.

Mrs A.K. HAYDEN: There are quite a few people in this room debating that the community is well aware of the term “euthanasia”. The minister has admitted that the modern terminology has come from all the community consultation and debate, yet we have now confirmed that the title of the bill was not up for consultation or debate. To ensure that there are no grey areas for the vulnerable and remote people of Western Australia who are not across the minister’s modern language and terminology, would the minister even consider, in good faith, renaming the bill by removing “assisted dying” and substituting it with “euthanasia and assisted suicide?”

Mr R.H. COOK: Respectfully member, no.

Clause put and passed.

Clause 2: Commencement —

Mr Z.R.F. KIRKUP: I understand as part of the minister’s second reading speech and again this evening in his summary, he has outlined to the house that there will be an 18-month implementation program, which I expect is captured as part of the commencement clause. Can the minister walk us through what the process and implementation of part 1 and the remaining divisions by proclamation of the bill will look like? I note that the minister has used some slight variance about the 18 months, and I appreciate that it might take a longer or shorter time. Does the minister have an understanding about what that implementation phase will look like, and from the minister’s perspective, is there an absolute minimum for the implementation of the remainder of the act, which I assume it will become at that fixed date according to proclamation?

Mr R.H. COOK: We anticipate that the proclamation date will be 18 months from the date of passage of the bill so that health services in the community can prepare for the changes. Obviously, a lot of regulations need to be put in place and, in particular, the Voluntary Assisted Dying Board will have to be constituted. We will require the establishment of a suite of new procedures to enable the scheme to be implemented properly, including the establishment of the board. In particular, it will require the establishment of the training process and the Royal Australian College of General Practitioners to ensure that it meets all its accreditation requirements. The ministerial expert panel recommended the 18 months and certainly our health colleagues in Victoria have anecdotally advised that a minimum of 18 months will be required for the implementation period. We have some advantages over Victoria, because we can learn from some of the things it has already done. We have some disadvantages because we have a different landscape both medically and geographically, so we need a regime that fits across those things. It is considered that 18 months is really the bare minimum we need to help with that process.

Mr Z.R.F. KIRKUP: To confirm, the absolute minimum would be 18 months in that case. I appreciate the language the minister has been using thus far about it being approximately 18 months. Even if the health services were very well advanced and were comfortable with implementation 12 months from assent, would we still see a proclamation stage in 18 months?

Mr R.H. COOK: That is correct.

Ms M.M. QUIRK: Minister, given that we are contemplating an 18-month implementation period, I wonder why we are hastening it through at this stage.

Mr R.H. COOK: Does the member mean the haste in terms of —

Extracted from finalised Hansard
Ms M.M. Quirk: I mean in passing this bill now.

Mr R.H. COOK: Obviously, there is a range of issues in relation to that, but as the member has just observed and I have just stated, our Victorian counterparts have advised that a minimum of 18 months will be required for implementation. Clearly, we need to make sure that we get that process going. The passage of the bill will ensure that we have things in place as soon as possible. The community has been clear that there has been a need to go beyond palliative care services and provide Western Australians with the genuine choice that they require to experience fulfilling lives and respectful deaths. The 18 months will provide for the proper implementation of the processes and other measures, such as the establishment of the board. Clearly, the sooner we can pass this bill, the sooner they can get on with that work.

Ms M.M. QUIRK: Another issue I want to raise with the minister in this context is that when we had a very helpful briefing from various advisers, they contemplated that there would not be extensive regulations, which the minister seems to have suggested now, and that a lot of these issues could be handled administratively. We see peppered throughout the legislation “the CEO will do this” and “the CEO will approve that” and so forth. They are all indications that matters will be handled administratively and, I would have thought, that could also be done for training. I am curious to know what the minister contemplates, other than the setting up of the board. What else will be the content of the regulations?

Mr R.H. COOK: I perhaps used the word “regulations” too broadly, so I apologise for that. The bill does not require any regulations to be made in that context. The bill has been drafted as a comprehensive piece of legislation to operate as is. There is a general regulation-making cause as a futureproofing mechanism; however, it is not anticipated that there will be any regulations made under this bill. In particular, the member should understand that each of the processes is required to be noted in relation to certifiable forms. The CEO has a responsibility to specify the nature of the information provided to the patient. We will have a lot of work to do to not only establish the Voluntary Assisted Dying Board, but also make sure that we have the necessary training in place, and, as I said, we are very determined to make sure that that training package is comprehensive. I think there is other important work that needs to be done and that is to make sure that there is public awareness of the legislation once it comes into effect. The member for Darling Range has already voiced her concerns about community understanding and awareness of the nature of the bill, and that is an important part of it. Other measures that the CEO has to approve include the list of voluntary assisted dying medication and further criteria for medical practitioners. Once we have decided what the further criteria are, we can design training program. It is a pretty comprehensive process and from that point of view, we can well understand that 18 months is very valuable time to get things in place.

Ms M.M. QUIRK: Member for Riverton, this is it for me. Can I confirm that part of the 18 months is not going to be because it is anticipated there will be a raft of regulations that need to be drafted and that most of the filling out in this legislation will be done administratively?

Mr R.H. COOK: Yes, member.

Dr M.D. NAHAN: One of the issues that has been raised with me about the bill is why it is coming in so quickly and why we have not spent more time learning from the Victorian legislation that just came into place. Did the minister put effort into learning from the Victorian legislation? It just came into action. I think there has just been a handful of applicants, and one person has followed through. In the next 18 months while this administrative process is being gone through, will there still be an eye kept on the lessons learnt, if any, from Victoria, particularly on some of the definitions that we are dealing with now to do with risks and addressing coercion, what is voluntary and when people can make a conscious voluntary action? Will the minister give a commitment to this place that he will monitor what is going on in Victoria? I am sure that Victoria has various types of processes to assess what happens.

Mr R.H. COOK: I advise that the ministerial expert panel and the Department of Health had extensive consultations with the Victorian Department of Health and Human Services and also the thinking of other jurisdictions in relation to this. As I said, the Department of Health has spent some time with the Victorians and is already learning from a lot of the implementation processes Victoria went through, which, as the member would appreciate, is a key aspect of what needs to be put in place and anticipated. Certainly, we will continue to monitor that situation and work with the Victorians to learn from their experiences.

Dr M.D. NAHAN: The minister mentioned that Victoria advised of the minimum period of 18 months. Given the geographic reach of our state relative to Victoria and, I have to say, the diversity of communities, does the minister not think it will take longer to put this type of legislation in place in WA than Victoria?

Mr R.H. COOK: I think we will learn a lot from Victoria, particularly with the training packages. We can look at what it does, borrow some of that curriculum and utilise some of the stuff out of that. In that aspect, we will be able to move fairly swiftly. The member is right: we have our own unique challenges. From that point of view, they will present a unique set of challenges for us to overcome. But we are advised by the Victorians and those who are closer to this process that 18 months is, on balance, what we will probably need to get everything in place, even with the learnings from Victoria.

Extracted from finalised Hansard
Dr M.D. NAHAN: One of the issues raised by the members for Dawesville and Kimberley is the unique and special nature of some of our Aboriginal communities. They do not exist in large numbers in Victoria. Would the minister have a special program to address those? I think the problems that were brought up around those issues are quite profound and require special focus in terms of implementation.

Mr R.H. COOK: Member, I think that is certainly the case. The expert panel has obviously itself had the opportunity to be informed by extensive consultations with the Aboriginal community. We will obviously take the opportunity to make sure that we continue to work with all the stakeholders on this. That includes not only people from the culturally and linguistically diverse communities, but also community stakeholders such as the WA Primary Health Alliance, the Australian College of Rural and Remote Medicine, the WA Country Health Service and the Australian College of Nurse Practitioners. We will continue to need to talk to a range of people in order to make sure that we have a good understanding about the needs of not only the people in the community, but also the people delivering the service.

Ms M.J. DAVIES: I have a question about the interaction of the bill with the commonwealth Criminal Code, which is something I foreshadowed in my contribution to the second reading debate, and whether or not we will have clarity around any of the implications for face-to-face interactions with doctors and patients or health professionals and patients before the commencement of the bill. We have expressed concern about this issue, particularly around access to voluntary assisted dying in regional communities where we utilise telehealth and teleconferencing, and I imagine that will be canvassed as part of the implementation process. Commonwealth legislation has certainly raised some concerns in the Victorian jurisdiction, and from a Western Australian point of view, we would be seeking clarity before the commencement of the bill.

Mr R.H. COOK: Yes. I did speak fairly extensively on this at the conclusion of my summary of the second reading debate. As I mentioned, there are a range of reasons that we believe that it is not in contravention of the commonwealth Criminal Code. As I reported, not only has the Department of Health been in contact with the commonwealth, but also the Attorney General has been in communication with the commonwealth Attorney-General, so we will certainly know before the expiry of the implementation period exactly where we stand on that. I am pretty confident that we will be able to resolve those issues. If not, we will do it the good old-fashioned way and make sure that it works.

Mr V.A. CATANIA: Further to the issue raised by the member for Central Wheatbelt, can the minister clarify what steps he has taken in talking to the commonwealth prior to introducing this legislation? I think it is a pretty major issue that needs to be resolved prior to the commencement of the legislation. It could affect the whole legislation if the commonwealth does not agree with the government’s reading of and reasoning why it should not come under the commonwealth act, or its interpretation of the commonwealth act. Can the minister elaborate a little more, given that it will play a major role in how this legislation may perform if it gets through both houses of the Parliament of Western Australia and gets royal assent?

Mr R.H. COOK: Member, nothing will stop us from implementing the bill. It hinges around one specific aspect, and that is the use of a carriage service in relation to the commonwealth Criminal Code Act 1995. As I said in my response to the second reading contributions, two sections of that act deal with the issue of controlling, producing, supplying or obtaining suicide-related material or using a carriage service for suicide-related material that directly or indirectly counsels or incites committing or attempting to commit suicide. The sections of the commonwealth Criminal Code Act are specifically about those issues. The member for North West Central will remember that it was legislated because of websites that promote suicide or cyberbullying in that context. Certainly the advice we have is that it will not be an impediment to our legislation. Our legislation also explicitly states that this is not suicide, which is not part of the Victorian legislation.

There has been some preliminary communication between the Department of Health and the commonwealth Attorney-General’s Department. The government is consulting with the commonwealth to ascertain its position with a view to seeking an undertaking that the commonwealth will not prosecute or that it will take steps to amend the Criminal Code Act 1995 to make it clear that the provisions do not apply to voluntary assisted dying. However, absent an undertaking from the commonwealth, a legislative amendment of the relevant provisions of the Criminal Code Act or a decision of the court, we acknowledge that there may be uncertainty about whether communications about voluntary assisted dying over a carriage service will contravene the commonwealth legislation. The advice we have is that it will not or that it can be resolved amicably with the commonwealth. Having said that, it will not ultimately impact upon the commencement of the bill but it will potentially impact that section of the legislation.

Mr V.A. CATANIA: When did the minister’s department make contact with its federal counterparts or the Attorney-General’s office? Was it prior to the bill being introduced or in recent times? Has the minister written a letter to the commonwealth Attorney-General seeking that clarification; and, if so, when did the minister write to the Attorney-General? It is important that we ascertain this because if it was only yesterday, obviously the minister will not get a response for a while and it could play a large role in perhaps being the downfall of the bill if it is seen to be in breach of federal laws.

Extracted from finalised Hansard
Mr R.H. COOK: I am advised that the Victorian legislation was identified as having some difficulties in relation to that act in early June. Conversations have been taking place since then. I cannot provide the member with the details but I am happy to get them to the member. I have not written to the Attorney-General. The Attorney General has written to the federal Attorney-General, as we would expect, but it is not something that I have undertaken.

Mr V.A. CATANIA: The minister said that our Attorney General has written to the federal Attorney-General. Does he know when the Attorney General wrote to the federal Attorney-General to seek clarification?

Mr R.H. COOK: I do not have that information for the member, but I am happy to get it for him. I think we will be doing this for a little while so there is plenty of time to get back to the member.

Ms M.M. QUIRK: The minister referred to having received advice on this issue. Who provided that advice?

Mr R.H. COOK: My advisers, member.

Ms M.M. QUIRK: From that I take it the advice was provided by people within the department and there was not a separate counsel’s opinion or State Solicitor’s opinion.

Mr R.H. COOK: I am advised that the Solicitor-General and the Department of Justice provided that advice.

Mrs A.K. HAYDEN: I refer to clause 2(b). Why do clauses 14 to 184 require delay? That is a massive amount of clauses, considering that there are only about 180-odd clauses in this bill. Can the minister explain why clauses 14 to 184 need to be delayed?

Mr R.H. COOK: Those clauses deal with the substantive aspects of the bill, so are subject to the implementation period.

Mrs A.K. HAYDEN: Just to clarify—does every single clause from 14 to 184 come under the explanation the minister has just given?

Mr R.H. COOK: Yes. They have to do with the details of the legislation, including training and things of that nature. That is why they are subject to the implementation period.

Clause put and passed.

Clause 3 put and passed.

Clause 4: Principles —

Mr Z.R.F. KIRKUP: Clause 4(1) lists a range of principles people must have regard to under the act. I am keen to understand how those principles will bind anyone who participates, either as a participant, a patient or anything like that, to the act. The language used is that they must “have regard to” the principles that are laid out. What legal implication will that have? What mechanisms will be in place to enforce the relationship that a patient or a practitioner might have with those principles? What does “have regard to” mean in practicality?

Mr R.H. COOK: The principles will serve as a guide to interpreting and applying the act in relation to those matters. They will not create any new obligations. The principles were recommended by the ministerial expert panel. As the member can see, they are cast widely and underpin the values and principles of the bill.

Mr Z.R.F. KIRKUP: I refer to the language “must have regard to”. I appreciate that a range of very extensive principles have been taken from the expert panel. Some of them are quite esoteric and quite well-meaning. What will the practicality be if someone does not have regard to them? I suppose it will not mean a whole lot for people who disregard them. Can the minister confirm that there will be no legal implication if people do not have regard to any principle listed? I am assuming that this is the intent and that the government is hopeful that people will follow the principles enshrined there, but there will be nothing that will bind them to do that and no penalty if people do not have regard to elements (a) to (j) of those principles. Could the minister walk me through that process a bit more? I would appreciate that.

Mr R.H. COOK: It is consistent with legislative drafting practices; that is, when someone, particularly in a judicial role, is trying to understand the intent of the legislation, potentially when the member and I have left this place, they will go back to the legislation to work out the intent of the legislators at the time and can go back to the principles to understand and interpret it. In a judicial or regulatory situation, they would look at the principles of the legislation to understand what we were trying to achieve.

Mr Z.R.F. KIRKUP: I thank the minister very much for that. How much of this binds the government as well as part of its own health policy? I note there are a number of references there. Specifically, for example, clause 4(1)(d) provides that people should have access to high-quality care and treatment, including palliative care options, and clause 4(1)(h) provides that a person is entitled to genuine choices about their care, treatment and end of life, irrespective of where they live in Western Australia, and having regard to their culture and language. How many of these principles apply to the government in terms of its own health policy settings as they apply to end of life?

Mr R.H. COOK: It is certainly binding on the Crown, but there is no penalty involved in it as such. Obviously, we would have regard to the fact that the government’s obligation, like everyone else’s obligation, is to observe those principles as well. In that context, it is obviously an aspect of the bill that really underpins those principles. The government, like every other entity in the community, is caught within those.
Mr Z.R.F. KIRKUP: I thank the minister. Paragraph (d) is an area of concern for me. That principle states that the person must have access to high-quality care and treatment, including palliative care options. A number of members in this place have spoken about the lack of palliative care options in the regions. In particular, I have spoken about impacts on regional and remote Aboriginal communities and the lack of culturally appropriate palliative care in those areas. I am interested to know what that might look like, given that we are enshrining this as a principle of the legislation. People might not actually have access to high-quality palliative care. There is obviously a lot of merit in any government wanting to see the option for a patient to have access to high-quality palliative care, and I appreciate that that has been included as part of the principles, but what happens when there is an obvious failing in that respect? As we have spoken about a number of times, including in the minister’s reply to the second reading debate, there is identified inequity with regard to regions and socioeconomic demographics, particularly with Aboriginal communities. What happens in areas where the government is clearly failing? The principles are there. How can we make sure that the government follows through on those principles to ensure that there is high-quality care and treatment, including palliative care, for all people, wherever they are in the state?

Mr R.H. COOK: I thank the member. There is no penalty associated with the principles as such, but from that point of view, the government would be informed by the principles, like anyone else. For example, the end-of-life and palliative care strategy that is currently being crafted under the 2018–2028 strategy process will have regard to the principles that are part of this bill because they should inform general government policy. From that perspective, it will inform and mould the policy framework within which the government operates.

Mr V.A. CATANIA: The member for Dawesville obviously raises a very good point. As the minister said, the government must adhere to the principles. It is all well and good adhering to the principles, but the legislation highlights that every person has the right to be able receive palliative care. As I said in my contribution to the second reading debate, in regional Western Australia it is very difficult to access palliative care, particularly in the north west; I do not think there is anywhere in the north west where people can access palliative care and, therefore, they are being pushed out. Clearly, it is all very well and good that the government has set out these principles, but regional Western Australia needs financial backing to be able to get the palliative care it actually needs to fulfil the principles the government has set out in clause 4. Clause 4 clearly provides that the government needs to be able to adhere to its own principles and to deliver the opportunity for people to be able to receive palliative care. I take that as being in the town in which they live or close to the town where they live; not saying, “Yes, you can access palliative care, but if you live in the Kimberley, the Pilbara, the Gascoyne or the midwest, how about you head down to Perth to receive that palliative care treatment?” We all know that is not feasible in a lot of ways. People do not have the resources to do that or the ability to find out how to go about receiving palliative care. Often, there may not be a doctor, or a nurse practitioner at the very least, to be able to explain that. People rely on those trips—whether they can afford them or not or whether they get assistance from the patient assisted travel scheme—to go to a major town or city that can provide that care and also to be educated about their choices in palliative care and the treatment they could receive. It is all very well to have principles, but how will the government back up its principles with the amount of money that is needed to put palliative care in regional WA, which is currently non-existent?

Mr R.H. COOK: I appreciate the comments the member made. The member and I have had many discussions about the opportunities that someone has to access health care in Carnarvon generally. One of the member’s constituents once came to me, before we were in government, because he was struggling to get dental care in Carnarvon. It is a challenge in regional communities, as is any health service. This bill envisages a situation in which people do not make a choice between palliative care and accessing the functions of this bill. That is not the intent. It is about setting out the principles with which the government should have intent in terms of the overall ecosystem that people work in. This does not give rise to litigation, if that is the point the member wanted to make, but it does say that people should have access to quality palliative care. In that context, I guess actions speak louder than words. That is why we have had that significant increase in palliative care funding, particularly in the regions. For instance, in the north west, where rural palliative care teams have coverage in areas such as the member’s, we will be able to boost those services so they do have the outreach that people need.

Mr V.A. CATANIA: I understand the minister’s explanation, but I suppose what I find difficult is the minister says there are principles the government would like to adhere to—we hope that all governments would adhere to these principles—but the reality is something different. To me, this seems like more of a motherhood statement saying, “She’ll be right, we’ll provide that support and opportunity to receive palliative care”, but in reality it is just not there. The reality is it is just not in the government’s budget. That is the issue that a lot of people have. I said, and I think the member for Warren–Blackwood also said, that the two are different—voluntary assisted dying and palliative care. Palliative care is in the bill as one of the principles. As I said, it is more of a motherhood statement. To gain the confidence of people in the other place perhaps, is there a way the government can back up these principles so they are not motherhood statements? Is the government able to offer some serious financial backing to people in regional WA, and people anywhere in Western Australia, so they have the opportunity to receive palliative care, rather than saying it is a principle and basically a motherhood statement? In my view, we need to solve the palliative care crisis. The government’s financial pocket is lagging behind its principles.
Mr R.H. COOK: I thank the member. I take the member’s counsel in relation to how we might deal with the other place, and I thank him for his input. I guess our pockets are deeper than they have ever been, with over $206 million for palliative care across the forward estimates, of which almost $60 million is dedicated to regional palliative care services. The member has said, quite rightly, that more needs to be done. We can always do more, and we have plans to do more, but we have to work with what we have. The member describes the principles as motherhood statements. They are principles. They are not prescriptions. They are principles that we want to see observed to inform the approach to the bill. I take the member’s point that he might consider them to be motherhood statements, and in some respects they are. They are principles that will bring to the process without necessarily being a prescription about services.

Mrs L.M. HARVEY: I refer to clause 4, “Principles”, in particular subclause (1)(d), which states —

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

I am interested to know why the minister has used the word “should” be provided with care, rather than “must” be provided with care. The word “should” is more about a recommendation or a desirable goal. It does not really compel action. The word “must” brings with it an obligation for action. I am curious to know why the minister has chosen “should” over “must”.

Mr R.H. COOK: I guess it is because they are principles. They describe intent, rather than prescribe action. I understand that the point the Leader of the Opposition is making is that she would want everyone to be given high quality care and treatment, including palliative care. I certainly agree with the sentiment that the Leader of the Opposition is reflecting. However, this is consistent with drafting practices. This is about the principles or the intent that we are bringing to the process and that underpin the values that sit within the bill.

Mr T.J. HEALY: My question relates to clause 4(1)(g), which states —

A person should be supported in conversations with the person’s health practitioners, family and carers and community about treatment and care preferences;

We have spoken about this briefly. This question has been raised by a few of my constituents, and I want to get it on the record. I am in favour of the bill. However, I would like to get some clarification. People die. People get hit by cars. People have heart attacks. We have a mourning process within our society that deals with that. I want to talk about the ripple effects for a family that is involved in administering the final part of this process. I have reflected on the fact that my mother might be eligible for voluntary assisted dying and might say that she would like to go down this path. This is not something I would ever want to do, but I know it is one of the scenarios. My mother might say that she would like us to administer it, and we sit together as a family and decide to do that. I am not sure I have the right word for it, but, if that were to happen, my family would be far more involved in the death of that person than if they had died from a heart attack or in a car crash or from something else. I am not after a $10 million figure. I just want to put this on the record. Has any consideration been given to where we might be in five years or 10 years when a number of patients and a number of families have had a more intense level of involvement with the death of a loved one? Could the minister give some commentary on that?

Mr R.H. COOK: I thank the member. He has touched upon some very important issues, particularly around the interaction of family with the person involved. The intent of this bill is to place that person at the centre of the decision-making in a voluntary nature, with the empowering nature of it. Just to come to one aspect of it—we can come to it later on the specific clause of the bill—the family would not administer the substance in that context. The bill enables administration only by a practitioner or the patient. The member for Southern River’s mother could not say, “Terry, could you take care of this for me?” The bill does not allow for that. Obviously, a medical practitioner has many years of training on the patient–medical practitioner relationship. The conversation about end-of-life choices would be a very long one and would inevitably involve the family members and supporters and carers of the person involved. I do not want people to characterise this as, or get the impression that this is about, a quick conversation that would happen by the bedside, with the medical practitioner scurrying out to fill out forms. This is obviously a very considered and careful process, and understandably the family would be quite involved in that process. From that perspective, bereavement support could be provided to family members to make sure that they were also supported in the process. As many members have observed, end of life is a difficult process. I read with interest the experience of Kerry Robertson, who was the first patient to access voluntary assisted dying in Victoria. Her daughters talked about being intimately involved in the lead-up to the process and sitting with her when she took the voluntary assisted dying substance. By its very nature and by the nature of love, support and care that someone receives, this will involve families. I hope that answers some of the member’s issues.

Dr D.J. HONEY: The minister referred a little while ago to the $206 million for palliative care over the forward estimates, which I assume includes a four-year period. Is there any comparative estimate of the cost of the voluntary assisted dying process once it is up and running? I appreciate that we will go through an initial period of getting it up and running, but there will be costs for the board and board members, administrative procedures and the medication and for providing other services in regional areas. Does the minister have an estimate of that, please? It is just to give a comparison and to contextualise the estimated expenditure on palliative care over that period.

Extracted from finalised Hansard
Mr R.H. COOK: It is a difficult question, but I thank the member for it and understand his intent. Perhaps by way of another explanation, in looking at the Victorian legislation, Victoria has committed $6.35 million per annum in the 2018–19 budget. Obviously, Victoria has a bigger population, so it has more people to manage in that process, but it has a smaller jurisdiction so there is less cost associated with travel. I hope that gives the member some handle on the sorts of numbers we are looking at. Obviously, we will have to be informed during the implementation phase about the ultimate budget for the legislation as we discover where the costs lie.

Dr D.J. HONEY: I appreciate that it is a little bit intangible at the moment, but would it be in the order of no more than $10 million? Would that be a fair question?

Mr R.H. COOK: I was about to say that the member cannot quote me, but of course he can because it is in *Hansard*. Yes, that seems to be the sort of ballpark that we are looking at.

Mr R.S. LOVE: Clause 4(2) states — reference to a person exercising a power or performing a function under this Act includes the Tribunal exercising its review jurisdiction in relation to a decision made under this Act.

Could the minister explain what that will mean in practice? For instance, if someone cannot necessarily access palliative care, how can that change the interpretation or a decision by the State Administrative Tribunal? I really do not understand what this clause means and I beg the minister to explain it.

Mr R.H. COOK: Member, we will have an opportunity to dig into the role of the State Administrative Tribunal under the clause that relates to it. However, subclause (2) suggests that essentially when the tribunal exercises its review functions under the act and makes decisions, it must respect the principles of the decisions that it has made. For instance, it might come down to whether someone has a decision-making capacity and, let us say, someone appeals against that process. The SAT must sit down and think, “What is the basis upon which we should make our decision?” Obviously, it refers to the technically prescriptive aspect of the legislation, but it will also be informed by the principles that underpin the legislation.

Mr R.S. LOVE: I take it—I do not know for sure—that given that many health services are provided by the state, the state is also expected to abide by the principles outlined in the bill. Therefore, when the SAT makes decisions about a particular matter, is there a power, or an expectation—to some degree, a rectification—if some principles are not met? For instance, if a person in the Kimberley is reviewed and it is found that there is no adequate palliative care for that person in the Kimberley, can the SAT order the state to provide it?

Mr R.H. COOK: The tribunal has specific roles under this legislation. Someone cannot go to the tribunal, for instance, and say that this principle says this, but they are not getting that, so the tribunal should make a decision about the allocation of resources or the provision of a service. However, it will allow the tribunal to make decisions in those areas that it does have responsibility for. Let us say we are talking about advice a person has received from a medical practitioner. It would be consistent with the bill and its principles that the tribunal could cross-examine a medical practitioner and ask them whether they have informed that person about the availability of palliative care services, or something of that nature—being informed by the principles in this particular aspect. I think the member might be at the same point that the member for North West Central got to. The principles do not give rise to litigation, but in terms of working with the act, it informs those making decisions, particularly in a judicial context, about what the bill is trying to deliver.

Mr P.A. KATSAMBANIS: I have a number of questions on this clause, but since we are discussing subclause (2), I will ask the minister about that. The minister has explained that the principles to which any person exercising a power or performing a function under the act will have to have regard will apply equally to the tribunal when it exercises its review jurisdiction in a decision made under the act. I seek clarification from the minister whether, after the tribunal makes a review decision and it is appealed to a higher body—in a court—that appeal body will also be subject to the principles outlined in this clause. If that is the case, how will that operate under this legislation, given that there is no specific power for the court to have regard to any of those principles?

Mr R.H. COOK: I understand that the answer to the member’s first question is yes. Obviously, someone can appeal a State Administrative Tribunal decision. The member would know this better than I, having a legal background, but I understand that the process is that it is then taken to the Court of Appeal. All those issues sit within the State Administrative Tribunal Act 2004, as such, so we do not need to spell out those appeal processes in this bill.

Mr P.A. KATSAMBANIS: That was not my question. My question was that when someone goes to SAT under this bill, for any purpose—we will get to that—the member of SAT presiding over this review has to have regard to these principles. That is all well and good; that is fine, and we accept that. After SAT has made its decision, if one of the parties is not happy with the decision and appeals to a higher authority, to a court, will that court have to have regard to these principles in making its decision? If so, how will that operate, given that there is no specific reference to a court or any appeal powers from SAT in this clause?

*Extracted from finalised Hansard*
Mr R.H. COOK: I guess it will depend on the nature of the appeal, but, from my understanding, a person can appeal a decision of the State Administrative Tribunal only on a point of law. From that perspective, they would not be referring back to the original legislation. I am happy for the member to guide us in that process, but my understanding is that if a person is unsatisfied with the decision of the State Administrative Tribunal, they would be appealing against the way in which that tribunal made its decision and whether that was consistent with tribunal processes, not going back to the original legislation. They would be appealing on the point of law.

Mr P.A. KATSAMBANIS: But the point of law may relate to the decision that the tribunal has made. That is the point here—that to appeal a point of law, a person is effectively appealing the decision made by the tribunal in interpreting the law, which is contained partly, and in this case almost wholly, in this legislation. Again, I ask my question: whenever an appeal lies beyond SAT, beyond the tribunal, will the court hearing that appeal be bound to take these principles into account or will there simply be some sort of best regard references that have no force or probative value in law?

Mr R.H. COOK: The advice I have in relation to that is yes.

Mr P.A. KATSAMBANIS: Sorry, my question was either/or. Will they or will they not? I just want to clarify. Will the court be bound to apply these principles in making any decision that lies on an appeal from a decision in SAT?

Mr R.H. COOK: Yes, member.

Mr P.A. KATSAMBANIS: I return to clause 4(1). The minister has stressed that these are simply principles. If someone who is exercising a power or performing a function under this act does not give regard to these principles, what remedy is available to the person who feels aggrieved by that person not having regard to these principles in exercising their power or performing their function?

Mr R.H. COOK: First of all, obviously, the person would have to have standing with regard to taking the issue to the State Administrative Tribunal, but, ultimately, the State Administrative Tribunal would make a decision on the basis of the decisions it is required to make. It would be informed but not bound by these principles, as is consistent with the nature of principles.

Mr P.A. KATSAMBANIS: I think that has given us some insight into the fact that this is just a wish list, but irrespective of that, I hope that in practice someone will give some regard to them. There are a number of principles and some of them have been articulated around palliative care. I share the concerns raised by members around palliative care. A number of us, including me, raised it in our second reading contributions. Clause 4(1)(i) states —

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

I want to clarify what that means. I note that the next clause is a rather lengthy definitions clause that does not define the term “abuse” in any way. Can the minister enlighten us about what abuse it is envisaged a person will need to be protected from under this regime?

Mr R.H. COOK: That comes down to what would be considered abuse in the ordinary use of the language. Abuse can be physical abuse, sexual abuse, financial abuse or emotional abuse. This is part and parcel of one of the key principles of the legislation; no-one who would be accessing voluntary assisted dying is in any way subject to abuse. From that point of view, I am not quite sure why the member has difficulties with that provision being in there or why he wants the meaning of "abuse" prescribed. I think it means abuse in the broader sense of the word.

Mr P.A. KATSAMBANIS: “Abuse” is quite a strong term. There are a number of concerns about people’s influence on patients’ decisions, such as coercion, duress, undue influence and the like. A lot of those terms have specific legal meaning, which is not defined by reference to the word “abuse”. I am not aware of any legislative provision in Western Australia or any precedent that defines coercion or duress as abuse. I am simply concerned about where the boundary will be drawn for what constitutes abuse and what is considered bad behaviour that may not necessarily reach the point of being abuse. In asking that question, I seriously ask the minister to contemplate broadening this definition, because, as I said, abuse has quite a high bar to go over to be proven. Alternatively, I suggest an inclusive definition that says something along the lines of “abuse includes duress, coercion and undue influence”. Otherwise, irrespective of whether these are principles or enforceable legislative provisions, we leave this act open to question marks about serious matters that could have strong influence on a person who is contemplating making these sorts of decisions that may not necessarily reach the point of being considered abuse but would still be considered to be having an unfair and undue influence on that individual.

Mr R.H. COOK: I acknowledge the member’s concerns about abuse, but I think in the context of the principles of the bill this is not considered a binding or prosecutable aspect. It is about the principle of it in the broadest possible terms. It has been brought to my attention that this is the very same wording that has been used in Victoria, and ultimately this would be what it says; that is, we do not want someone to be subject to abuse. It does not say “a level of abuse” and it does not say “a type of abuse”; it is about the concept that a person is subject to abuse. We want that to be considered an important aspect of the principles of legislation and what is being brought to the process through it.

Mr P.A. KATSAMBANIS: We all agree that no-one wants anyone to be subject to abuse, but the point here is that there are levels of pernicious behaviour towards a vulnerable individual that may not necessarily be considered to be
Mrs L.M. HARVEY: Clause 4(1)(e) states — a therapeutic relationship between a person and the person’s health practitioner should, wherever possible, be supported and maintained;

Why is this in the bill?

Mr R.H. COOK: It was a clause recommended by the panel. It is about the enduring relationship between the practitioner and the patient. It is also in the Victorian bill.

Mrs L.M. HARVEY: I am curious to know why that needs to be a principle. Is it anticipated that there is going to be an interruption to the therapeutic relationship as a result of this legislation? Why does that need to be there? I find it really curious. It sounds as though there is an expectation that somehow through these discussions, the therapeutic relationship between the practitioner and the patient may potentially break down in some way. I just do not know what is anticipated and why this should be in the bill as a principle.

Mr R.H. COOK: Again, member, the principles are about the values that underpin the legislation. In particular, what we are trying to emphasise here is the importance of the health practitioner and the person’s relationship. We all understand that a strong, long-term, intimate therapeutic relationship is good for both the health practitioner and the person involved. We typically see that in a GP–patient relationship. However, obviously, there will be times when that relationship cannot be maintained, for reasons of conscientious objection or something of that nature. This is stating that we believe that relationship is an important one and should be supported wherever possible in the context of this legislation, because we know that the strength of that relationship produces good outcomes.

Ms M.M. QUIRK: I have a couple of queries on this clause. One follows on from the queries of the member for Southern River on proposed clause 4(1)(g), which states — a person should be supported in conversations with the person’s health practitioners, family and carers and community about treatment and care preferences;

Conversely, an individual can choose not to have a conversation with any of those people, for example, in the case where there is a family dysfunction; is that correct?

Mr R.H. COOK: Yes, that is right.

Ms M.M. QUIRK: The other issue relates to autonomy. A definition would probably be helpful; that is not in the act. That is contained in clause 4(1)(b). Would you agree with the proposition that autonomy is an absolute? There are many areas and many laws that limit autonomy. For example, I do not have the autonomy to sit in a car and not wear a seatbelt, or to ride a bike but not wear a bike helmet. There are limits to people’s autonomy.

Mr R.H. COOK: Yes, there are limits to autonomy; that is correct. This is enunciating, I guess, the principles or the values that underpin that person making their end-of-life choices. We want them to make those choices unshackled, in some respects, to make sure that they are able to make that decision freely. Their agency in that process is obviously important. I guess that is why it alludes to autonomy being an important principle.

Dr D.J. HONEY: Minister, I want to come back to the point that was being explored by the member for Hillarys—that is, under 4(1)(i), the need to protect persons who may be subject to abuse. I spoke to a large number of people about this bill and a large number of lawyers. Every lawyer I spoke to expressed their immediate concern on the issue of undue influence. Undue influence can occur all the way from what would be legally described as abuse—that is, someone who is threatening or intimidating or very overtly bullying someone—to someone who is loving and caring and otherwise has a positive relationship with the patient, but seeks to influence them. As I said, it could be out of love. There is an enormous body of case law around undue influence and coercion, particularly undue influence, which goes to a conflict when someone may have a pecuniary interest. Again, it may be a loving and caring daughter, sister, brother or son who does it, but that gets confused. I am very concerned. The minister said earlier that if there were an appeal to the Supreme Court, these principles would form part of the basis of that appeal, and that would give the Supreme Court in considering the matter. I am concerned that using the term “abuse” is far too narrow. I wonder, minister, why it would not be proper to include abuse, coercion and undue influence in that clause, to make it very clear.

Extracted from finalised Hansard
I resonate that I am not a lawyer, which is patently obvious, but it strikes me that this legislation could set a very high bar. In the great majority of cases, it will be not be overt bullying; rather, the influence will be subtle and difficult to detect and would be called undue influence, which is a body of law, obviously, and coercion. Why will the government not extend it to that to make it very clear that this is something that should be considered?

Mr R.H. COOK: The point is well made. Obviously, we have used the term “abuse” in the widest possible sense. I draw the member for Cottesloe’s attention to clauses 99 and 100, which go to the very heart of what he is talking about and provide the offences under the act. For example, clause 99(2) states that a person commits a crime if the person, by dishonesty, undue influence or coercion—I think the member used those words—induces another person to make a request for access to voluntary assisted dying or to access voluntary assisted dying. Further, under clause 100—

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

The reference to abuse anticipates the full range of ways that a person might influence a person to make a decision, which would be illegal under the legislation.

Dr M.D. NAHAN: The member for Cottesloe will come back later. I refer to principle 4(1)(d).

Mr R.H. Cook: Is it 1(d) or (e)?

Dr M.D. NAHAN: Clause 4(1)(d), which relates to palliative care.

Mr R.H. Cook: It is (d) for dog.

Dr M.D. NAHAN: Yes, it is a dog day at night.

The minister said that $206 million has been allocated over the forward estimates, which is an increase on what has been spent in the past. Can the minister provide by way of supplementary information what was spent on palliative care in the previous four years so that we can see a transition, a time series, of government expenditure on palliative care? Could the minister also give us an indication, if he can, of the number of people in each one of those years who accessed palliative care so that we can put it on a per patient basis?

Mr R.H. COOK: Yes, member, I undertake to do that.

Dr M.D. NAHAN: It is late at night and maybe I am hallucinating. I refer to clause 41(a), which states that every human life has equal value. I accept that as a central value set of almost all legislation we deal with, but what we are dealing with is legislation to facilitate a patient’s decision that their life does not have the same value as those whose lives to which this legislation will not apply. How does that provision work in the legislation? I am a bit confused about this.

Mr R.H. COOK: The member is right—every life does have equal value. I do not accept the member’s argument about a person who exercises decisions about their life when their pain is intolerable. Their life, like all lives, will inevitably come to an end, but in their case that end is imminent. I do not think that necessarily devalues the person’s life. It underpins the values of this legislation—we do value life and we value a person’s capacity to make decisions about their life.

Dr M.D. NAHAN: I will leave that; it is too heavy for me right now, but I understand the principle of it. Some of us have learned experiences and have heard stories. I go back to clause 4(1)(i) and the issue of abuse. We hear stories of what is not even undue influence, in which a patient believes that they are a burden on society. The loved one might not even give that impression, but when someone is on a pathway to death, particularly if they are older and life has largely passed them by, there is a natural inclination, we have heard, for a patient to be slightly depressed. We often hear that people do not want to be a burden on their family or children. That is not abuse if the family is not giving that impression. If they are giving the impression, even subtly, that is not abuse, and I do not think it would be picked up as abuse, but this issue keeps coming up when dealing with elder abuse and perceptions of elderly people who, I suggest, will be a large part of the demographic that will use voluntary assisted dying. How will that be dealt with?

Mr R.H. COOK: The member is right. That is potentially not abuse. It is coercion. I understand the point the member is making.

Dr M.D. Nahan: It might be very subtle.

Mr R.H. COOK: Absolutely! It is incredibly important that the training the medical practitioner undertakes provides them with the capacity to understand that coercion and the subtlety of it or someone inadvertently encouraging the patient to access voluntary assisted dying. When there is even an inking of that, the medical practitioner will be bound by the legislation to seek further advice and not simply say that it might or might not be. If there is a shadow of a doubt, they will have to refer it to someone else who can provide further advice about that. Members should not forget that two medical practitioners will have to come to the same conclusion independently of each other. The mandatory training that they will engage in will equip them with a number of extra skills, in addition to the skills that they already have as medical practitioners, which will allow them to gain further insight into that process. The member

Extracted from finalised Hansard
is right. That has been looked at extensively in all the jurisdictions. My attention has been drawn to the Oregon data, which looked at the reasons people wish to access voluntary assisted dying. Basically, it indicates that being a burden was not the only or even main motivating factor for choosing assistance to die. In fact, it was well down the list. The chief reasons for accessing voluntary assisted dying were loss of autonomy, dignity and enjoyment in life. The member is absolutely right to highlight the importance that coercion may play in that process. That is why we have set out explicit offences under the legislation when someone coerces someone to access voluntary assisted dying.

Dr M.D. NAHAN: To confirm something for future adjudication perhaps, is the minister of the view that the word abuse includes even subtle coercion? Again, this is the feedback that I receive from my constituents when I talk to them about this.

Mr R.H. COOK: Yes. That is absolutely my understanding.

Dr D.J. Honey: I’m outranked again!

Mrs L.M. HARVEY: You have to speak up!

The SPEAKER: It is called the pecking order!

Mrs L.M. HARVEY: Clause 4(1)(h) states —
a person is entitled to genuine choices about the person’s care …

Why is that described as genuine choice?

Mr R.H. COOK: Again, a range of members in this place made comments during the previous debate that if people are to access voluntary assisted dying, they want them to do so for the right reasons, not for the reasons the member for Riverton just pointed out. They want that decision to be genuine and for them to be able to make that choice based upon their needs, not upon a range of other factors that might impact on it.

Dr D.J. HONEY: Just to close the loop on that, clause 99 refers to prosecutions, and I appreciate that the minister has outlined that other words like “undue influence” and “coercion” are used there. Is it possible for us to get a considered opinion from the minister’s legal advisers that abuse in this clause can, indeed, include coercion and undue influence? I appreciate that it may not be possible to give that clear explanation now, but if a court is going to use this as a basis for challenging a decision, I think it is important that it is very clear that the term “abuse” includes coercion and undue influence.

Mr R.H. COOK: Again, we come back to the issue of what the principles are about. They are basically about the intent of the legislation and they inform the way in which it should be interpreted in the future. To put the member’s mind absolutely at ease, that is why I highlighted clauses 99 and 100, which actually go to the single point of coercion. “Abuse” is a broad term that captures concepts of coercion, influence and so forth. “Coercion” is explicitly stated in the bill.

Mr D.T. REDMAN: Good morning, minister. Clause 4(1)(h) refers to a person being entitled to genuine choices about their care, treatment and end of life, irrespective of where in Western Australia they live, and having regard to their culture and language. When someone sees a doctor for a normal consult, depending on their circumstances they may perhaps be means tested and they may access some concessions and support services from the federal government. Can the minister confirm that the same concessions and subsidies, such as the patient assisted travel scheme, will apply to someone who is seeking voluntary assisted dying services—in other words, the whole package of concessions and supports that would normally go to someone, compared with when they are seeking voluntary assisted dying services?

Mr R.H. COOK: The member is right to refer to people who access a range of services in a range of contexts, but certainly they will be eligible for all the other services that we would expect them to access through the Department of Health.

Mr D.T. REDMAN: Further to that, there could be some elements of the process of voluntary assisted dying that perhaps fall slightly outside what might normally be called the health arena. For example, would PATS concessions apply to those elements of the pathway of voluntary assisted dying?

Mr R.H. COOK: It would be the same as if they were accessing the range of specialist services. The example the member gave was PATS; yes, they would be eligible for PATS. If they are accessing services through their GP, obviously a range of federal concessions and rebates could be brought to bear in that context. In the normal manner that we would expect someone to interact with the health system, they will have access to all those forms of subsidy, assistance and public funding.

Ms M.M. QUIRK: Again, I return to clause 4(1)(i) and the discussion that some members have been having about the term “abuse”. The minister has rightly pointed to the offences under clauses 99 and 100. Clause 99(2) commences —

A person commits a crime if the person, by dishonesty, undue influence or coercion, induces another person —

Extracted from finalised Hansard
I am not quite sure why that language is not used in clause 4(1)(i) to make it consistent. It occurs to me, for example, that if a patient assistant or a nurse were to go up to a person who wanted more pain relief and said, “You silly old bugger”, that, in the natural meaning of the word “abuse”, would fall within that category.

The other issue about section 99 is that the horse has bolted by then. It would be better if that person could not be subject to coercion or duress before they die. It is such a short time frame that the investigation and a finding about coercion and abuse will be after the event. I am really concerned that that is very loose language and there should be some consideration given to it. I do not know what is in the Victorian legislation—I can probably look it up while the member for Cottesloe gets to his feet—but to me that is not consistent with the criminal provisions that the minister alluded to.

**Mr R.H. COOK:** We can deal with the details of clauses 99 and 100 when we get to them. What we are doing through the principles, essentially, is casting the net wide and then narrowing it down when we specifically talk about the offences. To use the concept to say “someone who may be subject to abuse” is to cast it in the very widest terms. “Abuse” in this context has been borrowed straight out of the Victorian legislation and is about the general context and influence on a person when they make their decision.

**Mrs A.K. HAYDEN:** If clause 4(1)(c) is not the right place to ask this question, I would really appreciate the minister indicating under what clause I can discuss this. I note the member for Cottesloe asked about the cost over the next four years and the minister provided the answer. Clause 4(1)(c) states—

a person has the right to be supported in making informed decisions about the person’s medical treatment …

Obviously, this is all about the treatment that they are able to access and that is available to them through this legislation. I know the minister addressed some of it in his reply to the second reading, but I did not hear all of it. The minister has said that the state government is going to bear the cost. Will it bear the cost of the whole service? Will there be a cost to the patient at all? Will a Medicare number be associated with any of the costs, whether it be a doctor’s appointment, assistance, reports and so forth? I would really like to understand the cost of this legislation. What will it cost to access voluntary assisted dying? What part will the government pay and what part will the patient pay?

**Mr R.H. COOK:** There is no specific Medicare benefits schedule item in relation to this. At this stage, we are still getting a line of sight of any out-of-pocket expenses in the Victorian legislation. It would be the same way that a person would access any other health service. As I said to the member for Warren–Blackwood, there would be one specific relationship with the GP, for instance, who is involved in the process. It might be undertaken in an aged-care setting and, clearly, a person would have their own arrangements with the aged-care provider. They might be in a tertiary hospital. Clearly, that is within the health jurisdiction, so there would not be any costs associated with that. There will be no costs associated with specialist services that are accessed via the Department of Health. I cannot vouch for every aspect of a person’s care, because it will be a fairly complex matrix of services that are accessed. In terms of the basic services they would receive from the WA government through the Department of Health, those services will be publicly provided like any other health service.

**Mrs A.K. HAYDEN:** I want to understand. When I access any other public health service, I present my Medicare card and I get the rebate. Some GPs charge for the gap between the cost and the Medicare rebate. If this will not have an MBS item number, how will the minister guarantee that there will be no cost and the state government will cover the bill? Will the person need to go to a state hospital? I am not trying to be awkward or extend the debate; I am trying to understand. If I go to a doctor, I use my Medicare card, and I am either bulk-billed or pay the gap. If I go to a private doctor, I pay that doctor his or her fee. There is a whole process that we need to understand. If there is a gap, who will pay for it? How will people be able to pay for it if they cannot afford to get themselves to palliative care? This is my concern. If people cannot afford that, how will they be able to afford this? I would like an explanation. Has money been allocated in the budget for this, or will it be new money?

**Mr R.H. COOK:** It will depend on the context in which the person accesses the service. For instance, if the person was an outpatient at a public hospital, they would not even have to present their Medicare card. They would simply receive the service, as they would if they were receiving a service in any other hospital as an outpatient. If the person engaged a general practitioner, they would have a relationship with that general practitioner. I guess the nature of the GP relationship may be such that, as the member said, there are no out-of-pocket expenses. However, if people have a particular GP in mind, there might be expenses. The medications would be provided by the state in that particular context. Again, it goes to the question that the member for Warren–Blackwood asked. If a person is receiving care under the Department of Health, it would be free of charge.

In answer to the member for Cottesloe, the cost to the state in Victoria was $6.35 million. Obviously there will be a need, following the implementation period, for the department to provision for the costs associated with administering this act.

**Mrs A.K. HAYDEN:** I thank the minister for that explanation. The person has gone to their GP and their costs have been covered, and they are then able to access the substance or the poison or the drug or whatever we will call it. Does the minister know how much the actual substance that people will take will cost?

*Extracted from finalised Hansard*
Mr R.H. COOK: No, member. That will obviously be worked out in the implementation phase. There will need to be a clinical oversight panel that will first decide what those substances will be.

Ms L. METTAM: I refer to clause 4(1)(c) of the principles, with reference to palliative care. I assume this is an acknowledgment that palliative care is necessarily interlinked with the introduction of the Voluntary Assisted Dying Bill. To that end, the issues surrounding palliative care in regional Western Australia are obviously significant. I acknowledge that the government has committed $30 million to palliative care in regional Western Australia. What sort of time frame can we expect for a strategy for the delivery of those additional funds to the regions?

Mr R.H. COOK: That was a wide interpretation of the principles, but I am happy to go to it because it is good to have the information out there. I committed to consult with the palliative care industry on the best way that we can spend the resources that we have. Part of that commitment was to hold a summit, which was held the weekend before last. Representatives from the palliative care industry looked into a range of those issues. I have asked the department to take away those learnings and ensure that the outcomes of that summit inform us.

Ms L. METTAM: What sort of time frame can we expect before we understand where those funds will be allocated in the regions?

Mr R.H. COOK: It will not be very long, member. I have asked the department to get a wriggle on with that. The findings from the summit are now public, and I think they are available on the Department of Health’s website. I have asked the department to come back to me as quickly as possible so that we can put some flesh to that. I understand that, particularly in the context of this debate, people want to get some understanding of that stuff.

Mr P.A. KATSAMBANIS: Still discussing the principles, I note that paragraph (j) states —

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

I think that is a statement that everyone in this place can agree with in all respects, not just in respect of this legislation. We discussed during the second reading debate specifically the issue of those health practitioners who have ethical, moral, conscientious or other concerns about engaging in this process of euthanasia, assisted dying or however we phrase it. I am concerned that the provisions in the bill fail to meet the principles articulated in the bill for health practitioners. As I pointed out in my second reading contribution, as did other members, there are plenty of cases in our medical system in which doctors can simply say, “I don’t engage in that practice.” They can do that for things such as medicinal cannabis, abortion and the like. Some clinics pride themselves on not supporting a patient’s choice to have iron infusions and would prefer them to take supplements instead. That is an example that I am aware of. Doctors and other medical practitioners are not forced to undertake steps beyond simply saying, “No; it’s a competitive market. You can see somebody else if you want to continue with that practice.” To comply with this legislation, which I think is unique in Western Australia, if a doctor has a conscientious objection, they will need to follow a series of legislative steps. They cannot simply say, “No, I’m not interested in that; I’m not going to participate. You might want to seek advice from someone else.” They will have to provide the patient with a certain form. It is not a prescribed form; it is a form authorised by the CEO, and I am sure we will deal with that when we get to that clause. We do not know what that form will look like, but we can imagine that it will contain information about how people can access the assisted dying regime under this legislation. They will also have to fill out a separate form, with all sorts of details, including the reason why they refused the request, and send it to the board. There could be multiple reasons or it could be because they did not believe the person had capacity, they were concerned about coercion or they were simply conscientious objectors.

Why would we frame a series of principles with these noble statements, including the noble statement that all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics, and then a few clauses later—we will discuss it in detail later—in clause 19, trash that very principle that is enunciated in the bill? Is this a good way to show good faith with the principles that the minister and the government are enunciating in this legislation?

Mr R.H. COOK: As the member said, we will come to that clause in due course, so I will not discuss the details of that right now. Essentially, we are balancing the need for medical practitioners to be in a position to participate on a voluntary basis against the duty of care of the patient involved. The legislation not only acknowledges that a health practitioner should be respected in those dimensions that the member has mentioned, but also is balanced against the need of the patient to receive the information that they need. So, it is a balancing act between the duty of care and the obligations that we have for that patient to be supported in the process, with the voluntary nature of the participating health practitioners.

Mr P.A. KATSAMBANIS: So why does clause 4(1)(j) not say “all persons, including health practitioners, have some right to be shown respect for their culture, religion, beliefs, values and personal characteristics”? Why does it not say that they have that right subject to a balancing act between various other rights? Why does it make this glib statement that health practitioners have this right when, clearly, the legislation that makes this statement is taking away a significant part of that right?

Extracted from finalised Hansard
Mr R.H. COOK: The member would be familiar with the context of the principles that underpin the legislation. They are there to be read as a whole. Essentially, the principles come together to form the values that underpin the legislation. The member knows that we are always balancing rights and obligations against each other to make sure that we strike a balance that the community regards as appropriate.

Mr P.A. KATSAMBANIS: I know it is late at night—early in the morning actually—and I promise the chamber that I will not sing, but I am reminded of some lyrics by one of my favourite bands, Metallica, in their song *Eye of the Beholder*. I will not sing the lyrics, but in *Eye of the Beholder* there is a great line that says, “You can do it your own way if it’s done just how I say.” That is how I feel when I hear that from the minister tonight on this principle, because, yes, it is enunciated there, but it is enunciated as a clear right. That is what it says. We challenged the minister and asked: Is it really the case? Does this legislation enshrine this right? The minister said, “No. It’s a combination; it’s got to be read together and it’s got to be balanced.” But it does not say that in the bill. If we take out this clause, which is a statement of principle—it is meant to be the guiding and shining charter, if you like, for what we are doing here—it does not say that. It does not say that everything has to be balanced. It does not say we have to play one off against the other. It says, “You can do something”, and further down it says, “You can only do it in the way that we say you can do it. You don’t get any other choice.” Again, this is another issue that gives rise to concern in not only people like me—I have stressed that from the outset—but those people who would probably feel comfortable supporting a bill that did some of the things that the bill purports to do and was based on the principles that this bill claims to be based upon, but are genuinely concerned that it will infringe upon a right to conscientious objection and a right that is actually spelt out in the very legislation that infringes upon that right. I think that this is a terrible precedent to set—to articulate a right and in the same bill fetter it or take it away. I guess we will reach an impasse on this, but it really strikes me as though these principles were lifted out of the Victorian legislation. It is almost a direct lift, not quite word for word, and then nobody compared the principles with the operating provisions of the bill. It is at best sloppy, but at worst, and I fear that this is the case, it is really only paying lip-service to a principle when, in actual fact, it is a right that will be taken away, not affirmed.

Mr R.H. COOK: As I observed before, these principles underpin the operations of the bill; they do not of themselves prescribe the clauses of the bill. Every doctor and health practitioner regardless of their beliefs and so forth still have professional ethical obligations for the way they carry out their work. Obviously, they do it in the context of their faith and cultural setting in a number of ways, but that still does not detract from the fact that they have a range of obligations to patients regardless of those features. As I explained before, these principles together underpin the values that inform the legislation, and, ultimately, by which it would be interpreted and inform other decisions. But it does not undermine the obligations that a medical or health practitioner would have in any respect to a duty of care to patients.

Mr P.A. KATSAMBANIS: I am no expert in body language or lip-reading or anything like that, but I thought that when I suggested that these principles were based very closely on the Victorian principles, the minister mouthed, “No.” Did I miss that?

Mr R.H. Cook: I think the member was trying to suggest that we lifted from the Victorian legislation. That is not the case.

Mr P.A. KATSAMBANIS: Can the minister articulate to me in which meaningful way the principles contained in clause 4(1) differ from the principles that are contained, I think, in section 3—I am happy to be corrected—of the Victorian Voluntary Assisted Dying Act 2017?

Ms M.M. Quirk: It is section 5, member.

Mr P.A. KATSAMBANIS: Section 5, is it? Okay.

Mr R.H. COOK: As I have explained before, the ministerial expert panel spent a lot of time considering the principles that underpin the legislation. We are informed mostly by its considerations. I am advised that both pieces of legislation contain guiding principles similar to each other, with the Western Australian bill reflecting the drafting language used in WA and the unique WA context—for example, making reference in the principles to regional accessibility and genuine choice, irrespective of where a person lives in WA, and having regard to the person’s culture and language. I am quite happy to provide the member with a copy of the Victorian legislation principles in due course if that is helpful.

Mr P.A. Katsambanis: I have it right here.

Mr R.H. COOK: Fair enough. As I said, the ministerial expert panel spent a lot of time looking at the Victorian principles and examining legislation in other jurisdictions. It in turn informed what it thought was appropriate for Western Australia.

Dr M.D. Nahian: Further on this issue, it has just come to mind—this might not be the right spot—that later in the legislation we apply clause 4(1)(j) to health practitioners. What about the institutions in which people are resident, whether it is a hospital, a hospice, or an aged-care home that has an institutional ownership that is against VAD? Let us say it is a Catholic hospice. I have not seen that raised in the debate so far. Could the minister discuss that?
Mr R.H. COOK: I raised it in my concluding remarks in the second reading stage, but I am informed that the faith-based hospitals are able to object to participating in the voluntary assisted dying processes for any reason, including, but not limited to, conscientious objection. The bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of an individual or organisations who do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility.

Dr D.J. HONEY: I want to talk about this clause, but I note it is now after 12.30 am and most people have been up for more than 18 hours. We talked about treating people with respect and that this is the most important bill that many people have probably ever seen. I do not think it is appropriate for us to be here now. We are all tired —

The SPEAKER: Member, can you talk on the clause.

Dr D.J. HONEY: I can, thank you, Mr Speaker, but I think this is an important point. I do not think it is appropriate that we are doing this now. We are not treating it with the respect it deserves. Hopefully, this can be the last point, minister. Clause 4(1)(f) states, in part —

a person should be encouraged to openly discuss death and dying …

I refer also to paragraph (g). I wonder whether those provisions will compel a doctor to be involved in those discussions. The minister referred to my response to the second reading speech a number of times, so obviously he has read that and certainly listened to it. Therefore, he would know that one of my great concerns is that a doctor—I believe that many doctors are in this position—who is genuinely totally opposed to this and wishes to have no involvement whatsoever could be compelled by these provisions to be involved in those discussions whether they care to be or not.

Mr R.H. COOK: As the member would be aware, and as I was just discussing with the member for Hillarys, there are obligations on health practitioners and medical practitioners under this legislation. That is not one of them.

Dr D.J. HONEY: Is the minister saying that under this legislation, doctors will be compelled to have those discussions with patients? It is a late hour. Is the minister saying that they will or will not be?

Mr R.H. COOK: No, they will not be compelled.

Dr D.J. HONEY: Further to that, I see that clause 4(1)(j) states —

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

I will not go through the clauses now; we will do it at the right time when we come to it in the bill, but it appears that a doctor can be compelled, for example, to give a person who is requesting access to voluntary assisted dying under this legislation information so that they can access it even if they do not personally agree with that at all. I wonder why we do not have any specific statement about the rights of a doctor. I think it would be appropriate to legislate that a doctor should not be compelled to participate in VAD because, as I have said before, many doctors with whom I have spoken are fundamentally opposed to any involvement in this process.

Mr R.H. COOK: I appreciate that the member for Cottesloe, of all members, would have a number of doctors in his constituency who have taken an acute interest in this debate. I answer that by saying that the principles guide the legislation and underpin the values that inform it.

The specific area the member is talking about is covered in clause 9, which we will come to in due course. But, again, a doctor, medical practitioner or health practitioner will be governed by a whole range of laws, jurisdictions and regulations consistent with their training and their registration as a health or medical practitioner, which places obligations on them and affords them rights and privileges. This legislation is no different. As I explained to the member Hillarys, this is about making sure that we balance the needs of the doctors’ perspectives to be respected against the need to provide a duty of care within an ethical framework for the patient.

Dr D.J. HONEY: I am not quite sure I heard the answer in there, but just to be clear, does clause 4(1)(j) include the principle that a doctor should not be compelled to participate in voluntary assisted dying?

Mr R.H. COOK: That is correct. I think the member’s initial question was: are they compelled to be involved in conversations? No, they are not. In the event that someone makes a request under voluntary assisted dying legislation and that person cannot for a whole range of reasons participate further, their obligations are about what they must do in terms of the provision of information.

Ms M.M. QUIRK: We had a discussion earlier about the similarity between the principles in section 5 of the Victorian act and clause 4 of this bill. As the minister correctly pointed out, clause 4(1)(h) is somewhat different because we include the phrase —

… irrespective of where the person lives in Western Australia and having regard to the person’s culture and language;

Extracted from finalised Hansard
How does the minister see that playing out in practice, given that the WA police service—luckily the minister is not in the room!—seems to have enormous problems training its officers in cultural competence in the Pilbara and the Kimberley? I wonder what the minister anticipates and how that will be implemented in practice.

Mr R.H. COOK: In my response to everyone’s second reading contributions tonight, I talked about the system navigators that have been employed in Victoria. We could certainly see those navigators playing a role to assist someone to interact with the process itself, and we could see them playing a cultural or language role as well. Those issues will ultimately be teased out in the implementation phase. The member is quite correct. This is important legislation, so it is important that, firstly, people have access to it regardless of their culture, language, background or where they live, and, secondly, when they seek access to it, they are completely informed of their rights and obligations. From that point of view, we will need to proceed carefully. There would obviously be a big obligation with regard to the written information and how it comes across, and that is why the director general has an explicit role in this legislation through oversight and the prescription of a lot of that information.

Mr Z.R.F. KIRKUP: I am keen to clarify one element that the member Hillarys raised about clause 4(2), which states that the tribunal must have regard to the principles as well. I realise this is largely a replication of the Victorian legislation and replicates, I think, the Victorian Civil and Administrative Tribunal clause. I am keen to understand, if we can, why the legislation specifically outlines that the tribunal needs to give regard to these principles. Of course, all practitioners and every other participant must have regard to this clause, as per my first question. I am keen to understand why we spell that out for the tribunal.

Mr R.H. COOK: Member, I am informed that the reason that is explicitly stated is that the tribunal plays a pretty crucial role in how this bill would work. From that point of view, it is important that the bill explicitly states how the tribunal should inform itself.

Ms M.M. QUIRK: I want to get some clarification from the minister about clause 4(1)(j), which states — all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

Could the minister outline what would be encompassed by the term “personal characteristics”?

Mr R.H. COOK: It could be a range of things. If we think about it, we could anticipate that a health practitioner may have a disability or issues to do with age that might impede them from participating. This is about making sure that we really underpin the voluntary nature of this legislation.

Ms M.M. QUIRK: I understand the overall reason for having these umbrella principles, but if the minister were to draw a Venn diagram, how would they differ from, say, a patient’s rights under the Australian Charter of Healthcare Rights? Would there be any overlapping or are they different in some way? I am curious because that sort of thing would be in existence anyway, I would think.

Mr R.H. COOK: I am not personally familiar with specific charters, but it is obviously using the same sort of language—person-centred care, valuing the patient, valuing the therapeutic relationships—so there would be some intersection between the two documents.

Mr P.A. KATSAMBANIS: In clause 4(1)(c), the first mention is made in this legislation of the term “palliative care”. Many of us have discussed in our contributions how palliative care can be misunderstood in many ways. By what reference is palliative care defined in this legislation? I note that there is no definition of palliative care in the definitions section. What definition of palliative care is being used in drafting these principles?

Mr R.H. COOK: I am advised that the term “palliative care” is not defined in the bill because the contemporary common meaning will apply. In this way, registered health practitioners are not excluded or limited from applying, consistent with their duties, wider care and palliative care treatments aimed at improving the quality of life for the individual, including assistance to the patient’s family and/or carer. There are well-established palliative care networks in Western Australia that assist with this, and the Department of Health works closely with them. For instance, I am advised that the definition referred to in the Guardianship and Administration Act is quite outdated. This view was reflected strongly by the Ministerial Expert Panel on Voluntary Assisted Dying via the Department instance, I am advised that the definition referred to in the Guardianship and Administration Act is quite outdated. This view was reflected strongly by the Ministerial Expert Panel on Voluntary Assisted Dying via the Department of Health’s consultations, including the consultations with the palliative care networks. I think the member is right. Palliative care is an emerging field of care in the health jurisdiction and nowadays it has a much wider meaning than was previously considered.

Mr P.A. KATSAMBANIS: Is the term “palliative care” defined anywhere in Western Australian health legislation?

Mr R.H. COOK: It is defined under the Guardianship and Administration Act 1990.

Mr P.A. KATSAMBANIS: I do not have a copy of the Guardianship and Administration Act in front of me, but I believe—the minister might be able to correct me if I am wrong—that it is defined by using a reference to other matters rather than a direct definition.

Mr R.H. COOK: I will seek some advice.

Extracted from finalised Hansard
Mr P.A. KATSAMBARIS: Can the minister clarify that? Just read out what it says, maybe.

Ms M.M. QUIRK: If I could assist, under the Guardianship and Administration Act 1990 —

**palliative care** means a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure …

I have foreshadowed that I will move an amendment to insert a definition of “palliative care”. I have used that definition because it is elsewhere in legislation. I cannot see what in that definition makes it outdated.

Mr R.H. COOK: Member, we were simply informed during consultations with the palliative care networks and other experts in the field that it is considered to be a rather restricted and outdated perspective of what palliative care means. Palliative care in the broader sense is now a much longer, more holistic treatment process and, from that perspective, even as the member quoted the definition from the act in that instance, I found that it would jar with some of the hospice work and broader work done in the palliative care field.

Mr P.A. KATSAMBARIS: I note that as we discuss clause 4, the principles contained in it are very closely aligned with the principles in the Victorian legislation, which passed about two years ago. The Western Australian Ministerial Expert Panel on Voluntary Assisted Dying was strongly informed by those principles. I also note that the principles in the Victorian legislation use the term “palliative care” but its drafters chose to define the term “palliative care” in the legislation. They define it by referring to the Victorian Medical Treatment Planning and Decisions Act 2016, which states —

**palliative care** includes the following —

It is an inclusive definition —

(a) the provision of reasonable medical treatment for the relief of pain, suffering and discomfort;

(b) the reasonable provision of food and water;

The drafters of the Victorian legislation chose to provide a definition of “palliative care”. They use the definition that was included in the broader legislative framework, the Medical Treatment Planning and Decisions Act 2016. Have we identified a gap in the Western Australian legislative framework, the Medical Treatment Planning and Decisions Act 2016. The principles use “palliative care” in the broadest terms and in the contemporary common usage of the term. It is not, in that context, necessary for us to nail down the definition because it does not create an instrument anywhere else in the legislation.

Mr P.A. KATSAMBARIS: The member refers to contemporary common usage. What are the limits of the contemporary common usage? Is there a series of guidelines or some sort of framework provided by the Department of Health to articulate what palliative care is or what may be included in palliative care? When the minister refers to a contemporary common usage, where should people go to find out what the contemporary common usage is?

Mr R.H. COOK: I refer the member to Palliative Care Australia and other reputable organisations that are involved in the industry. I also commend the “WA End-of-Life and Palliative Care Strategy 2018–2028”, which provides a very broad and detailed account of what end-of-life care looks like, and palliative care in that context.

Mr P.A. KATSAMBARIS: I thank the minister for the reference. I will look at it when I get an opportunity, because it is important. From our discussion, it appears to me—the minister can confirm this if he can—that within the Department of Health there is no agreed common meaning of palliative care. If that is the case, is it not a bit glib to say that “palliative care” means its common contemporary meaning? There does not seem to be a settled phrase. At the very least, Victoria has a settled inclusive definition in its legislation. I cannot see what in that definition makes it outdated.

Mr P.A. KATSAMBARIS: Again, I refer the member to the department’s strategy document for definitions of palliative care. In particular, I refer the member to the fact that this clause is about broad principles that inform the rest of the legislation rather than something that might be considered an application or litigation of an issue. These are the broad principles that together inform the values that underpin the legislation. From that point of view, I do not think it is necessary to define “palliative care”. I take the member’s point and appreciate that he wants to nail down this aspect, but I do not think it is necessary for our bill. Of course, I cannot speak on behalf of the Victorians. They have taken the direction they have. Our drafters have taken a different approach.

Extracted from finalised Hansard
Mr P.A. KATSAMBANIS: The minister can take this as a comment. I heard from the member for Girrawheen that she intends to move an amendment to attempt to rectify what I consider to be a failing in the legislation, and I am heartened by that. I look forward to the debate continuing so that we can at least consider that as an option. As I keep saying, I do not want an exclusive definition. I recognise that it is an evolving field—almost all medicine is an evolving field—but I think an inclusive definition would at least get us to a common starting point that we can move from.

Ms M.M. QUIRK: Just briefly, in this context, this will come up in the next clause, “Terms used”, and as we have already heard, there is no definition. I very much commend the Department of Health for the “WA End-of-life and Palliative Care Strategy 2018–2028”. Under the previous government, the palliative care strategy actually lapsed. I had to dig through it, and I finally found that at page 18, it states —

Palliative care
An approach that improves the quality of life of people and their family/carer facing the problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial and spiritual.

The minister might want to think about that overnight. I accept that perhaps the definition in the Guardianship and Administration Act is a bit narrow, but I think there is some value in having a definition in the legislation.

Mr R.H. COOK: I thank the member and appreciate her counsel.

Mr S.K. L’ESTRANGE: I have been listening to some of the concerns around definitions of “palliative care”. I bring us back to clause 4(1), which states —

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

The word “must” implies that if they do not, they cannot exercise that power. The word “must” is critically important to what I am about to say. Clause 4(1)(c) states —

a person has the right to be supported in making informed decisions about the person’s medical treatment, and should be given, in a manner the person understands, information about medical treatment options including comfort and palliative care and treatment;

“Must” have regard to that. Let us say, for example, that a doctor acting under this legislation knows full well that the patient they are dealing with in a regional or remote town does not have access to palliative care that would give that person the right to be supported. Under this legislation, that doctor will not be allowed to perform their duty or function. That is what I interpret that to mean. How, then, is the minister going to ensure that palliative care is available to every remote and regional community so that, under the legislation, the person exercising the power will be able to meet the requirement that they “must” have regard to what is written in clause 4(1)(c)?

Mr R.H. COOK: As I have said to other members, these are the principles that underpin the legislation, so “must have regard for” means “must consider these principles” in the context of exercising people’s powers, obligations and functions under the legislation. From that perspective, obviously people would give regard to the range of medical treatments that are available to someone.

Mr S.K. L’ESTRANGE: There is a reason why “Principles” appears right at the front of this bill; it is because these principles underpin the very nature of how every aspect of the bill is to be executed in the community once the bill is passed and made law. So, no, minister; principles are not just things we look at and have a think about, because when we fail a principle, it can have a consequential damaging effect on how we go about executing what this bill proposes to do. I ask: how can the minister ensure that a doctor acting under this legislation must have regard to clause 4(1)(c) for that person to be supported with proper palliative care? How is the minister going to prevent that doctor from acting if they cannot achieve what is set out under clause 4(1)(c)?

Mr R.H. COOK: I think we are starting to get into the realms of repetition. As I have explained, these are the principles that inform the bill. Someone exercising their power or performing a function under this bill would have to consider these principles. They are not binding, they are not exclusive and they are not inclusive; they are principles they have to have regard to. With respect, member, we have ventilated the issue of the principles extensively in terms of what is their function. I understand the member’s passion about his, but he is really just bringing us back to the original point: what is the role of the principles? We have really ventilated that issue quite well.

Mr S.K. L’ESTRANGE: I thank the minister for his counsel. I stand here as the member for Churchlands, irrespective of what any other member representing their seat has said so far on this debate, and whilst I have heard the minister’s counsel, it is irrelevant. What is relevant is that the minister just said these principles do not matter and that a person does not need to act on those principles.

Mr M. Hughes interjected.
Mr S.K. L’ESTRANGE: The member for Kalamunda can have his say when he gets to his feet to take the call. Is the minister saying that, under the bill, a person exercising power does not have to have regard to these principles?

Mr R.H. COOK: With respect, member, that is not what I said and I think the member knows that is the case. The principles serve as a guide in interpreting and applying the bill but they do not create legal obligations. They are principles that people should consider or have in mind in relation to this legislation. From that perspective, I think this is the same point that I made to the member for Hillarys, the member for Darling Range and the member for Cottesloe, and I appreciate the points that people have raised. They are very important.

Clause put and passed.

Debate adjourned, on motion by Mr R.H. Cook (Minister for Health).

Legislative Assembly

Wednesday, 4 September 2019

[page 6398]

VOLUNTARY ASSISTED DYING BILL 2019

Consideration in Detail

Resumed from 3 September.

Debate was adjourned after clause 4 had been agreed to.

Clause 5: Terms used —

Mr Z.R.F. KIRKUP: We are dealing with the terms used in the legislation. I am sure there are a number of questions from members about a range of the terms used. I was keen to get more clarity on one of the terms if I could. I am conscious of the principles that we have discussed and the minister’s second reading speech. Page 4, line 28 of the bill states —

contact details, in relation to a person, includes the address, telephone number and email address of the person;

In a remote or regional context Aboriginal people might not have a fixed address, email address or anything like that. Can the minister provide some insight into how that might work when an individual might not have a fixed address? I am aware that throughout the legislation there is a requirement for contact details of the patient to be provided to the Voluntary Assisted Dying Board throughout the process. What happens in the event that they do not have contact details? Does that interrupt their ability to access voluntary assisted dying should they choose to do so? What does that look like?

Mr R.H. COOK: Member, I am advised that this is a standard approach. However, we would be including this information on contact details, but one would anticipate that there would be other information about the ongoing therapeutic relationship with the patient involved, which will be included in that process consistent with the circumstances of that patient.

Mr Z.R.F. KIRKUP: If I could get some confirmation or satisfaction about this. By way of example, I am going to keep using an Aboriginal person in a remote setting who may not have a contact address. Does that interrupt their ability to access VAD?

Mr R.H. COOK: No, member.

Mr Z.R.F. KIRKUP: In a similar situation, and being conscious of the minister’s earlier comments, there is obviously the ability for more details to be provided to the board through the form. For clarification, is the minister suggesting that it is likely that more information will be garnered or is this just the basic and bare minimum?

Mr R.H. COOK: I could not put it better myself, member. Yes.

Dr D.J. HONEY: I cannot see in the definition section a definition of the assisted dying substance. One of my concerns with this bill is that it appears to have been constructed so as to avoid any possible controversy, if you like, or anything that could trigger some criticism of it. We had an extensive discussion yesterday on the short title. Throughout the bill, reference is made to the assisted dying substance. It is obviously the key part of the process; that is the thing that kills the person. Why is there not a definition of the assisted dying substance in the definition section?

Mr R.H. COOK: “Voluntary assisted dying substance” is defined under clause 7 and on page 8, line 10, and “prescribed substance” is defined on page 6, starting at line 28.
Dr D.J. Honey: Why would that not be put in the definition section so people do not have to search for it in the bill? It is a key part of it. I am not sure why things are put in that definition section otherwise. That would appear to be a critical definition for interpreting this bill.

Mr R.H. Cook: I draw the member’s attention to the definition section on page 6, line 28, and page 8, line 10, where both of those specific items are clarified. The member can also refer to clause 7, which provides further clarity on a voluntary assisted dying substance.

Mr Z.R.F. Kirkup: On page 6, line 1, the definition of “medical practitioner”, as it stands, is —

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

Can the minister provide us with some examples as to which practitioners might be captured within that? I have looked at the Health Practitioner Regulation National Law (WA) Act —

Mr R.H. Cook: That’s a laugh.

Mr Z.R.F. Kirkup: Yes, it is a good fun read. It is very general in what it provides. Can the minister provide some insight as to the professions that would be covered by that provision?

Mr R.H. Cook: I draw the member’s attention to clause 16 on page 13, which sets out the specific details of what a medical practitioner is. For further clarity on that, we make the distinction between a medical practitioner and a health practitioner, which is a broader definition.

Mrs A.K. Hayden: I want to follow the line of questioning by the member for Cottesloe about the definition of “substance”. Can the minister explain to me why the word “substance” is the choice of terminology?

Mr R.H. Cook: I am advised that it is to create consistency with the Medicines and Poisons Act 2014.

Mrs A.K. Hayden: Why are we not simply outlining it as it is outlined under the poisons act, and under clause 7 under the Voluntary Assisted Dying Bill.

Mr R.H. Cook: As I pointed out in both of my contributions to the second reading debate, one of the strengths of our legislation is that it borrows all the regulatory robustness of the Medicines and Poisons Act. Under the Medicines and Poisons Act, “substance” includes a compound, preparation, mixture or plant. The member would understand that in that context it is absolutely appropriate to use the same language in the Voluntary Assisted Dying Bill.

Mrs A.K. Hayden: On that line of questioning, it is going to be more than just a poison. It could be a plant or an abstract—anything. Is the minister able to advise what will be in that substance? There is a definition for substance, there is a meaning for substance, but we do not know what the substance is.

Mr R.H. Cook: As the member would have seen mentioned in several aspects of the debate, but also in terms of the bill, it is anticipated that it will be either a schedule 4 or schedule 8 drug as defined under the Medicines and Poisons Act and process would take care of under the guidance of the clinical oversight committee.

Mrs A.K. Hayden: The minister just said it will be a schedule 4 or schedule 8 drug. It is actually a poison, so let us get the terminology right. A schedule 4 drug is a poison; a schedule 8 drug is a poison. As I outlined in my speech in the second reading debate, and as I outlined last night, the terminology and language that has been chosen to be used throughout this legislation is, in my opinion, a little soft. It disguises what it actually is. The minister just referred to a schedule 4 drug; it is a schedule 4 poison.

Ms A. Sanderson: Morphine is a poison under what you are saying. That is the logic you are putting to the chamber.

Mrs A.K. Hayden: What I am trying to say is that this legislation refers to a schedule 4 poison and a schedule 8 poison; the legislation uses the terms “schedule 4 drug” and “schedule 8 drug”. We need to make sure that the language used in this bill is easy for people to understand and follow. If it looks like a duck and sounds like a duck, it is a duck.

Mr R.H. Cook: I recall a number of aspects of the member’s speech, so I will reflect on those as I provide this answer. Essentially, all poisons are a substance, but not all substances are a poison. As was mentioned in my previous response, we have nominated a schedule 4 or schedule 8 poison, having their meaning as given in section 3 of the Medicines and Poisons Act 2014 and contained within the national Standard for the Uniform Scheduling of Medicines and Poisons. Schedule 4 drugs are prescription-only medicines or a prescription animal remedy. They are substances the use or supply of which should be by or on the order of persons permitted under the act to prescribe, and should be available from a pharmacist on prescription. Schedule 8 drugs are controlled drugs. They are substances that should be available for use, but require restriction on manufacture, supply, distribution, possession and use to reduce abuse or misuse or physical or psychological dependence.
I recall that the member asked in her speech in the second reading debate for us to clearly set out what particular drugs would be used. Respectfully, we will not do that, and there are a number of reasons for that. Obviously, information in relation to those drugs is sensitive for the public health and the good of the community. Also, we do not want to create a situation whereby we are essentially nominating a drug in the legislation and throwing up flags for the particular company, whichever it may be, to say, “Great—if they all have to use my drug, guess what happens to the price of the drug?” I recall that the member spoke at length in the second reading debate about the issue of affordability. Obviously, that comes very much into sharp focus if we nominate the specific drug. I am reminded that that is essentially what happened in Hawaii when its legislation pointed to a specific drug in use—ultimately, the price of that drug skyrocketed.

The member would have heard from interjections in the chamber that it is the nature of medicines that some are poisonous and used in a therapeutic way to produce particular health outcomes. It is simply part and parcel of the medical profession’s tools of trade.

Mrs A.K. HAYDEN: I thank the minister very much for his response. I really appreciate the manner in which he is doing this. I understand that the minister is trying to keep costs down. At the end of the day, the state government will have to foot the bill. The minister said that he would not release information on what the substance will be made up of, but will the minister be advised confidentially of what the decided substance will be? Will someone be advised of that? There has to be some oversight. I do not mean an elected board or certain CEOs; I mean at a parliamentary level.

Mr R.H. COOK: I would not be ordinarily; it is one of the requirements, or duties, that is specified under the legislation for the chief executive officer, which, of course, in ordinary language, means the director general. I understand the director general will also be advised by a clinical panel that will provide advice on what schedule 4 and schedule 8 drugs could be included in the voluntary assisted dying substance.

Mrs A.K. HAYDEN: On that note, what will happen if something goes wrong? How could a government step in and say, “What are you using? There’s something going wrong”? What will be the avenues for government to find out what substance is being used to make sure that nothing adverse is going on and there are no unintended consequences? We have to remember that we are legislating for the worst-case scenario, not the best-case scenario. If the minister or the government of the day is unaware of the substance and what makes up that substance, at what point could the government intervene? At what point would the government have the knowledge and the ability to ensure that the legislation it created and put in place was able to deliver on its intent and question what was being used? As we all know, once the deal is done, if those people have suffered any pain, they will not be coming back to tell us.

Mr R.H. COOK: As everyone in this place would be aware, the health system is under acute surveillance at any point in time—I refer members to the member for Dawesville. In addition to that, obviously, there will be patient records, prescriptions and any death that is inconsistent with this act will be referred to the State Coroner. There are critical incident reports that take place in any health setting, be it in a hospital, aged-care setting and so on. There is critical oversight of all these things by the director general as the system manager. The member would be aware of a range of forums that take place in which we examine root cause analysis and other forums in which we look at any adverse medical outcome.

Mr V.A. CATANIA: Staying on page 6 and clause 5, I refer to the definition of “nurse practitioner”. Can the minister outline to members the role nurse practitioners would play under this legislation and his thoughts on the role of nurse practitioners?

Mr R.H. COOK: The member would be familiar that the ministerial expert panel, which our friend here, Malcolm McCusker, chaired, recommended that nurse practitioners should be a consulting practitioner in relation to the voluntary assisted dying process. We thought that we should take a more cautious approach, but we did foresee a role for nurse practitioners as potentially an administering practitioner. The member would be familiar with nurse practitioners and the rigorous nature of their training for postgraduate qualification. In that context, we envisage the nurse practitioner playing only a single role—that is, potentially the administering practitioner.

Mr V.A. CATANIA: Can the minister elaborate on the role of nurse practitioners as an administering practitioner? Would they play a role as part of the bill, as well as another doctor or nurse practitioner? Would they be able to sign off, for want of a better word, to enable a person to progress along the voluntary assisted dying pathway?

Mr R.H. COOK: I am advised that the answer is no. The nurse practitioner cannot play the role of either the coordinating or the consulting practitioner. Although we do foresee a situation in which potentially a nurse practitioner could be the administering practitioner, which is a role delegated from the coordinating practitioner to create the role of the administering practitioner.

Mr V.A. CATANIA: In terms of any consultation that has occurred with, say, doctors—that is, the Australian Medical Association or the Department of Health—have concerns been raised about any role that nurse practitioners may play in this process? The minister said that it is only an administering role—that is, obviously administering the substance. Has any consultation been done with doctors around that issue?
Mr R.H. COOK: I have received advice from both Malcolm McCusker and the departmental officials to say that the AMA was of the view that doctors should not be involved in any part of the process and certainly did not want nurse practitioners to be either the coordinating or the consulting practitioner. It did foresee a situation in which the nurse practitioners could be an administering practitioner. My understanding is that the nurse practitioner representatives are keen for them to be involved in as much of the process as possible. We have defined it around that single role.

Mr D.T. REDMAN: We are debating clause 5. We have definitions in legislation to give clarity to the exact scope of the words used. My question is not directed to a particular word in the definitions clause but one that is not. Although it will be considered in due course, I refer to clause 15(1)(c)(iii), which in reference to a diagnosis states —

is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

Why is there no definition of suffering in the legislation? I ask that because the word “suffering” when used in the natural sense refers to pain. If someone is in pain, they have an issue and we have to try to relieve that pain. Suffering can have a much wider scope to include emotional and spiritual pain. It has been put to me that the word “suffering” in this context is being used in its widest scope. I would have thought that suffering might have been defined so that there is no ambiguity around the intent of the legislation in respect to a person who is suffering and whether the full scope of the word should be used or considered in the assessment of the nature of a person’s suffering. Why is suffering not defined in the legislation to clarify its use?

Mr R.H. COOK: I thank the member for raising the issue. Suffering is not defined because it is entirely subjective. I think the member for Kalgoorlie spoke quite a lot about one person’s suffering being another person’s niggle. From that perspective, it is to resolve issues of suffering as felt by the person involved. The Joint Select Committee on End of Life Choices and the ministerial expert panel formed the view that a patient’s suffering was an intensely personal experience and may take a variety of forms, such as physical, mental, emotional, social, spiritual or existential.

Mrs L.M. HARVEY: I want to go back to the definition of substances to pick up on something the minister said in his response. All the way through this debate the minister has been saying that he expects a small number of people to access voluntary assisted dying, so it does not make sense to me that by naming a substance in Hawaii, the price escalated rapidly. I would like the minister to explain a little more about why that happened, because if we do not have thousands of people wanting to access the drug, why would the price escalate?

Mr R.H. COOK: The circumstance in Hawaii was that the specific drug that had to be involved was named. Regardless of how much it was used, the price reflected the monopoly market that was created as a result. The member is right; this will apply to a smaller number of people than perhaps many people would like. I think the member for Moore spoke about that in his second reading contribution. A lot of people will be disappointed by this. The member is absolutely correct to characterise it as a small number of people. These substances are obviously very important to the process and to the public health issues that are involved as well. I have been subsequently advised that in Hawaii the price went from $70 to several thousands of dollars. We know what drug companies are capable of, so from that perspective I think we have moved in a prudent manner.

Mrs L.M. HARVEY: Thank you for explaining that; that actually makes a lot more sense, because it did not make sense to me why, if a small number of people are accessing a drug, the price of the drug would go up. I understand that there is some sensitivity around this. We do not really want to be advertising the drugs that people can use to end their lives, but it is well known that we have problems with fentanyl overdoses. We know that morphine is administered as a form of palliative sedation, and for people with respiratory difficulties, that hastens their death, unfortunately. It is a balance that the medical fraternity manages at the moment. We know that sodium barbital is involved in palliative sedation. Are these the sorts of drugs that are likely to be used and prescribed by the CEO, or are there other drugs that we are not aware of? I accept that the minister is not going to want to name a specific drug that might give a particular company a market advantage, but we are just trying to get an idea of whether these are readily available substances that are currently prescribed or whether a new drug is likely to be used for this purpose.

Mr R.H. COOK: I am advised that, ultimately, the drugs involved in this process will be overseen by a clinical panel, so I would not want to pre-empt the decision that it will make. The drugs would also have to be appropriate for the individual and their circumstances. The member would understand that a person who cannot absorb drugs orally would require a different form of voluntary assisted dying substance. It is also specifically for the Western Australian setting, where some communities may be more isolated than others. The member is quite right to nominate the issue of the abuse of prescription drugs. Many drugs that can do great harm to the community are already out there, so it is important that we proceed with these things very carefully.

Mr Z.R.F. KIRKUP: I refer to the definition of “prepare” at line 21 on page 6. I note that the word is used a number of times—in the administration decision, the administering practitioner, and a number of different iterations throughout the bill. There is obviously a need for the patient or the administering practitioner to prepare the substance in some way, shape or form. I note that a definition of “prepare” has been provided in this case. Is it required that the substance be prepared? Are we anticipating a substance that needs to be prepared in order to be

Extracted from finalised Hansard
self-administrated in that instance? In that case, we would have some comfort, therefore, that it is not just a singular pill, but there would be a step involved in the process, given that it is stated a number of times in the legislation that the patient must prepare the substance.

Mr R.H. COOK: I am advised that a combination of drugs may be involved. It may also be a combination, to give a typical example, of an active ingredient or medication that may be very bitter and a substance to make it more palatable. In this context, it provides the authority to make that preparation.

Mr Z.R.F. KIRKUP: I appreciate the minister’s response. I am concerned because part (b) is a bit of a chemistry summary—decant, dissolve, reconstitute. This puts a lot of onus on the patient, particularly if they come from a disadvantaged background and may not be able to undertake such a task. It is obviously not prescriptive; it just gives the option for that to occur. Why was the flavouring and colouring, in particular, included as part of the preparation definition?

Ms M.M. QUIRK: I refer to the absence of the term “palliative care” amongst the definitions provided in clause 5. I drafted an amendment that referred to the definition in the Guardianship and Administration Act, and the minister indicated that that was too narrow and outmoded. Overnight, in my spare time, I have drafted another amendment that I think better reflects the minister’s view of current palliative care practice. I move —

Page 6, after line 10 — to insert —

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

The minister will see that the word “incurable” is included. It was used elsewhere in the legislation, but it is in the same form as the Victorian legislation. This definition was partially based on the definition on page 18 of the “WA End-of-Life and Palliative Care Strategy 2018–2028”.

Mr R.H. COOK: I thank the member for her amendment. As I confirmed to the house last night, palliative care is not defined in the bill, as the contemporary common meaning will apply and is associated fundamentally with the principles or values which underscore it. In the context of this bill, the term “palliative care” is used in three provisions in which it does not need defining. First, it is used to set out the principle that a person has the right to be supported in making informed decisions about the person’s medical treatment and should be given, in a manner that the person understands, information about the medical treatment options, including comfort and palliative care. The second one requires the coordinating practitioner, if satisfied that the person meets all the eligibility criteria, to inform the person about the palliative care options available to the person and the likely outcomes of that care. The third provision requires the consulting practitioner, if satisfied that the person meets all the eligibility criteria, to inform the person about the palliative care options available to the person and the likely outcomes of that care. I respectfully submit that we do not need to have a definition of “palliative care” to meet the needs of the bill. Ultimately, I would have some difficulty with the wording that the member used. Without going to the substance of the actual definition, I come back to the key point that a definition around palliative care is not needed.

Ms A. SANDERSON: I am also of the view that this is not an appropriate amendment. It is not appropriate to be defining medical treatments in legislation. Medical treatments evolve over time and develop with new technology and new treatments. It would be inappropriate to actually define what those treatments are. Palliative care is different according to different palliative care specialists. One person’s idea of palliative care is different from another person’s idea of palliative care, so defining it is virtually impossible and would be incredibly restrictive under the legislation. I will not be supporting the amendment. If a person goes to one hospice to seek palliative care treatment, they will get one set of treatments; if they went to another palliative care specialist, they would get another set of treatments. Some palliative care specialists believe in the mind-body-soul treatment of palliative care. Other palliative care specialists believe in the treatment of pain and that patients are able to resolve their own spiritual issues at the end of life. It is a very broad area of medicine. I think it is very dangerous and unhelpful to start defining medical terms and treatments in legislation. We are not doctors. Essentially, if this amendment were passed, it would be in place for many, many years to come.

Ms M.M. QUIRK: The member for Morley has actually hit it on the head. I do not know whether she has a copy of the amendment in front of her, but this amendment uses the word “includes”. The member also mentioned that palliative care means different things to different people. We are going on trust in terms of clause 26, for example, under which a medico will be placed under an obligation to advise a patient of the availability of palliative care. He could be in legal jeopardy if he does not do so, yet we do not know what he will be telling his patients. I know that some form of words may be developed by the CEO, but I make the point that this amendment—and I accept that it is not perfect—is inclusive of other broader definitions, as the member for Morley talked about, because it
uses the word “includes” and refers to relieving pain, discomfort or distress. That covers psychosocial issues as well as pain management and spiritual issues. It is a broad definition for that reason. If anything, when I sent the amendment to parliamentary counsel, I did not have something about the timing of palliative care, but for the convenience of drafting, I have omitted that. I am just perplexed, because the term is used throughout the bill and obligations are placed on doctors to advise patients of the availability and prognosis of palliative care, but nowhere is the term defined.

Mr P.A. KATSAMBANIS: I thank the member for Girrawheen for bringing this amendment to the house. This is an issue that we identified last night in consideration in detail when we were going through earlier clauses. It is obvious that the term “palliative care and treatment” is not defined in the legislation, although it is used extensively. As I pointed out last night, or early this morning, this term is defined in the Victorian legislation. Perhaps the Victorians are lucky that they have an existing legislative framework that includes a definition of the term “palliative care”. In the only other Australian jurisdiction that has live legislation in this very complex area, it was clearly considered vital that the term “palliative care” be defined in the legislation. As we discussed last night with the minister—I think the minister was quite accepting of the general concept—these sorts of definitions ought to be inclusive rather than exclusive. We were not talking about palliative care at that time; we were talking about the concept of abuse.

However, irrespective of the word or term that is being defined, because of advances in medical science, because of changes in theory or concept around treatment, and simply because some people have a different definition from others, it is better to have an inclusive rather than an exclusive definition when defining these sorts of terms. But we do need a starting point—a baseline—of what an important term such as “palliative care” ought to be in relation to this legislation. That is magnified when we then consider the debate more broadly around funding for palliative care and the need to ensure that palliative care is available where it is needed and when it is needed, so that it is one of the genuine, realistic options available to it and that it is not just simply an option to which we pay lip-service but cannot provide in reality, whether it is in the metropolitan area, the suburbs, regional towns and cities or more remote areas of Western Australia. It presents challenges. I recognise that it presents challenges to provide palliative care in any setting, let alone a setting such as our state with its extraordinary geographic reach and far-flung population. Many members of our population live in small groupings—one would not call them more than villages, really—in extraordinarily inaccessible locations. If we are to live up to and achieve the lofty principles that are outlined at the start of this bill and the principles in clause 4, which we debated so well last night, including the principle that a person is entitled to genuine choices about the person’s care, treatment and end of life, irrespective of where the person lives in Western Australia, and having regard to the person’s culture and language, a starting point would be to know what we are talking about. A definition of “palliative care” would be critical to that. I think everyone accepts that palliative care ought to be one of those genuine choices. Given the similarity, in many respects, of our legislation to the Victorian legislation, including —

Dr M.D. NAHAN: I would like to hear further from the member for Hillarys.

The ACTING SPEAKER: Member for Hillarys, carry on.

Mr P.A. KATSAMBANIS: Given the close proximity of the wording of the principles in the Victorian legislation and the proposed Western Australian legislation, given the extraordinarily critical importance of the availability of palliative care in relation to giving people legitimate, genuine choices about their care and treatment at the end of life, and given that the Victorians chose to provide a definition, I think it is axiomatic that this legislation have that very same definition. It is an inclusive definition, rather than an exclusive or exhaustive one. However, it gives us a starting point for what palliative care may entail so that we can then fund that care in order to provide those genuine choices. Without a definition, we will constantly debate whether new money is going to palliative care. The member for Girrawheen, who made a substantive and excellent contribution to the second reading debate, highlighted, by the table that she provided, the question marks about what may or may not be palliative care funding. There is genuine concern in the community that legislation such as this may actively encourage governments—perhaps not this government or the next government, but governments in the future—to treat the provisions in this bill as the primary way of dealing with people at end of life. In my contribution to the second reading debate, I described that as a humanitarian tragedy of the highest order, and it would be. I know that is not the intention of this minister; I know that is not the intention of the Premier. They have both indicated that they want to provide greater funding for palliative care. However, at the moment, all we can do is take them at their word. We have not seen that additional funding. We hope it is provided, and we hope it is provided in the context of the debate on this bill. However, without even a definition in the bill, and in the act if this bill eventually becomes an act, we will not even have a starting point.

The member for Girrawheen indicated in her contribution that she would be happy to consider alternatives. I do not want to speak for other members, but if the definition provided by the honourable member for Girrawheen is not acceptable to the minister, I also will be happy to consider alternatives. It would be a fundamental flaw if this definition were not included in the legislation. The reason it would be a fundamental flaw is that palliative care ought to be a primary and genuine choice. I will leave it to the minister. We know how the weight of numbers in

Extracted from finalised Hansard
Mr J.E. McGrath: I, too, will not be supporting the amendment. I was a member of the joint standing committee, which looked at this subject over 12 months, and went with a palliative care nurse to hospitals at which palliative care was provided. I know that palliative care is a wideranging health service that people can avail themselves of. We all agree that palliative care is an essential element of our health system for people who are dying. I want to raise an interesting point. In 2008, the then government made an amendment to the Criminal Code to protect doctors who administer palliative care. That amendment did not include a definition of palliative care. Therefore, if I am to believe what members are saying now, what went wrong back then? I think the reason that no definition was provided is that palliative care is such a wideranging medical service that it is very hard to define. That is my view.

Mrs A.K. Hayden: I congratulate the member for Girrawheen for this proposed amendment. The minister referred to the Victorian legislation as a come-back to some of the questions that have been asked by members on all sides about why things are the way they are in the legislation. The minister said it is in the Victorian legislation and that is why we are doing it. This proposed definition is in the Victorian legislation, yet the minister has chosen not to include it in this legislation. The minister has said that this legislation is benchmarked on the Victorian legislation. The minister cannot use that to support one argument and not another. I struggle with why the minister is not willing to include that definition in this legislation. I understand the argument that has been put against this proposed amendment—namely, that palliative care is very broad. However, I honestly believe that is encapsulated in this proposed amendment. I will read the amendment, in case members have not read it—

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

That is as broad as we can make it. Palliative care is broad. It is also a major step in this legislation that an individual must go through, and should go through, before they can access voluntary assisted dying. However, that major step in this assisted dying process has not been defined in this clause. We are talking about a simple request to include this proposed definition as a safeguard, and as a way of appeasing people who have concerns about this legislation. Just about every member in this chamber, no matter what their position is on this legislation, raised palliative care as a major concern. Palliative care is a concern in our community. The fact is that over 80 per cent of people who need to access palliative care are not able to access it. The fact is also that many people are unaware of palliative care. We need to make it clear that we are not just saying, “Hey, go ahead with assisted suicide or assisted dying”, or whatever we want to call it. We are saying, “Hey, here is some help. Here is some relief and some assistance.” This needs to happen before people make the final decision. This is a simple request from the floor of the chamber that this definition be included in the bill as a safeguard to ensure that people understand. I think this is an extremely reasonable request. It is not in the best interests of the government to not support this proposed amendment. We expect Western Australians to be aware of palliative care. This will be another step that will enable that to occur. I fully support this amendment.

Mr W.R. Marmion: I will not go over the reasons that have already been given in support of the proposed amendment. I think the member for Girrawheen has put a legitimate argument. I have some questions that I would like the minister to answer. What would be the impact on the bill if we did include a definition of palliative care? Would it take away anything from the bill? I do not know the meaning of a lot of big words, so when I look at a bill, I always look to the definitions clause to find the meaning of the words that are used. When I read this bill, I looked at all the definitions of what people will have to do as they go through the process. The logic I go through is that if I see a word I do not know, I go to the definitions clause. I think a compelling case has been put for the proposed definition. I would like the minister to put the case for why he would not include this proposed definition. I do not think it is valid to say that because it is general and if we cannot define it, we will not put it in. I think we should have a crack at it. Young people—they might be at university or in primary school—could read the bill and want to look up what “palliative care” means and they would find a definition at the front of the bill. I would like the minister to outline the negative impact on the bill if we included that definition.

Mr S.K. L'Estrange: I join a number of people in this chamber who have argued why a definition of palliative care should be included in the bill. The member for Morley outlined that it is too difficult because it can be too broad, or words to that effect. I notice that on page 7 of the bill —

Ms A. Sanderson: Don’t verbal me, member.

Mr S.K. L'Estrange: I am happy for the member for Morley to interject and let me know what she said.

Ms A. Sanderson: I said it was inappropriate to legislate for medical definitions—inappropriate.
Mr S.K. L’ESTRANGE: In this instance, there is a definition on page 7 of the bill for “professional care services”, which frames what professional care services are. Somebody has gone to a fair bit of trouble to work out how to frame what professional care services are. What all those people who have stood so far to argue in favour of this amendment have said is that we should make sure that people understand what palliative care is. If we were to go down Hay Street Mall today and grab 30 people off the street and ask them their understanding of palliative care, I think that they would be like I was a year or two ago and would say, “Well, it’s when you are within hours of death and you are being supervised on a bed and you are being cared for in the final hours of life.” They might not say what the professionals at the palliative care unit at Bethesda Hospital told me, which is that palliative care can last for five years or longer, and that when a person is diagnosed with a chronic or terminal illness, they will receive counselling, support services, family and medical support, and an ongoing point of contact with people who care for and look after them on that journey.

I think it is pretty important that we help the community, and the media who report on these things, to understand how we as a Parliament are framing what palliative care means. We are about to sign-off on a pretty important and serious bill, which a number of us in this chamber are really concerned about. I do not think this need be a binary thing. It does not need to be an “us versus them”—a win–lose. This is simply a definition—that is all it is—so that people can better understand what palliative care means, as part of a care program, in this bill.

The minister will recall that towards the end of last night, when we were looking at clause 4, “Principles”, I highlighted subclause (1)(c). The final part of that paragraph states —

… including comfort, palliative care and treatment;

It is important that when a fundamental principle that underpins this bill refers to the need for people to be advised on palliative care, that term should be included in the definitions. We should at least let them know what palliative care means. I do not think we need to take this as being about winning or losing, a binary thing, or about losing a vote on the floor. Do not think like that. It is purely about making sure that people understand what palliative care is. That is it. I am sure we can craft something that can achieve that outcome.

Mrs L.M. HARVEY: I want to respond to the member for Morley’s interjection. She said that it is inappropriate to describe a medical service. I draw members’ attention to the bottom of page 5, which states —

health service has the meaning given in the Health Services Act 2016 section 7;

Section 7 of the Health Services Act states —

Meaning of health service and public health service

(1) A health service is a service for maintaining, improving, restoring or managing people’s physical and mental health and wellbeing.

(2) Without limiting subsection (1), a health service includes —

(a) a service mentioned in subsection (1) that is provided to a person at a hospital or any other place;

(b) a service dealing with public health, including a programme or activity for —

(i) the prevention and control of disease or sickness; or

(ii) the prevention of injury; or

(iii) the protection and promotion of health;

(c) a support service for a service mentioned in subsection (1);

(d) the provision of goods for a service mentioned in subsection (1).

The amendment that the member for Girrawheen has moved provides a definition for “palliative care and treatment”. In looking up the definition of “palliative care”, we find that it is care for the terminally ill and their families especially that provided by an organised health service. It is suitably broad. The term medical, which is also used in this amendment, is defined as of or relating to the science or practice of medicine. The term surgical pertains to or involves surgery or surgeons. Nursing procedure is defined as a course of action intended to achieve a result in the delivery of health care. The word palliative in and of itself is defined as relating to a medicine or medical care that is involved in relieving pain but without dealing with the cause of the condition.

We are trying to achieve some consistency in these definitions. The words palliative care are used consistently throughout the legislation. There are definitions in the bill for terms as innocuous as department, disability, medicine and nurse practitioner. Numerous medical definitions are described aptly in the definitions clause of this legislation. All we seek from the minister is that the bill be consistent with the Victorian legislation and have a definition of “palliative care and treatment”. The proposed definition is suitably broad. It covers off on a wide range of services and treatment options—a range of aspects in the delivery of palliative care. I hope that when I sit down, the minister will explain how putting in a definition of palliative care and treatment has an adverse impact.
on the legislation, as I fail to understand it. How can having a definition like this in the bill be detrimental to the purpose of the legislation, given that palliative care is actually mentioned as part of the purpose of this legislation—that an individual should have access to palliative care? I seek the minister’s explanation of why we cannot have this definition in here when nearly every other term used in the legislation is defined.

Several members interjected.

The SPEAKER: Hold on! The minister has a right to reply before everyone jumps up.

Mr R.H. Cook: I do not mind hearing all the arguments first, Mr Speaker. What would you like?

The SPEAKER: Whatever suits you, minister. I am very easy.

Mr D.T. PUNCH: I wish to speak against this amendment. Putting a definition of palliative care into the legislation will put an artificial constraint on what palliative care could and should be. In my second reading contribution I spoke extensively about palliative care. It is not a trade-off between assisted dying and palliative care; it is about putting the patient central to a range of options that the patient, in discussion with their family and medical practitioner, can make some choices about. I think the amendment would put a constraint on the notion of what palliative care is, because we principally see palliative care as a medical response to end of life with some social components. A lot of evidence is coming out overseas and emerging in Australia that says that end of life is about the quality of life and social environment, with some medical aspects. I am concerned that this debate is shaping the response to palliative care to be in a medical context, which would see more and more Australians dying in hospitals, which is not their preferred situation. We need a much broader view of community-based palliative care within a medical context that supports pain and symptom management, but puts the patient first in their community and with their family. That is why I am speaking against this amendment. We need a much broader vision for the future. I certainly think there can be a debate about palliative care, but it needs to be separate from the bill that we are debating today, which puts the patient at the heart of a decision about whether they want to end their life voluntarily in light of intolerable suffering and a life-limiting disease.

Mrs L.M. HARVEY: I have to get up and rebut what the member for Bunbury has just said. The Health Services Act 2016, from which I earlier read out a definition, refers to “health service”. Section 5 of the Health Practitioner Regulation National Law (WA) Act 2010 states, in part —

health service includes the following services, whether provided as public or private services —

(a) services provided by registered health practitioners;
(b) hospital services;
(c) mental health services;
(d) pharmaceutical services;
(e) ambulance services;
(f) community health services;
(g) health education services;
(h) welfare services necessary to implement any services referred to in paragraphs (a) to (g);
(i) services provided by dieticians, masseurs, naturopaths, social workers, speech pathologists, audiologists or audiometrists;
(j) pathology services;

This is in the context of “health profession” being defined in the same section as —

... the following professions, and includes a recognised specialty in any of the following professions —

(a) Aboriginal and Torres Strait Islander health practice;
(b) Chinese medicine;
(c) chiropractic;
(d) dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthodontist and oral health therapist);

That is probably not relevant —

(e) medical;
(f) medical radiation practice;
(g) midwifery;
(ga) nursing;

Extracted from finalised Hansard
The act lists a range of health professionals and health services. I challenge anybody in this place to come up with a health service that could be provided by way of palliative care service that would not be included those definitions that are clearly referred to in the legislation. I know, having been through a palliative care program, that we had reflexology, a range of massage therapies and all sorts of things available to us to help with chemotherapy and other palliative treatments. Every one of those therapies that were accessed was more than adequately covered by existing definitions. The only healthcare service that is not actually described by way of definition is the palliative care service that is essential and intrinsic to the issue that we are debating. People will not access voluntary assisted dying unless they are in the same group of people who are accessing palliative care should it be available. To have a definition of “palliative care” in this legislation is worthwhile and necessary. Clearly, the Victorian Parliament thought that it was needed and essential because it forms part of its legislation.

We would really appreciate it if the minister got to his feet and explained to us how this will have any manifestly detrimental outcome for the operations of the legislation. I cannot see that it could, given that there are so many other definitions in the bill. The definition of palliative care and treatment is very broad. Including this definition would increase the significance and prominence of our focus on palliative care going forward. As a society, we need to focus on this area; we are all aware of that. The Joint Select Committee on End of Life Choices made numerous recommendations on the provision of palliative care services. I see the inclusion in the bill of a definition of palliative care as key and essential. It would make the bill stronger. I would like the minister to get to his feet and explain why he is not considering it.

Mr R.H. COOK: I do not think I had got to my feet yet, but I am very happy to do so now. The member for Hillarys observed that the concept of palliative care is used extensively throughout this bill. It is not. As I explained in my contribution earlier, it is referred to twice in the broadest possible way. One is in the principles and the second is in the context of the coordinating practitioner and the consulting practitioner. The concept of palliative care is not material to this bill. The member for Darling Range observed that palliative care is intrinsic to this bill. This bill is about voluntary assisted dying. People may access voluntary assisted dying without necessarily accessing palliative care. I know that some people here find that concept offensive, and very much in their minds the issue of palliative care and voluntary assisted dying are conflated. Indeed, in some contexts it is seen as either/or, and from that perspective it is true that the government has a very different approach from that.

It is not appropriate to define palliative care in the context of this bill because this bill is about voluntary assisted dying. In that sense, it is not appropriate for us to try to insert “palliative care” definitions in this bill because, quite frankly, that is not what this bill is about. The joint select committee made a range of observations on palliative care. One of those is that it is a very evolving and misunderstood area, but in its broadest definition, it can mean a range of things. I notice that Palliative Care WA states —

Palliative care identifies and treats symptoms which may be physical, emotional, spiritual or social. Because palliative care is based on individual needs, the services offered will differ but may include:

- Relief of pain and other symptoms e.g. vomiting, shortness of breath
- Resources such as equipment needed to aid care at home
- Assistance for families to come together to talk about sensitive issues
- Links to other services such as home help and financial support
- Support for people to meet cultural obligations
- Support for emotional, social and spiritual concerns
- Counselling and grief support
- Referrals to respite care services

Palliative care is a family-centred model of care, meaning that family and carers can receive practical and emotional support.
I take the point that the member for Bunbury made. The concept of palliative care is an emerging one, and although we often picture palliative care taking place in a hospital or hospice setting, it goes beyond those simple definitions. As I said, this is not about palliative care versus voluntary assisted dying. It is not material to this bill. In the broadest possible term—that is, the generic concepts of palliative care—it is referred to in the principles, but it is not material to this bill. It does not give effect to aspects of this bill. From that perspective, I understand what members are saying in terms of it would be nice to have it in the legislation, but that is not appropriate because this bill is about voluntary assisted dying. I know from a range of speeches given by members that people are keen to conflate the two issues and I understand that, and a bunch of work on palliative care is going on, which is also an exercise or an activity of government.

Members should be very clear about what we are doing here. We are describing and prescribing a process around voluntary assisted dying. It is not appropriate to seek to craft a definition or that a definition sits in the context of this bill.

Mr S.K. L’ESTRANGE: I found the minister’s answer unusual to say the least.

Mr R.H. Cook: You usually do, member.

Mr S.K. L’ESTRANGE: No, I do not. The minister knows that is not true. He is saying that it is not part of the bill, but it is. It is a part of the bill.

Mr R.H. Cook: I said it is not material to the bill.

Mr S.K. L’ESTRANGE: I think it is material to the bill.

Mr R.H. Cook: I understand that.

Mr S.K. L’ESTRANGE: Clause 26, “Information to be provided if patient assessed as meeting eligibility criteria”, is a key part of the bill and states —

(1) If the coordinating practitioner is satisfied that the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters —

... 

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

If a coordinating practitioner reads that bill, goes to the definitions and says, “Okay, according to this legislation, I must inform them”, and then cannot find a definition of what they need to inform, where do they go?

Mr W.R. Marmion: The Oxford dictionary!

Mr S.K. L’ESTRANGE: Great! They could go to the Wikipedia definition. Is that going to fulfil clause 26? The problem is that it might not. This is not about being binary, or us versus them. As I said before, it is fundamental to the bill that information is to be provided to a patient who is assessed as meeting eligibility criteria for voluntary euthanasia. This is about the patient being eligible to go ahead and take on a premature death. The clause states that the practitioner must inform the patient of the palliative care and treatment options, and the minister is telling us now that palliative care is not a part of his bill. It is, minister! It is in clause 26. If it is not defined in the definitions, then it is left to these practitioners to make up their own definition. When legislating on such a serious matter, I think that is leaving way too much to chance.

Mr R.H. COOK: I thank the member and appreciate that this is an important issue. If the member refers to clause 26, it states —

... the coordinating practitioner must inform the patient about the following matters —

There is no obligation for that patient to actually be taking palliative care; it is simply to say that the issues and the treatment options, including palliative care, are made available. This is about the patient, not about the doctor. From that perspective, we could chase ourselves down a hole trying to define all the issues that come within that eligibility criteria. This is something that is simply part of the conversation that takes place between the practitioner and the patient.

On the use of the term “palliative care”, Palliative Care WA, as I said, defines it in the very broadest terms, and the Department of Health and palliative care providers already refer to that policy statement. It is not necessary to define it, because it is not going to determine whether a patient is eligible or not. That is the crucial aspect here in clause 26. It does not determine it, and it does not say that palliative care is determined in a particular way, therefore the patient is eligible; it is simply that it is part of the conversation, and the practitioner must be satisfied that the patient has been made aware of other care pathways. But it is not for the practitioner to decide whether that person is appropriately captured within it. This is about the patient, not the practitioner.

Extracted from finalised Hansard
Mr S.K. L’ESTRANGE: I have a follow-on question. Can the minister then explain to this chamber what he thinks palliative care is, so that we have an understanding? This is the government’s bill and it is not defined within it. Can the minister at least tell us what he thinks palliative care is?

Mr R.H. COOK: Member, as I stated a very, very short time ago, I am informed by the Palliative Care WA policy statement, which includes those features that I put in Hansard in my previous remarks.

Mr A. KRSTICEVIC: Obviously, I am listening to what everyone is saying about this. Palliative care is critical. The fact that the minister cannot give us a definition, or is not prepared to put a definition into this bill, concerns me greatly. Supposedly, over the next four years, the government is putting $206 million into palliative care. The question is: where is that going and what is it being spent on? We do not know what palliative care is. Nobody wants to put a definition to it, or give us an explanation, or, at least, the minister cannot, and he refuses to put it in the bill. Will that money be spent on capital expenditure, on buildings and infrastructure, as it has been in Carnarvon; or will the money go into people and pain relief and services? It is very concerning from that perspective.

When I listen to other members argue that palliative care should not be included because the definition of medical services should not be included, I assume those same members will be moving amendments to take a number of definitions out of this legislation where those services are defined, to rationalise the arguments that they have made here today.

Another part that concerns me is that point (i) of the definition of “professional care services” outlines a whole range of things such as bathing, showering, personal hygiene, toileting, dressing, undressing or meals, but it does not say anything about fluids, or about helping people to drink. Fluids are the most important aspect, and nowhere are they included in professional care services. Again, that definition and explanation is flawed, based on the rationale I am hearing today in this discussion. I will get back to that point later on with that amendment—whether or not meals includes fluids, and whether there is another definition somewhere else.

Again, palliative care is critical. I know the minister says that they are not linked, and I know people talk about listening to the community. An article by Nathan Hondros that appeared in yesterday’s WAtoday states “Polling reveals country voters want palliative care fixed before euthanasia legalised”. Some 2 000 people were surveyed, and 73 per cent said, “No, you’ve got to fix up palliative care first.” Of course, according to the minister, this bill has nothing to do with palliative care. Palliative care is not part of euthanasia—sorry, voluntary assisted dying. Palliative care is nothing to do with it. It is mentioned three times; by the way, we are putting $206 million into palliative care, but we do not want to define it. Even though this definition is very broad, and the minister cannot give us a definition, he refuses to accept it, and he refuses to put it in there because it has nothing to do with the bill. However, it is a key part of the process. Palliative care is critical to people’s decision-making and the end-point they get to at the end of this process.

We have heard from experts who say that palliative care works in 99.9 per cent of cases, if it is carried out and funded properly. Even for the percentage for whom it does not work, I think experts responded back to the inquiry to say that in those cases, they have a solution that works. From the medical perspective or the palliative care perspective, they can deal with 100 per cent of cases, if they have the right funding and resources. I am not an expert in that field; I do not think any of us are. But if that is what they say—the 15 people in that field in this whole state—they are the people we should be asking: What is palliative care? Should it be defined? Should it be in this legislation? We should not be asking people who have no idea about the specifics of all that palliative care entails. I think it is a major shortcoming and a major flaw not to include the definition of palliative care.

Another part that concerns me, minister, is when we get to the more serious areas of concern where the community needs to be scared of this legislation, where there is the possibility of coercion or of people ending their lives without getting fair and proper advice, and a whole number of other aspects that are concerning, it makes me wonder what chance we have to fix that up, when we cannot do something as simple as a definition that I am pretty sure most people agree with. Apart from the minister, the arguments I am hearing from everybody else are focused on whether those definitions should or should not be in the bill. I am interested to know what the minister thinks about that, and whether some of these other definitions need to be taken out, based on the arguments put by members.

The DEPUTY SPEAKER: Members, before we have any other conversations on this subject, I have been listening to the debate, and I have heard the minister respond to this question quite a few times. It is entirely up to the minister what he does and how he responds. I would urge members to remember that this is not a repetitive debate; it is to try to bring new issues to the table. Could members please think about that when they respond.

Mr R.H. COOK: I hope the member does not mind if I respectfully stick to responding to the point that he is making, which is consistent with the amendment that has been moved. As I said, a definition of palliative care is not needed because it is not material to this bill. Professional care services are referred to in relation to other aspects of the bill and do have a material effect on it. That is essentially that. If the member wants to dig a little bit further on the definition of professional care services, I think we need to do that separately from the member for Girrawheen’s amendment.
Mr R.S. LOVE: I want to make some comments on this proposed amendment. The amendment that I have read seems to closely follow in some aspects the definition of “eligibility criteria” for a person to access voluntary assisted dying in clause 15(1)(c), which states —

the person is diagnosed with at least 1 disease, illness or medical condition that —

(i) is advanced, progressive and will cause death …

This definition of when palliative care is applicable seems to closely follow what is in the voluntary assisted dying legislation, which I think is somewhat at odds with my understanding of when palliative care should be sought. Finding 12 of the report of the Joint Select Committee on End of Life Choices states —

Access to specialist palliative care in the early stages of a diagnosis might improve remaining quality of life, mood, resilience, symptom management and allow for death in the patient’s preferred location.

Although I am not opposed to the principle of inserting a definition of “palliative care” in the bill, I do not think I would accept this definition for palliative care because it is clearly aimed at the end stage of a person’s disease when progressing towards death. As the committee found, it is better if palliative care treatment is undergone sooner. I do not agree with the definition, but I agree with there being one.

The DEPUTY SPEAKER: Member for Cottesloe.

Mr R.S. Love: I was hoping to get a comment from the minister.

The DEPUTY SPEAKER: I think the minister wants to respond, member for Cottesloe.

Mr R.H. COOK: Thank you, member for Cottesloe. I agree with the member for Moore. I, too, have problems with the definition. Palliative care is also for the treatment of pain and suffering, not necessarily at the end of life. However, I differ from the member on the need to have a definition in the legislation. Palliative care is referenced, as would be expected, but it is not material to the bill.

Dr D.J. Honey: Deputy Speaker.

The DEPUTY SPEAKER: The member for Girrawheen was on her feet. We will come back to that. We have a day to do this.

Ms M.M. QUIRK: I am sorry. I will try to bring the debate back on track.

The Victorian legislation, which ours closely mirrors, has a definition of “palliative care”. That references the definition in the Victorian Medical Treatment Planning and Decisions Act 2016, in which it is defined as including —

(a) the provision of reasonable medical treatment for the relief of pain, suffering and discomfort;

(b) the reasonable provision of food and water;

I would probably say that is too narrow, given the comments of people such as the member for Moore, but what is it about Western Australia that makes it different from Victoria? Victoria seems to have no issue about including a definition. That is the crux of the matter.

Mr R.H. COOK: I am advised that it is essentially a drafting convention in Victoria and it is not imperative. As I have already mentioned, it is not material to our bill.

Dr D.J. Honey: I was concerned that the minister was worried that people were trying to conflate the issues of palliative care and the Voluntary Assisted Dying Bill. In fact, that is one of the very specific concerns that people who are opposed to this bill have; that is, that the inadequacy of palliative care in the state and the inadequacy of the training of practitioners in palliative care will, in fact, lead people to access voluntary assisted dying and will be causative of it. I think it is entirely appropriate that we include a definition. I echo the comments of the member for Girrawheen. The truth is that the Victorian bill is not an idle bill, as the minister knows. Victorian legislators went to enormous effort to put the definition in there. They saw it as very important and we do as well.

I note that the minister’s intent with this bill is genuine and comes from the right place, but when we look at any bill, we are not here to look at the best of possible circumstances; we are to look at the worst of possible circumstances. One of my concerns about this bill is that if we do not specifically recognise palliative care and treatment in the bill, over time, voluntary assisted dying will become the default and the alternative to adequate palliative care in the state. I think that was reflected in the debate today. Over time, we will see drift. It is important that we recognise palliative care. Adequate palliative care to the end of life should be the primary focus of all governments. It is the contention of members across this parliament that voluntary assisted dying should be another alternative at the end of life. I do not think it is in any sense conflation to include this definition in the bill. It is critical that we recognise palliative care and that inadequacies in palliative care could, in fact, lead more people to access voluntary assisted dying that otherwise would be the case.

Mr R.H. COOK: I think the member has summarised well some of the concerns that were voiced in the second reading debate, but I do not accept his premise. I certainly do not accept his premise that there is a problem with palliative care
in Western Australia and I reference our record investment in it. I also challenge the other premise of the member’s argument—that is, to discuss voluntary assisted dying is to somehow diminish or move away from palliative care. I do not see the two as being played off, one against the other. In fact, the evidence from overseas is that investment in palliative care across countries is growing at the same rate in those that already have voluntary assisted dying legislation as those that do not. The fact of the matter is that voluntary assisted dying invites the conversation and provides a greater policy focus for palliative care. I simply reject the premise of the member’s argument.

Ms M.M. QUIRK: I know when I am flogging a dead horse, but I have two questions. The first is about clause 26, which we will deal with later. But in the context of a conversation having to take place between a medical practitioner and the person, the person needs to be alerted to the existence of palliative care treatment. Will that be in a form drafted by the CEO so that there are standard words?

Ms A. Sanderson: I can’t see what that has to do with the definition.

Ms M.M. QUIRK: It has something to do with the definition because if there is a standard form of words, member for Morley, there is less possibility of there being a misunderstanding. At least we will be able to satisfy ourselves that a consistent approach will be taken. The second matter I wanted to raise, subject to what the member for Morley wants to say, is that the minister has said that it is a drafting issue. I am not quite sure what that means. Could the minister please expand on that?

Mr P.A. Katsambanis interjected.

Mr R.H. COOK: I think I should do the mover of the motion the courtesy of responding, member for Hillarys.

I hope the member for Girrawheen will forgive me if I do not go into details about clause 26 now. I will be very happy to do so when we arrive at that clause. Suffice it to say, as I mentioned earlier, there are a range of issues around which, in the context of the therapeutic relationship between a practitioner and patient, we would ordinarily expect for there to be a conversation. One of those will be the range of treatment options available to the patient, including palliative care. That does not, in and of itself, make palliative care a material aspect of this bill. As I said in my earlier remarks, it is not material. I refer to the Victorian legislation. I am advised that it is a drafting convention. Not being a drafter of legislation, I do not necessarily appreciate the full drivers of that, but as the member knows, laws have particular styles and approaches. That is simply the approach that was adopted in Victoria. I am not here to advise the Victorian government whether its legislation is competently drafted; I certainly know that ours is.

Mr P.A. Katsambanis: Deputy Speaker.

The DEPUTY SPEAKER: Is this a new issue?

Mr P.A. Katsambanis: It is just on this issue.

The DEPUTY SPEAKER: Do not ask the same question again, please, member.

Mr P.A. KATSAMBANIS: I will not. I have to say that I welcome the minister’s refreshing honesty when he said that a definition of palliative care is not material to this legislation. I think that is a fear and concern of everyone who has read this legislation. Palliative care is used in a number of contexts. It is used several times in the principles in clause 4 —

Ms A. Sanderson: I have a point of order.

The DEPUTY SPEAKER: That is fine, member. You do not need to make a point of order. Member for Hillarys, I think the minister has addressed this. Minister, do you wish to address this question again?

Mr P.A. KATSAMBANIS: I am allowed to comment. It is consideration in detail.

The DEPUTY SPEAKER: You absolutely are. I am just encouraging you not to repeat issues that the minister has already addressed.

Ms A. Sanderson: It is tedious repetition.

Mr P.A. KATSAMBANIS: I am not repeating it. I have not made this point.

The DEPUTY SPEAKER: Would you make the point, please.

Mr P.A. KATSAMBANIS: Would you like me to start again?

The DEPUTY SPEAKER: No. I would like you to make the point.

Mr P.A. KATSAMBANIS: If I was not interrupted, perhaps I would not need to start again.

The DEPUTY SPEAKER: I am doing it to try to get us through this, member.

Mr P.A. KATSAMBANIS: The issue here is that lip-service has been paid to palliative care in the introduction of this bill. The minister’s position is clear—he is not accepting —
**Point of Order**

**Ms A. SANDERSON:** Standing order 97 states —

A member who persists in irrelevance or tedious repetition, either of the member’s own arguments or of the arguments used by other members, may be directed by the Speaker to discontinue the speech.

I would argue that this is tedious repetition of other arguments that have been put several times on this clause.

Several members interjected.

**The DEPUTY SPEAKER:** Members, I tend to think that the member for Morley has a point. Can we please move on.

**Debate Resumed**

**Mr P.A. KATSAMBANIS:** I will move on. The point I was making before I was rudely interrupted was that, unfortunately, despite all of the motherhood statements we have heard, lip-service is being paid to palliative care. It is really immaterial to this bill and that is really, really seriously disappointing. It is even more disappointing that when it is raised in this house, other members want to shut down debate. That is disgraceful.

**Division**

Amendment put and a division called for.

Bells rung and the house divided.

**Mr V.A. Catania:** Point of order, Deputy Speaker. There are five members who are not sitting down.

**The DEPUTY SPEAKER:** Could members please be seated to be counted.

The division resulted as follows, the Deputy Speaker casting her vote with the noes —

**Ayes (13)**

Mr V.A. Catania  Ms A. Krsticevic  Ms L. Mettam  Mrs A.K. Hayden (Teller)

Mrs L.M. Harvey  Mr S.K. L’Estrange  Dr M.D. Nahan

Dr D.J. Honey  Mr R.S. Love  Ms M.M. Quirk

Mr P.A. Katsambanis  Mr W.R. Marmion  Mrs M.H. Roberts

**Noes (39)**

Ms L.L. Baker  Mr T.J. Healy  Mr M.P. Murray  Ms J.J. Shaw

Mr I.C. Blayney  Mr D.J. Kelly  Mr K. O’Donnell  Mrs J.M.C. Stojkovski

Dr A.D. Buti  Mr Z.R.F. Kirkup  Mrs L.M. O’Malley  Mr C.J. Tallentire

Mr J.N. Carey  Mr M. McGowan  Mr P. Papalia  Mr D.A. Templeman

Mrs R.M.J. Clarke  Mr J.E. McGrath  Mr S.J. Price  Mr P.C. Tinley

Mr R.H. Cook  Ms S.F. McGurk  Mr D.T. Punch  Mr R.R. Whitby

Ms J. Farrer  Mr D.R. Michael  Mr J.R. Quigley  Ms S.E. Winton

Mr M.J. Folkard  Mr K.J.J. Michel  Mr D.T. Redman  Mr B.S. Wyatt

Ms J.M. Freeman  Mr S.A. Millman  Ms C.M. Rowe  Ms A. Sanderson (Teller)

Ms E.L. Hamilton  Mr Y. Mubarakai  Ms R. Saffioti

**Amendment thus negatived.**

**Mrs L.M. HARVEY:** On page 5, line 16 of the bill, there is a definition of “family member”. The definition states —

*family member*, of a person, means the person’s spouse, de facto partner, parent, sibling, child or grandchild;

This is particularly pertinent to clause 42 of the legislation, which is on page 27. Clause 42 identifies people who are inappropriate to witness the signing of a written declaration of a person wanting to access voluntary assisted dying. Clause 42(2) states —

For the purposes of subsection (1)(b), a person is an ineligible witness if the person —

(b) is a family member of the patient making the declaration; or

Given that in modern times there are various kinds of family arrangements—blended families—I want to understand whether step-parents, stepchildren, half-siblings and foster-children are included in this definition; and, if not, why they would not be listed. When we get to the issue of inheritance from patients, it is often at its worst when there is a blended family with a sick family member, with competing members from two different families potentially applying pressure, if you like, or competing for that inheritance. Could the minister please explain whether stepfamilies are included in these definitions, or whether it might be prudent for us to amend this so that they are included?

**Mr R.H. COOK:** I am advised that the term “family member” is narrowly defined in the bill because it is primarily applied to limit who is eligible to witness a patient’s written declaration, to act as an interpreter or to witness the administration of the prescribed substance via an administering practitioner.

Several members interjected.

Extracted from finalised Hansard
Mr R.H. COOK: There are, however, materiality provisions that exclude a person from being a witness if they may obtain a material benefit from the patient’s death. The term “family member” does not include a step-parent, stepchildren or extended family member; however, the materiality provision will serve to exclude a wider range of persons from taking advantage of a patient making the declaration.

Mr P.A. KATSAMIBANIS: The definition of “medical practitioner” at the top of page 6 states —

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

That definition mirrors definitions used across a range Western Australian legislation for the purposes of defining a medical practitioner, save for this concept at the end, “(other than as a student)”. I seek clarification from the minister of why that has been included and why it is necessary to include “other than a student” in this legislation when it is not included in any other Western Australian legislation that defines a medical practitioner.

Debate interrupted, pursuant to standing orders.

[page 6425]

Resumed from an earlier stage of the sitting.

Clause 5: Terms used —

Debate was interrupted after the clause had been partly considered.

Ms R. Saffioti: Look what you did!

*Withdrawal of Remark*

Mr P.A. KATSAMIBANIS: I seek a withdrawal of that statement by the Minister for Transport.

The SPEAKER: I did not hear it.

Mr P.A. KATSAMIBANIS: The Minister for Transport made a personal imputation against me and I seek a withdrawal.

Mr D.A. Templeman: There was no imputation made.

The SPEAKER: No, it is not up to you. I did not hear it. If the minister made one, I am sure she —

Mr P.C. Tinley interjected.

The SPEAKER: Minister for Housing, you do not run this place.

Mrs L.M. HARVEY: Acting Speaker, further to the point of order —

The SPEAKER: You are the Acting Speaker. I did not hear it. I asked the minister whether she said something. She said that she has not, so she cannot withdraw it.

Several members interjected.

*Extracted from finalised Hansard*
The SPEAKER: What did you say, minister?
Ms R. SAFFIOTI: I said, “Look what you did!”
The SPEAKER: That, to me, is not —
Mr P.A. KATSAMBANIS: I seek your clarification —
The SPEAKER: No. I did not hear it. I have one side and the other side. I cannot take one against the other. The minister said that she did not do something. That is all I can go on.
Mr P.A. KATSAMBANIS: She just —
The SPEAKER: Excuse me! Sit down. Now we are going into consideration in detail. I cannot take one person’s version because I did not hear it myself.

Debate Resumed

Mr R.H. COOK: Before we go on, Mr Acting Speaker, prior to question time, the member for Hillarys was on his feet and asked a question. I was going to ask whether he could ask it again to refresh our memories, but he is not here.

Mrs L.M. Harvey: He’ll be back.

Mr R.H. COOK: Okay. I am sure that there are other issues.

Mr Z.R.F. KIRKUP: All of us here would know that we have just responded to an amendment that was proposed by the member for Girrawheen addressing the lack of a definition of palliative care. As I understand it, as part of those definitions, there is a reference in clause 26 of the bill to palliative care. It specifically states that information must be provided to a patient in respect of their palliative care treatment options and the like. When the member for Girrawheen and a number of members on our side asked about that, the suggestion in response was that, effectively, we could not insert such a clause because there are no real definitions of palliative care in other legislation that exists in the state. Could the minister reiterate that that is the case?

Mr R.H. COOK: I do not think that is the case. I think the point the member for Girrawheen made last night was that the Guardianship and Administration Act offers a definition around those issues. My response was in regards to the relevance it has to this bill. It has no material role in the context of this bill.

Mr Z.R.F. KIRKUP: Just to satisfy everyone here, “palliative care” is defined in the Guardianship and Administration Act 1990 as — … a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure;

Although palliative care is not defined in this bill, it is referenced in clause 26. The minister suggested that that reference in the Guardianship and Administration Act does not reflect what would be required under clause 26. Is my understanding correct?

Mr R.H. COOK: Yes, that is correct.

Mr Z.R.F. KIRKUP: Could the minister provide some context about why that is the case? I am obviously very keen to work with the government to make sure that this bill is in good condition. If information is provided to a patient about their palliative care options, why does that definition not say that? To be perfectly frank, on my reading of it, it seems to be relatively congruent with what would be in the spirit of that clause and thus would warrant definition.

Mr R.H. COOK: I am happy to go into detail when we get to clause 26. The definition from the Guardianship and Administration Act is rather outdated. Quite frankly, I think the observation is that it is quite cold. Section 3 of the Guardianship and Administration Act defines palliative care to mean — … a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure;

In the context of the VAD bill, the term “palliative care” is used in three provisions that do not need defining. I have already described them. We are using the word in a generic sense, not within a defined or specific sense.

Mr Z.R.F. KIRKUP: Sure. I am not going to keep labouring the point. I was satisfied with the explanation provided by the minister and the member for South Perth. They suggested it was not defined in the Criminal Code, even though palliative care is also mentioned there. If we are providing information to an individual as per clause 26, it might be a cold definition in the Guardianship and Administration Act, but I do not quite understand why there is no need to prescribe it. Regulations and forms to be approved by the CEO are in a range of clauses in this legislation, so why would we not clarify or encompass what that is? I would imagine that we would want to do that. The spirit of this bill should be to provide a patient with their palliative care options. The Guardianship and Administration Act specifically refers to a medical, surgical or nursing procedure to help relieve a person’s pain, discomfort or distress. I would imagine that is exactly the type of information we would want to try to provide to a patient. There is no reason to try
to get too prescriptive here, but if a definition of palliative care already exists at law, especially in something like the Guardianship and Administration Act, which provides the right and ability for someone to act on someone’s behalf due to incapacity, why would we not seek to prescribe that for information that should be provided to somebody if and when they need to access palliative care information that is required under clause 26 and thus, I think, warrants definition?

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

Mr Z.R.F. KIRKUP: Thank you, minister, for that. A number of members from this side of the house have spoken about the Victorian voluntary assisted dying bill—now an act. I have looked at the origin point for the reference to palliative care in the Victorian legislation. In Victoria, palliative care means the provision of food and water. Obviously, not defining palliative care will allow practitioners to make their own interpretation. I think that is right—this legislation will empower practitioners to do a lot. We will It will rely on their good judgement and good character to operate accordingly. If the Victorian legislation defines palliative care as the provision of food and water to sustain life, and we already define that in Western Australian law, does that not leave open the possibility that a practitioner, if they are obliged under a section of the act to provide information about palliative care to a patient, could simply say, “Palliative care is food and water because that’s the definition in other jurisdictions around the commonwealth”? Does the minister think there is a risk at all, in not defining it, that there could possibly be a lower level of information provided to a patient? As the minister would appreciate, a number of elements are prescribed in this legislation—professional care services is one. If we provide a prescription in these definitions for what that looks like, we can at least ensure there is a minimum mandatory requirement to provide information. I point out again that in Victoria, it is simply the provision of food and water. I worry about what that looks like. If food and water is what one interpretation of palliative care looks like in another jurisdiction, at the other end is high-level, high-care and high-intervention clinical services. That lack of surety surely poses a risk if a practitioner simply meets the requirements, under clause 26 of this bill, by saying, “Your palliative care options are that you get food and water and we can end it there.” Does the minister think that a lack of prescription poses any risk at all? Is the minister absolutely comfortable with that? As someone who supports the legislation, can the minister provide me comfort that without the insertion of that definition, there will always be at a minimum a high level of information provided to a patient by a medical practitioner?

Mr R.H. COOK: I can give the member that assurance. In some respects I do not accept the characterisation of that relationship between the medical practitioner and the patient in the context of “I simply have to provide the bare minimum.” I do not think that is the appropriate way to describe those conversations. The medical practitioner will obviously be a doctor of some years training, and no doubt some experience, and in addition to that would have received extra training about what their obligations are, both moral and legal, under this bill. In particular, the medical practitioner would be obliged to provide a range of information about palliative care in the generic sense, but also other treatment options. From that perspective, I am happy that we have gone to the extent necessary to provide a safe set of circumstances around that conversation, although we can dig into that further at clause 26. In relation to clause 5, I do not think we need to provide further clarification.

Mr Z.R.F. KIRKUP: Thank you, minister; I appreciate that assurance. Just to summarise, and I do not necessarily expect a response: I worry that the term “palliative care” could be considered subjective because there is no definition. It is up to the interpretation of every practitioner as to how they might provide or furnish that information to a patient as per clause 26, for example. I point out that perhaps by providing them with a standard that must be met in these definitions under clause 5, we might be able to provide for a bare minimum level of information that is required. I accept what the minister said—that he expects a high level of information will be provided to a patient. I hope that the board or the CEO can interrogate that further, as this bill is implemented, maybe in its recommendations. Maybe the minister can provide an assurance that that will occur, so that at least the community can be satisfied there will be a minimum level. Disparity does exist in the commonwealth at the moment between, say, the Victorian legislation, which defines palliative care as the provision of food and water, and what our expectations are right now, and what is defined at law under the Guardianship and Administration Act 1990.

Mr R.H. COOK: Yes, I can provide the member with that assurance. The implementation phase will involve very careful design and construction.

Dr M.D. NAHAN: I am not going to go into the debate about definitions; we have done that enough. This might not be the spot in the bill to debate this, but I would like some clarification for my understanding of the bill’s Extracted from finalised Hansard
intent. I envisage voluntary assisted dying as the last stop, when someone is facing imminent death and in immense pain that, in my words, palliative care cannot address. That idea has been sold and promoted in the community, and I have profound sympathy for VAD if that is what is going to happen. From the minister’s response to a question about the definition of palliative care, I have an idea that VAD is actually a substitute for palliative care, left to the choice of the individual. One reason the minister does not want to go into the definition of palliative care is that it is an option out there for the individual to choose, and it is very variable, but what the minister wants to focus on with this bill is another potentially substitute action—VAD—when I thought it would be that a person would go to VAD when palliative care does not work. I think the minister is saying that the individual can step back and consider palliative care and the practitioners have to give that person advice about the options and how to access it, but they do not have to take it, and they can choose, even if palliative care could address the pain and make them comfortable, not to take it, and they can then access VAD. Is that the right understanding?

Mr R.H. COOK: In short, VAD may not be the last stop. Many patients will access the voluntary assisted dying provisions of the bill without taking a voluntary assisted dying substance. We know from international experience that giving people access to the substance relieves the suffering from which they seek remedy—that knowing that it is there provides them with the comfort to deal with their final days. The member articulated the nub of a lot of this debate, and perhaps one of the key things that separates the two sides in this debate; that is, the member said that in a lot of respects VAD is a substitute for palliative care. I respectfully disagree. Obviously, VAD may be part of an overall palliative care journey, but I do not accept the notion that we play one off against the other in the context of this debate. I understand the point the member is trying to make, but I do not believe that VAD may necessarily of itself replace palliative care, because palliative care will be potentially a very key part of someone’s end-of-life choices.

Dr M.D. NAHAN: Let us say a patient is facing imminent death and meets the criteria in the bill, and palliative care, whatever you define it as, can ameliorate the pain—probably not eliminate it, but ameliorate it—however, the patient, because of, let us say, existential trauma, decides not to pursue the palliative care option, but to apply for VAD and use the substance. Will that be possible under this bill?

Mr R.H. COOK: Member, we cannot force treatment options on a patient; it is the patient’s right to make these decisions. As the member knows, in many cases at the moment, patients are rejecting palliative care—refusing to take water or food or receive other treatment. In that respect, the issue of voluntary assisted dying is the relief of suffering; it is not, as the member has put, a way that a person can exit a palliative care scenario.

Dr M.D. NAHAN: I understand this is voluntary. I put it in the context of the patient making the choice. Let us say that a person has very bad kidney disease and is on dialysis. I am not sure whether that is palliative care, but I think it would fit the definition. I have a sister-in-law who was on dialysis for a long time. I understand that when a person is on dialysis, other parts of their body fade over time. It is pretty bad. However, it does sustain life. I think the member for Hillarys discussed a very personal experience in his time. This bill comes up with voluntary assisted dying for the first time by a person taking a substance that terminates life. Could a person on dialysis choose to take the substance to end their life, even if the dialysis, or palliative care in this instance, could keep the person alive and ameliorate their pain and address most of the symptoms of this disease?

Mr R.H. COOK: If death is, on the balance of probabilities, expected within six months and the patient is, in their view, experiencing suffering that is unable to be relieved otherwise, yes.

The ACTING SPEAKER: Member, you may find that some of these questions are more appropriate later. This clause is about interpretation. If you have questions regarding this clause, please ask.

Dr M.D. NAHAN: I will come back to that later.

A major policy issue in the health system is to set up a person who is called a carer. Often, particularly with disability, people are defined as carers—sometimes it is a relative and sometimes it is not, and sometimes carers are paid and sometimes they are not. I am surprised that the definition, perhaps, but also the reference to carers, is not treated more widely in the bill, because it refers to family members, but, as I think the Leader of the Opposition indicated, about 40 per cent of people in nursing homes do not have visitors and they have become detached from their families. Was the issue of carers, whether professional or otherwise, dealt with in the preparation of the bill?

Mr R.H. COOK: I refer the member to clause 4(1)(g), which deals with principles. There is no reference to carers per se in relation to other aspects of the bill, other than a definition around the provision of professional care services. I think in the scenario the member talked about, it would be in the context of an aged-care home, and a person in that context would be a provider of professional care services. There are ways in which that person is treated in the context of other aspects of the bill, but there is not the definition of “carer” as such.

Dr M.D. NAHAN: Limits have been put on the involvement of family members as defined. I am not arguing against that. Is there a limit on the role of carers also in terms of subsequent processes?

Extracted from finalised Hansard
Mr R.H. COOK: I am advised that it is in the context of the materiality provisions of the bill.

Mr P.A. KATSAMBANIS: I take the minister back to the issue that remains unresolved.

Mr R.H. Cook: Sorry, we could not remember which bit it was.

Mr P.A. KATSAMBANIS: It was the definition of “medical practitioner”, which is for all intents and purposes the standard definition that appears in dozens of acts of this Parliament, including the Adoption Act 1994, Combat Sports Act 1987, Firearms Act 1973, Mental Health Act 2014, Prostitution Act 2000, Road Traffic Act 1974 and many, many others. That is just a little snapshot. The same definition is used except that bit at the end, “other than as a student”. I seek an explanation as to why that additional bit, “other than as a student”, has been added in the legislation.

Mr R.H. COOK: I remember the Combat Sports Act, and the excitement it always generates amongst our friends at the Australian Medical Association. We made the amendments to that act as part of the national law, back in about 2016, I think it was. The member himself made the point that we are relying upon the national definition that is subject to that uniform law, although it is not quite uniform; I think ours is slightly different. In the context of this bill—that is, dealing with voluntary assisted dying—it makes sense that we do not utilise the services of a student medical practitioner as defined under the national law, because we want to make sure that it is a medical practitioner who is either the coordinating or consulting practitioner with some experience and level of seniority.

Mr P.A. KATSAMBANIS: I want to clarify that. First of all, does it say that a person can be registered as a student medical practitioner in Western Australia? Is there a possibility for that to occur?

Mr R.H. COOK: I am not an expert in the national law, but I think it is possible under the national law, and that is why we have made the distinction in this bill.

Mr P.A. KATSAMBANIS: Will our other acts need to be updated to cover that?

Mr R.H. COOK: I am not in a position to give the member that advice. If he would like me to get further advice from the department on that, I am happy to do so, but, in the context of this bill, I think the member and I would both agree that we want a medical practitioner other than a student, although it might be in a postgraduate context, which would be the reason they have the designation as a medical practitioner, but we want to make it quite clear that it is someone who is practising.

Mr P.A. KATSAMBANIS: Perhaps the minister can take that on board as we go on, but the issue I want to clarify in particular, simply because of the wording, is that, as the minister would be aware, there are medical practitioners across Western Australia undertaking studies in fields that may be either tangentially related to medicine or not related at all. I know medical practitioners who are registered and practising, and who might be undertaking studies for an MBA. One or two of them have taken out bachelors of law. I do not know why doctors would want to go back and do law, but some do.

Dr M.D. Nahan interjected.

Mr P.A. KATSAMBANIS: Perhaps they are interested in malpractice, member for Riverton—I do not know. It is not an area of law that I have practised in. I just want to know what the limits of this definition are. Obviously, we do not want a student who is studying as a medical practitioner and may have some form of limited registration operating under this legislation, and I think that is the intent, but can the minister clarify that a medical practitioner who is otherwise registered and qualified but is undertaking studies in a completely unrelated field to better themselves, would not be caught up in this unnecessarily?

Mr R.H. COOK: The words that will provide comfort for the member are “other than as a student”—that is, a student in the medical profession.

Mrs A.K. HAYDEN: I have a final question for the minister to place a clarification on the record. I have been listening to the debate made by the member for Riverton, and also throughout the previous amendment, and it alarms me—I believe I have it right, but if I have it wrong, please correct me—that the minister is saying that palliative care and voluntary assisted dying are two separate identities, and that, in the minister’s opinion, palliative care has no place in this legislation, nor is it required in order to access voluntary assisted dying. Alarm bells go off for me, and I am sure they will go off for 99 per cent of the population, so can I just get clarification from the minister that it is his intent, with this legislation, that someone diagnosed with a terminal illness can, immediately, without seeking palliative care, access voluntary assisted dying? As we have discussed in this place, palliative care can be as simple as a conversation to help with the idea of life coming to an end. Can I get confirmation that the minister is comfortable and the government is comfortable with the intent in this bill that once someone has been diagnosed with a terminal illness, they are able to access voluntary assisted dying without having to contemplate any palliative care services or options?

Mr R.H. COOK: No, not to contemplate, but certainly to undergo. As a number of members observed in their second reading contributions, not everyone who is at the end of life is actually in palliative care. Indeed, if someone receives a terminal diagnosis, and it meets all the associated requirements as outlined in this bill, they may refuse palliative care. It is not for us to force someone to undergo palliative care, but we would ordinarily, from a moral
standpoint, and I think there are some very good reasons why, want that person to be aware of those options. I think the member used the expression “contemplate”, and I think that is a great expression. We would want them to contemplate palliative care but we cannot force them to take it.

The ACTING SPEAKER (Mr T.J. Healy): The question is that clause 5 stand as printed. All those in favour say—my apologies, member for Girrawheen.

Ms M.M. QUIRK: Sometimes people do not realise that I am standing! The definition of “approved training” refers to training approved by the CEO under clause 158. Does the minister prefer that that be dealt with at clause 158, or now?

Mr R.H. COOK: As someone who is equally vertically challenged, I commiserate with the member, but yes I think that is probably best left to the consideration of clause 158.

Ms M.M. QUIRK: I am sorry to repeat myself, but should we wait until clause 159 to talk about the approved form, and, likewise, the board, under clause 115? I note that clause 115 is completely unenlightening. It does not refer to the composition of the board. I am happy to wait, but, as I said, there is not any additional material.

Mr R.H. COOK: I think that would be the appropriate clause to deal with that issue.

Ms M.M. QUIRK: I want to spend a bit of time on decision-making capacity, in clause 6(2), and I have just realised that I am now moving an amendment, but there might be some other stuff in clause 5 that we need to talk about first.

Clause put and passed.

 Clause 6: Decision-making capacity —

Mr Z.R.F. KIRKUP: I have a number of questions on clause 6(2), so I will go through them. I understand that a sequence of events will need to take place to assess whether a person has decision-making capacity, so that practitioners are certain of a person’s decision-making capacity. With reference to clause 6(2)(a), can the minister provide some advice on how a practitioner would seek to understand how any information or advice on voluntary assisted dying, as required under the legislation, is provided to the patient? What would the process be?

Mr R.H. COOK: I think it would be done in the usual manner in which we would try to ascertain whether someone understands the decision they are making. A line of questioning would be associated with that, until we could be satisfied that the person really understood the requirements under the bill. It would obviously be a specific element of the mandatory training that medical practitioners would be required to undertake, because understanding the requirements of clause 6 will be a very important part of the role of the coordinating or consulting practitioner.

Mr Z.R.F. KIRKUP: I appreciate that the legislation is quite complex and extensive and has a number of moving parts. The patient will be required to understand the information and advice that has been provided to them about voluntary assisted dying decision. Am I right to understand that there would be a process by which the practitioner would engage in a conversation with the patient, and that would be recorded and provided to the board as part of the authorised forms? I assume that the nature of the conversation would be prescribed by the CEO during the implementation phase. Would that be right?

Mr R.H. COOK: There would certainly be extensive reference to the patient’s medical records. In relation to the decision-making process, the coordinating or consulting practitioner would be required to fill out the authorised forms as prescribed by the CEO, and they are the ones that would be provided to the Voluntary Assisted Dying Board.

Ms M.M. QUIRK: In terms of assessing decision-making capacity, there is no requirement that the patient must see a doctor whom they have been seeing for some time; they may see two completely different doctors whom they have never seen before.

Mr R.H. COOK: We have contemplated the situation in which a person’s usual GP may be a conscientious objector or not eligible to be a medical practitioner involved in the process, so potentially, yes.

Ms M.M. QUIRK: I do not know whether the minister is aware, but certainly Alzheimer’s Australia has said that the time in which to diagnose Alzheimer’s and other forms of dementia, despite more community education for GPs, is stubbornly set at about two to three years. Therefore, there is a very large chance that a GP who might see a patient regularly will miss the fact that the person has lost capacity. Similarly, I do not know whether the minister is aware that there are differing levels of decision-making. Obviously, if a decision is made about voluntary assisted dying, that should be at the highest level of executive decision-making. It is not a decision about whether the person will have strawberry or chocolate ice-cream for dinner. It is a serious matter. Again, the assessment of capacity goes to the ability of the patient to make such a decision. It is not just a question of saying the patient seems lucid, because, as we know, lucidity will ebb and flow. I want to know how the legislation will safeguard against that. My final point is that the person who will do the assessment will not be required to undertake any training other than that is contemplated by this legislation. In other words, they will not need to be a specialist.

Mr R.H. COOK: Just to go to the member’s final point, the person who would be making the decision would already have had about six years of training as a medical practitioner, with all the obligations and requirements associated with that strenuous process. The member is obviously familiar with post-study work and graduation programs. Therefore,
they will be a person of some experience. Yes, they will be required to undertake further mandatory training in order to participate in this process. I would also say that clause 6(2) sets out a range of matters about which the person must have a level of awareness and understanding. That would be ascertained through not only an exhaustive conversation with the patient, but also a thorough examination of that patient’s records, and, indeed, a conversation with that patient’s other specialists. In particular, the patient must make ongoing and continuous requests and be assessed at different stages of the voluntary assisted dying process to ensure that they understand the decision they are making and have the capacity to make that decision, and that their decision is enduring. In addition, one of those requests must be in writing, and it must be certified by two witnesses that the person understands the decision they are making. This is not a process that we are taking lightly. I, like the member, appreciate that this is obviously a very important aspect of the bill. From that perspective, that is why we have provided for that extensive process to determine decision-making capacity.

**Dr M.D. Nahhan:** We are talking about capacity to understand and make this very important decision. We have heard stories in this place and we have talked to people who have had to give the bad news to a person that they have a terminal illness. We have also read some of the reports about that. I admit that I am a layman in this area. As I have mentioned, it is often traumatic for people to be given a death sentence, and they go into existential shock. My brother experienced this when he was diagnosed with Parkinson’s disease. His initial diagnosis was that he would live for about two years—I forget what it actually was. He lived for 15 years, by the way, and he passed away not from Parkinson’s but from something else. There is deep psychological impact on people when they get the bad news. The question is: would those people have the mental capacity to make a rational decision of this nature? Let us say the medical practitioner has done their best to put all the evidence to the patient. I am sure that 99.9 per cent of practitioners will try their best. In this country, we have a tremendously well-trained and dedicated group of health professionals. I am not worried about that. I am worried about the capacity of a patient who has been given the bad news to process all that information rationally. I do not think I could do that. My brother could not do it. As I have said, the Parkinson’s data is made for 65-year-old people. My brother was 41, so the doctor could not use the data, and the doctor said he had no idea about what was going to happen, and that was good. My brother went to a group of other Parkinson’s patients, and I went with him. A lot of them were over 65 years of age, and some of them went down very quickly. It is a terrible disease. They were in trauma. The disease accentuated that trauma. They were not rational. They simply were not capable of being rational. How do we identify that? When we deal with mental illness, which has different grades, the process is that there is a psychiatric assessment, and the psychiatrists will use their methodologies to determine the person’s capacity to make decisions. I would think in some instances—not all—we would need the same process here. We need to be able to judge the capacity of the person to make rational decisions. That is a really important issue. Could the minister tell us how he will deal with that real issue?

**Mr R.H. Cook:** The member is right. A number of members have made that observation about people who receive bad news. People receive that kind of bad news all the time. Medical practitioners will be very familiar with the scenario in which they say, “Chum, I’m sorry; it’s bad news.” Indeed, a medical practitioner in that career would frequently be faced with a patient sitting in front of them who is receiving bad news and, quite frankly, that person would not be rational and we cannot expect them to be. In that context, they would not have decision-making capacity, as is defined in this legislation. That is a common scenario, and that is why medical practitioners are well practised and trained in assisting patients to deal with what is essentially a death sentence; that is, they are told, “I’m sorry, but the news is not good.” That is not a time that a patient would be demonstrating decision-making capacity. That is a time when that patient would be informed about their treatment options—is it option A or option B? Even though that patient would be in a world of pain at that time, unfortunately, the medical practitioner would then have to assist them to make that decision as well. Obviously, how they manage that patient’s state of mind is a very important part of their trade as a medical practitioner, but in that context, having just received the information, the patient would be very distressed. As was the case of the member’s brother with Parkinson’s disease, this is not someone who has been in touch with a support group, and therefore provided with the full range of options associated with it—it is not for those people. The member very eloquently in his description raised the issue about what medical practitioners face on a regular basis, and the decisions that they have to help that patient make.

**Dr M.D. Nahhan:** Let us deal with this issue. The minister is right; general practitioners and specialists deal with this all the time. It is one reason some of us would not want to be in that position.

**Mr R.H. Cook:** It is much easier being a politician!

**Dr M.D. Nahhan:** We give bad news, but of a different magnitude. Anyway, they do not believe us! I digress. Will the minister leave it as is or have a methodology about what practitioners will discuss, to vet and say, “Here are your options, but you’re not in a position right now to make these. I recommend you go through this, this and this before you make the decision”? It might be to see a psychiatrist or it might be to go through some forms of palliative care. What happens if they say, “No, I decided a long time ago that I want this. I want assisted dying. I want out”? I will give the minister a story about my first experience with this as a member of Parliament. This is a really difficult issue around rationality and what that is. A lot of philosophers have spent their life discussing this, and we are dealing with an issue about death, potentially premature death, and talking about introducing a law that, in my view, fundamentally changes the nature of the state of a human being, and that is why we have to be very careful about walking this way.

*Extracted from finalised Hansard*
Mr R.H. COOK: That is why we have opted for six months. This is not for people who are contemplating a longer term end-of-life period. These are people for whom death is imminent, inevitable and, in their view, are experiencing intolerable suffering. If someone received the news that they are going to die within six months, by that stage the person would have already had a pretty rigorous interaction with the health system. They potentially have not, but obviously they will then begin on a very serious journey and it is one that their medical practitioner would want to assist them with. But if death will, on the balance of probabilities, occur within six months, if they have decision-making capacity, and if, in their subjective view, the suffering they are facing in the context of that is too great, but they are appraised of all their treatment options, this bill would contemplate that person having the agency to take matters into their own hands.

Dr M.D. NAHAN: Let us say a doctor gives a patient bad news and he says, “I want VAD”. The doctor says to come back in a week or so, cool down, or go talk to somebody such as a psychiatrist or whatever. The patient comes back and says, “No, I want it” and the doctor says that they do not think they are in the right state of mind. The patient then goes to other doctors to find the Nitschkes of the world who believe not in the system the minister is trying to develop here, but something much broader, such as the system Marshall Perron agrees with, and finds somebody who is more lenient in determining the rationality of the patient. Are there some safeguards against that?

Mr R.H. COOK: Yes, member. Essentially, the member is referring to the capacity of somebody to doctor shop. I appreciate that that has come up in both parliamentary debates and public discourse. It is not really under clause 6, but I think we should talk about it; I accept the spirit in which the member brings it. If a patient is assessed as being ineligible by a coordinating practitioner, they may commence a new request and assessment with another registered medical practitioner for that person to act as their coordinating practitioner. This is consistent with any person seeking a second or third medical opinion with different doctors. It is a basic component of the Australian healthcare system that patients are able to seek further medical opinions of their own volition. We cannot stop them going to see another doctor, but do not forget that that doctor will say, “I want to look at your records. Who are you currently seeing?” In order to assess a decision-making capacity, that doctor would inevitably go back to that first doctor and say, “Mr Smith is in front of me. I know they have seen you; I want your views on this.” This is the nature of the way in which a person would go about making that assessment.

We could paint a range of doomsday hypothetical situations around this place. I appreciate that that is not what the member is doing here; he is testing the safeguards of the bill. But we could be satisfied that under the current system there are safeguards around people doctor shopping ordinarily, and in this context I think there would be even greater safeguards, particularly around the decision-making provisions and the obligation on the medical practitioner to make that assessment and be abreast of all the issues that would impact upon that patient’s situation.

Mr R.S. LOVE: I am looking at both the bill and the explanatory memorandum. The first paragraph of the explanation of “decision-making capacity” in the explanatory memorandum states —

... acknowledges that a person is presumed to have decision-making capacity unless there is evidence that they do not.

That is under clause 6(3), which states that “a patient is presumed to have decision-making capacity”. I wonder, given that there is also capacity later for some of the decisions to be indicated other than verbally, whether there is a requirement or a duty upon the person assessing this capacity to make some inquiry; or it is just enough to say, “Okay, here is a person I assume has capacity, unless someone presents me with an idea or evidence that that is not the case”? What is the requirement for someone to investigate and see whether there is evidence that there is a lack of capacity?

Mr R.H. COOK: The definition acknowledges that a person is presumed to have decision-making capacity unless there is evidence that they do not. In Western Australian law, there is a presumption that a person has the capacity to make decisions about their own life. This is reflected in the presumption in the bill. It is assumed that someone comes to the process with agency and it is obviously an important assessment that the medical practitioner must make to assess whether that agency exists. We do not come to it with the assumption that they do not. It is about empowering the patient. From that perspective, the posture of the legislation is upon empowering rather than impeding that patient.

Mr R.S. LOVE: Capacity could be lost throughout the course of the patient’s relationship with the medical person who is making this decision. If that person loses capacity at any point, the process stops. What requirement is on the medical practitioner to satisfy himself or herself that the person continues to have the capacity right throughout the process?

Mr R.H. COOK: As I observed to the member for Girrawheen, it is an obligation on the medical practitioner; they must assess that decision-making capacity throughout the process by which the voluntary assisted dying is contemplated.

Mr R.S. Love: Despite the presumption, there is still a requirement to do an assessment.

Mr R.H. COOK: They still have to assess that person.

Debate interrupted, pursuant to standing orders.

Extracted from finalised Hansard
now.” I do not think many people will do that. We all want to live and we all value life. I think the one thing that we 
specialist that they have only six months to live they are going to walk out straightaway and say, “I want to end it 
the chemo had worked and he was on the road to recovery. Within six months he was dead. But he wanted to live. 
“What for?” He said, “I want to find that bastard who gave me the death penalty.” They had told him that day that 
more members, and we will have a chance to talk about this later as well, 
that especially for action-oriented people, there is a real risk that they will make the instantaneous decision that, 
“That’s it. I want to have control. I’m not going to let the disease take control. I’m going to terminate my life.”

In the examples, fortunately, very loving and caring people who deeply cared about those people and who knew 
they well prevailed upon them to not do that. There was the example of an individual who was told with certainty 
that they had months to live, but then lived for 17 years; and there were other examples in which people lived for 
several years afterwards. My concern is that when someone receives a prognosis, I am not sure that they are in 
a fit state of mind to make a decision to end their life. In fact, based on the examples—we were given real examples 
from people in this house—if people had made that decision, they would have robbed themselves of years of 
fulfilled living, for not just them but also their family. I am not sure whether the committee considered this, but 
would it not be prudent in that particular case—I am not saying in every case; we can talk about the waiting period 
later on—to seek advice on some sort of minimum waiting period before a person can make a decision to enter 
that final nine-day countdown? I say that because I am not sure it is possible for anyone who has just received such 
prognosis to be in the right state of mind. To a degree I anticipate the response will be, “Well, medical 
practitioners can assess that.” But we have heard in the debate on this bill that a medical practitioner will not need 
to know that person at all. They do not have to be a loving caring person who knows the person well; they can be 
a complete stranger, and may very well be a complete stranger. I imagine a lot of people’s family doctors will not 
want to be involved in this. Some people, particularly action-oriented people, can be very convincing and state 
that is what they want to do and this is their purpose. I will come back to that question.

I wonder, minister, whether it is not prudent to investigate some specified waiting period. I do not presuppose what 
that should be. I think that is something that the experts in this area would be able to determine, but it certainly 
seems that at least a week or weeks should be required to allow a person to be in the right frame of mind to make 
a properly informed decision—not a decision that is influenced by the shock and trauma of having just received 
a diagnosis. Quite often it is a surprise; many people know that. Quite often it is a complete surprise. Someone 
who has been feeling a little unwell may go to the doctor, have some tests done and all of a sudden they are being 
told that they have days, weeks or months to live.

Mr J.E. McGrath: I think my colleague the member for Cottesloe is losing sight of what happens in people’s 
lives. I agree that a lot of people when they get what is called the death sentence or are told by a doctor that they 
have only six months to live, they will be quite shocked. For some people it will be very difficult to cope with. But 
a lot of those people will be in shock for a few days and think, “Well, I reckon I can still beat this,” because people 
want to live. We forget that people want to live. I did not talk in my second reading contribution about what 
happened to my father-in-law, because my wife’s family were fairly private. They were racing people. When my 
father-in-law got cancer, his wife did not even want our kids to see him in hospital. He was in a pretty bad way 
and died a fairly private death. He was given six months to live. The doctor said, “We will put you on a course of 
chemo.” I used to drive him from the stables at Ascot to St John of God in Subiaco for his chemotherapy. One day 
after a course of chemo he came out to the car and said, “I want you to take me to Royal Perth Hospital.” I said, 
“What for?” He said, “I want to find that bastard who gave me the death penalty.” They had told him that day that 
the chemo had worked and he was on the road to recovery. Within six months he was dead. But he wanted to live. 
I think that is what we are losing sight of here. The member says that when people get a prediction from their 
specialist that they have only six months to live they are going to walk out straightaway and say, “I want to end it 
now.” I do not think many people will do that. We all want to live and we all value life. I think the one thing that we 
on the committee all learnt was that people will always want to live rather than die.

It will only be when they get to a certain stage that they cannot put up with it anymore.

I know the point the member is making, but we have to trust the general practitioners and the people who know. 
If a guy went to his GP and said, “I have been given six months by the specialists; I want to end it now”, I am sure 
the GP who had been his GP for a long time would say, “Hang on a minute, let’s think about it. There are things 
we can do and you can still get treatment.” I do not see that that will happen. I think people will want to cling to 
life for every hour that they can. It will only be when they get to the stage that life is unbearable and they do not

Extracted from finalised Hansard
I know there is some consternation in some quarters that it is a presumption that capacity exists, but, again, based apply that test at first instance? is to show that a person does not have capacity. What is the standard of proof in relation to that test and who is to

Mr R.H. COOK: I thank the member for South Perth for his observations. I think that is right. This is not a thought that springs to mind. The checks and balances in the bill, the 102 safeguards, are around the issues of not allowing that situation to occur. A person who would have been given a diagnosis that would in any way make them eligible under this bill would have an advanced and terminal disease. We are not talking about someone who suddenly discovered that they have something wrong with them. This is a process that is significantly advanced. The decision that that person would have to make has to be enduring, as set out in clause 15, and in addition to that, the request will have to be overseen by two medical practitioners. I understand the member’s anxiety, but he can be assured through the processes that will be in place that the scenario he described quite simply would not be possible.

Dr D.J. HONEY: I do not wish to drag this point out for a long time but I have to specifically disagree with the point that the member for South Perth made and that the minister reinforced. We have heard actual examples in this house of people who have had such a prognosis and said straightaway, “I want to terminate my life.” Let us take that a little further. If someone in that position said, “Actually, I have thought about this, and I don’t,” this does not apply. The member and the minister may well be right—most people will not want to access this; I know that. I am not concerned about those people. This will never affect them because they do not want to access it. I am worried about someone who will make that snap decision to access this on the cusp of being given a terrible prognosis. I am not talking about them never being able to access it. I asked the minister two questions. I asked whether the panel looked at this point and came to an idea around when a person would be in this position. I do not think it is feasible for a person to be in this position when they have just been told or within a few days of being told, but I am not a medical expert. Obviously, the minister and others have been talking to medical experts. Was this discussed and would it be prudent in that specific circumstance? It is not about someone who has had a disease for some time or who has known about it for some time; it is about someone who has just had that prognosis and makes that snap, but certain, decision. As I say, action-oriented people will be more likely to do that. The other thing is that there does not have to be any reference to their GP at all. If they decide, “I’m going to do this. I don’t even want my family to know”, and they go to a practice that has been set up to specialise in this area, no-one else has to know—not even the family has to know and they then cannot talk the person out of it.

Mr R.H. COOK: I appreciate the member’s anxieties, but it is simply not a realistic scenario. The checks and balances in place would simply not allow for that. Under this clause, the person has to demonstrate that they have decision-making capacity and they would have to be knowledgeable about what is happening. In subsequent clauses we will learn that if they are to be eligible in the first place, the condition has to be advanced and the prognosis has to be on the balance of probabilities that that person will pass away within six months. Their decision has to be enduring, not simply made on the spur of the moment or an act of inspiration, and they have to be suffering. I can assure the member that the scenario he painted could not take place. A medical practitioner would have to consider all the conditions and issues that confront that patient. Simply suffering from the shock of the news would not provide them with the opportunity to be considered eligible for voluntary assisted dying.

Mr P.A. KATSAMBANIS: Decision-making capacity is something that I spoke about for some length in my second reading contribution. As I have indicated, I have had significant professional experience in this area, but obviously in a different context of wills, estates, powers of attorney and decisions around medical treatment. I must say that I welcome the fact that there is a test of sorts codified in this legislation. I note that it is similar—I will not say identical—to the test that applies in wills, estates and medical decisions. I do not necessarily think that is a bad thing, because, again, we need some sort of guidance. I know it is a slightly different decision, but we need some sort of guidance, so I welcome that. My first query is about subclause (3), which says —

For the purposes of this Act, a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity.

I know there is some consternation in some quarters that it is a presumption that capacity exists, but, again, based on legal precedent in similar areas, I do not have a problem with that. I would like to know what the test to be applied is to show that a person does not have capacity. What is the standard of proof in relation to that test and who is to apply that test at first instance?

Mr R.H. COOK: The test is in front of the person and, obviously, it would be on the balance of probabilities.

Mr P.A. KATSAMBANIS: Who would determine that capacity is not there at first instance?

Mr R.H. COOK: It would be two people—the trained coordinating medical practitioner and the trained consulting medical practitioner—who both have to come to the decision and the conclusions independently of each other.

Extracted from finalised Hansard
Mr P.A. KATSAMBANIS: What specific qualifications would those people have to make the determination around capacity and to apply that test? Where else in their professional capability are they entrusted with this sort of framework for making this sort of decision and what sort of experience would they be able to apply in this area?

Mr R.H. COOK: This is territory that we have spent some time on. The medical practitioner would be a trained medical practitioner as defined under the Health Practitioner Regulation National Law (WA) Act. In addition, they would have to have undertaken the mandatory training, which we have discussed. In addition, if there is any doubt in the coordinating practitioner’s or the consulting practitioner’s mind about the person’s decision-making capacity, they are required to refer to a specialist who can provide them with further advice. That may be a geriatrician, a psychiatrist or someone of that nature.

Mr P.A. KATSAMBANIS: Why was the Chief Psychiatrist’s recommendation made to the Joint Standing Committee on End of Life Choices to include compulsory psychiatrist screening in this assessment not accepted in the framing of this bill?

Mr R.H. COOK: I am advised that to suggest that only a psychiatrist can assess decision-making capacity mischaracterises the role of psychiatrists. A psychiatrist treats mental illness. They are not general experts on decision-making capacity. During consultation with registered health practitioners, including the Office of the Chief Psychiatrist, it was made clear that it would not be appropriate nor necessary for every patient who requested voluntary assisted dying to undergo a psychiatric assessment. Furthermore, the Royal Australian and New Zealand College of Psychiatrists made clear that although the practitioner assessing capacity needs relevant expertise, they do not need to be a specialist and the capacity assessment is not solely in the domain of psychiatrists. Psychiatrists are rarely the most appropriate clinicians to do capacity assessments. As the member would be familiar, general practitioners and medical practitioners of all persuasions make decisions regularly about a patient’s capacity to make a decision, whether it is about refusing treatment or the type of treatment they want to receive. These are part and parcel of the skills and the training that a medical practitioner receives as a medical student, and, in addition, they would be subject to the mandatory training that is part of this bill.

Ms M.M. QUIRK: The minister will appreciate that the bar shifts in determining capacity depending on the nature of the decision. A low-level executive decision is less of a concern than if it is the ultimate decision—that is, to end life early. As I said before the break, someone can be a GP for many years and certainly miss that there is a comorbidity with dementia. Perhaps the minister can spell out for us the nature of the test for capacity and how long it lasts. In the case of aged care, we are talking about people who at medical school probably did two weeks on gerontology. As Alzheimer’s Western Australia says, the average time for diagnosis of dementia is two to three years. I hope it is more than asking who the current Prime Minister is. I know that for a while they stopped asking that question because there was such a turnover in Prime Ministers! It is not clear in this legislation. I was advised in one of the very useful briefings—we will get to this soon—that it was likely to be a six-hour module online, and that would include testing for capacity. Frankly, the community is littered with people who realise they have dementia only when they do not pass their driving test, and suddenly the families who live with them every day go, “Oh, maybe mum or dad has dementia.” It is like the frog in the cold water. We do not necessarily know. A 20-minute conversation with a person who is ostensibly lucid is frankly not enough.

Mr R.H. COOK: The criteria around that test is before the member in clause 6(2), paragraphs (a) through to (e). In addition, as I have reported to the house, it will be subject to training as part of the voluntary assisted dying process. The assessment of capacity in a clinical setting cannot be tick a box, but will involve a robust, international assessment as well as consideration of the specific criteria. The test has to be undertaken twice with two medical practitioners coming to the same conclusion independent of each other and the decision has to be enduring.

Dr D.J. Honey: Which clause was that?

Mr R.H. COOK: Clause 6(2).

Dr D.J. Honey: I saw that but the words that you mentioned —

Mr R.H. COOK: I am reading from advice. It is not part of the bill.

The two medical practitioners have to be able to continue to hold that the person has decision-making capacity right through the process. The patient has to make two requests verbally and a request in writing and ultimately has to undergo a final review. As the member will appreciate, the safeguards in relation to the decision-making capacity are quite robust.

Mr P.A. KATSAMBANIS: The test contained in clause 6(2) is not limited to only a voluntary assisted dying decision but applies generally in relation to the voluntary assisted dying process. As I understand it—the minister will correct me if I am wrong—initially two medical practitioners have to make an assessment on capacity. But in a case in which someone chooses to have the assisted dying substance administered by a practitioner, they can in certain circumstances have a nurse practitioner administer the substance. I understand that at the point the substance is administered, a decision has to be made as to decision-making capacity. What sort of training would a nurse practitioner have to determine decision-making capacity in those circumstances?

Extracted from finalised Hansard
Mr R.H. COOK: That is in part 4 of the bill, so we will come to that later. It will require the same level of mandatory training.

Mr P.A. KATSAMBANIS: We will discuss that there, and I will be interested to see what the case will be. But ordinarily in what other circumstances would a nurse practitioner, outside the assisted dying framework contained in the bill, have to make that sort of determination in the framework contained in the bill?

Mr R.H. COOK: As the member would be familiar, the nurse practitioner is a highly qualified position involving significant periods as a clinician as well as undertaking subsequent post-graduate studies. It involves diagnosis and prescription within the scope of the nurse practitioner field. They would be very familiar and very adept in relation to these sorts of decisions.

Ms M.M. QUIRK: The minister mentioned the two independent assessments of a person’s capacity by the medical practitioners. Where is the word “independent” used?

Mr R.H. COOK: Member, it is not part of clause 6.

Ms M.M. QUIRK: Is it used somewhere else in the bill? Rather than take up time now, I am happy to receive that advice later. It is in the explanatory memorandum in various places, but I cannot actually find the word anywhere in the bill. Since the minister mentioned it then, I thought I would check.

The other thing I wanted to raise is that clause 6(2) mirrors the Victorian legislation except in one material respect. In Victoria, not only does a person need to understand information and matters involved in a voluntary assisted dying decision, understand the effect and weigh up the factors referred to for the purposes of making a voluntary assisted dying decision, but also the test in Victoria requires a person to retain that information. If there is a comorbidity of a terminal disease and dementia, for example, that is a real challenge. I want to know why the word “retain” was removed. As the minister will be aware, if he were to ask someone with dementia what happened in 1963, they would be able to tell him, but if he were to ask them what they had for lunch, they would probably have no idea.

Mr R.H. COOK: I am advised that our clause is consistent with other decision-making capacity frameworks that we use in the health system, including the mental health system. Under our processes, the patient has to understand the information, they have to understand the matters involved and they have to understand the effect. Those requirements provide a framework for retention. From that point of view, it was not considered necessary to include the Victorian approach. As I said, this is consistent with other decision-making frameworks that are used in Western Australia.

Ms M.M. QUIRK: Someone made a conscious decision to take out that phrase, “Retain that information to the extent necessary to make the decision”. How did that occur and what instructions were given?

Mr R.H. COOK: It was not taken out. We are using the Western Australian framework, which is consistent across the medical field in Western Australia, including in the Mental Health Act.

Mrs L.M. HARVEY: In determining capacity, I draw the minister’s attention to clause 6(2), to give context, which states —

For the purposes of this Act, a patient has decision-making capacity in relation to voluntary assisted dying if the patient has the capacity to —

…

(e) communicate a voluntary assisted dying decision in some way.

Could the minister please clarify that a little more clearly? I note that one of the requirements in clause 14 to access voluntary assisted dying is that “the person has made a written declaration”. It would seem to me that an individual can be determined to have capacity if they can in some way communicate that they want to access voluntary assisted dying, but that individual may not necessarily have the capacity to fill in a written declaration. I want to know how clause 6(2)(e) intersects with clause 14.

Mr R.H. COOK: It is anticipated that a person in the last six months of their life and suffering intolerably may be incapacitated in their ability to speak or write. Clause 6(2)(e) requires them to be able to make a clear and unambiguous communication of their decision. For instance, they may not be able to write, so someone else might be able to write the declaration for them and they can make a mark. They might not be able to speak, so at that point they might be using an iPad, for instance, to communicate with their carers and things of that nature. This legislation contemplates that people will have differing capacity to communicate in the usual ways that we understand. However, this bill requires them to communicate in a clear and unambiguous way, even if it is not necessarily verbally or in their own handwriting.

Mrs L.M. HARVEY: The minister has made that clear. It raises some more questions concerning the person making a written declaration. I will deal with that when we get to clause 14.

Mrs A.K. HAYDEN: I would like to expand on the Leader of the Opposition’s question about clause 6(2)(e). It is a somewhat loose expression. Can the minister explain what will constitute an acceptable form of communication?
Mr R.H. COOK: It will be a clear and unambiguous one.

Mrs A.K. HAYDEN: Great. Fantastic! What is that? Two blinks for yes and one blink for no? I think we need to have a bit more of an explanation about that. If someone had been born with a speech impediment, they would know how to communicate without the ability to speak, but if someone has lost their voice due to illness, this will be a whole new area for them. I think we need a bit more of an explanation of what will be acceptable as a form of communication. If someone has lost their way to express their desires, opinions and thoughts, this legislation will allow them to access voluntary assisted dying, we need to have some form of acceptable communication.

Mr R.H. COOK: That is why under clause 6(2)(e), they have to be able to communicate a voluntary assisted dying decision in some way. It has to be communicated in a clear and unambiguous way. They may be signing or they may have other ways to communicate with their carers. We need to be satisfied that they have that capacity.

Mrs A.K. HAYDEN: Just to be clear, if it is a choice of one blink for no or two blinks for yes, would that be acceptable?

Mr R.H. COOK: It would depend upon the patient.

Mr P.A. KATSAMBANIS: I have a question about this issue. Again, I have some professional experience in this area. As I said about the test contained in subclause (2), I welcome that a clause such as 6(2)(e)—communicate a voluntary assisted dying decision in some way—is in the legislation. That is all well and good because some people may not be able to communicate verbally, and others may not be able to communicate in writing, as the case may be. However, I also have some experience in legislative interpretation. That is why processes such as the one we are going through right now, consideration in detail, are really critical for people who will interpret this legislation in the future, judicial officers in particular, to try to work out the legislative intent. Again, I speak from considerable professional experience. I am occasionally alerted to the fact that justices in Victoria quote my parliamentary speeches in Victoria when interpreting wills and administration legislation in gleaning legislative intent. I hope that actually provides them with some guidance. That is why I would have expected that when the member is asked to clarify in some way what the term means, he would have come here prepared by his most senior advisers to put on the record some examples to provide guidance in the future from the most senior of authorities—the minister sponsoring the legislation. In that way, judicial officers and others—perhaps medical, legal and nurse practitioners—could have at the outset some sort of guidance to perhaps even get to the point at which we could avoid judicial oversight and interpretation in this area. So, in the spirit of cooperation, I seek that from the minister. The minister knows I am uncomfortable with the legislation, but I still want it to be as good as possible when it leaves this place and goes out there into practice. The minister is the minister; can he at least utilise this process to put on the record some examples of what would be considered in some way, and perhaps some examples that might fall short of meeting the test? I think that would be valuable for the general public and actually add some significant betterment, if you like, to the legislation as it is currently drafted in this ambiguous way.

Mr R.H. COOK: Examples of how a patient might communicate would include such devices as a voice modulator, which the member will be familiar with the late Professor Hawking having used; someone might use an iPad to type out a message; someone might write things down; and people might utilise braille. These are the sorts of ways in which people might communicate, but the medical practitioner, with the required training, will be required to be satisfied that the patient is capable of communicating a voluntary assisted dying decision in some way.

Mr P.A. KATSAMBANIS: I think everyone understands a written request, whether it is written on a piece of paper or typed out on an iPad. Everyone understands communication of a message through a voice box. Those are the really simple ways—the ones that are unambiguous, if you like. What happens when we get into the more ambiguous decisions? For instance, would a nod, a wink or a squeeze of the hand suffice in response to a message that is communicated on behalf of the person by an assistant, be they a child, a friend or someone else they have taken along to the doctor? If, for example, someone presents to a medical practitioner with a friend, a child or a partner, and the person accompanying says, “Prior to losing their voice, my partner said they were in favour of”, would that be sufficient to satisfy this particular test?

Mr R.H. COOK: Member, I am not going to be able to satisfy your curiosity to explore all the ways in which someone might communicate. The decision-making capacity has to be clear. They have to be able to make a clear and unambiguous decision and communicate that decision. There are a range of ways of doing so. The member asked me to provide him with some examples, and I did so. I cannot satisfy the member any further than to provide him with that information. The coordinating medical practitioner and the consulting medical practitioner, who are both medical practitioners with years of clinical experience, plus the mandatory training that comes with this bill, would be required to make that decision.

Mr P.A. KATSAMBANIS: There is no point in debating this. I have made my point that this is a highly ambiguous area. The simple “write it down on a piece of paper, type it out on an iPad, communicate it through an artificial voice box that is still utilising the person’s own function”, as Professor Hawking and the like used, I think they are non-controversial. It is those areas that I raised. I understand that the minister might not want to give an answer, but it is that area that people who ordinarily may want to support this legislation have some issues about. I think they are legitimate issues. Sadly, they will need to be interpreted at some point by a court and unfortunately in many cases they are going to be post a terminal event and so the interpretation would be academic at best. I think

Extracted from finalised Hansard
that is why the requirement in the Victorian legislation, which has been removed from this provision, would have been extremely helpful in requiring the practitioner in this particular case to retain the information. I join with the member for Girrawheen in highlighting that there is an issue with this clause.

Mr P. Papalia: It is not a second reading debate.

The ACTING SPEAKER: Minister!

Mr P.A. KATSAMBANIS: I actually do not think these interjections are helpful. I am trying to highlight really important issues. I am almost at the conclusion and the peanut gallery comes in and starts throwing barbs that detract from a fair examination and simply try to make political points. I am not making a political point here. I have made my political point in the second reading debate. The minister has handled my queries here with great respect, and I was going to say aplomb as well. I commend him for that. I do not necessarily think those other interjections are helpful, especially when they are an attempt to derail my train of thought in a complex area that will be litigated. They will need to be examined even by practitioners before litigation. The majority of what we have in the bill before us is really good. I am not a supporter of the principle of the legislation, but I want the legislation to work in practice. What has been done here is really good. I have said that consistently as we have gone through this clause. Because of this difficulty in articulating all of the ways that a decision could be communicated “in some way”—I use those three words in quotation marks—the added protections in the Victorian legislation would have been preferable to what we have here.

Dr M.D. NAHAN: Clause 6(3) may need some clarification. It states —

… a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity.

I want the minister’s assurance that in all cases, a test will be made by two practitioners to assess that.

Mr R.H. COOK: Yes, member, that would be part of the assessment process.

Dr D.J. HONEY: I appreciate that this is dealt with later in the bill, but it appears that we are going down the path of whether the person should have a psychiatric assessment, so we might as well exhaust it now. I know of a reasonably personal story of a person in Sir Charles Gairdner Hospital who was dying and all they wanted to do was go home and die in their own house. A doctor carried out an assessment of their capacity to make a decision, which consisted of five perfunctory, rapid-fire questions, and then that person was deemed not to have any capacity and was trapped in the hospital until they died. That person used to get up every day, get dressed and pack their case so that they could go home and die in their house. It is certainly the view of other doctors that although that person was dying, they had plenty of capacity and, in fact, had the capacity to make that decision for themselves and not be literally trapped as a prisoner in the hospital. That brings me to the concern about how the assessment will be done and whether the people will be qualified. It may be right or wrong, but it was the clear view of other respected medical practitioners that that doctor had made a fundamentally wrong decision in a rush.

That brings me to how this assessment will be carried out and whether a psychiatrist is needed. The words in the bill are vague. It says that they will assess whether they have decision-making capacity, and we are going to rely on the fact that a doctor will do that. I will be very frank with the minister. I think we see the normal range of abilities in doctors that we see in people in any other profession. Some doctors are outstanding in every regard and some doctors, to be frank, should not be practising. They are not competent and quite often they are not found out. That is not to criticise doctors; doctors are like humans in every other walk of life. Some people are exceptional and outstanding; some are not. How they got through their exams is a mystery to everyone. What I am getting to is not a general discussion. The minister used some specific words. He had some advice that the test has to be world standard et cetera. How will that manifest itself in the application of the bill? The words that the minister used—I cannot remember them verbatim—sounded reassuring to me. There was going to be some rigour and detail in the standard of that test. How will that manifest itself in the bill? Is there any reason that that could not be included in the bill if it is not going to be guaranteed in some other way? As I say, I was reassured by that form of words, but I just do not see it reflected in the bill.

Mr R.H. COOK: The words I used were in the submission from the Chief Psychiatrist to the Joint Select Committee on End of Life Choices. From that perspective, I think the member understands the gravitas that that has and what would be brought to bear. As I said in answer to a number of questions, if the medical practitioners have any inkling that the person does not have decision-making capacity, they must refer on to a specialist who can then provide them with assistance in making that assessment. That person might be a specialist in a particular field of medicine. They might be a geriatrician or a psychiatrist if there are particular mental health issues and so on. The assessment of decision-making capacity goes on all the time in medicine, and the member has just described a very good example. These sorts of cases, in which a GP or a medical practitioner of some form has made a call about a patient’s capacity to make a decision, come before the State Administrative Tribunal regularly. It happens all the time. I am sorry if the member feels that there is too great a variation in the skills and qualities of the medical workforce. We have one of the best medical workforces in the world, but I accept that sometimes good decisions are made and sometimes bad decisions, or decisions that would otherwise be reflected on, are made. In health, they are made all the time.

Extracted from finalised Hansard
Dr D.J. HONEY: I do not want to drag this out, but is there any reason that we could not include that form of words in the bill? That is an explicit form of words; it defines a standard. Otherwise, we will just be leaving it up to that individual medical practitioner. There is a diversity of skills, and a diversity of inclinations, might I say, in the medical profession. Is there any reason why we could not use that form of words to specify how the assessment would be done? That would make it unequivocal. It would not give us absolute certainty, but it would give us much greater clarity about how the assessment would be done. This is probably one of the more important aspects of the whole bill—how do we assess that the person has capacity to make that final decision?

Mr R.H. COOK: Member, you and I would not come across this stuff very often, because we do not often delve into the world of medical practitioners and assessments of decision-making capacity. As I stated to the member for Girrawheen, the criteria that we have used are in common usage across the health system in Western Australia, including as part of our Mental Health Act. What I described is the clinical standard. From that point of view, I have provided that as a way of assurance to the member that these things will be dealt with in the appropriate way.

Ms M.M. QUIRK: Minister, I have put on the notice paper an amendment that relates to the insertion of a new subclause (aa). I therefore move —

Page 8, after line 24 — to insert —

(aa) retain the information or advice to the extent necessary to make the decision; and

I have already articulated that the reason for that proposed amendment is that it is in the Victorian bill. It will provide an additional test to ensure that the person whose capacity is being assessed can, if you like, reiterate what has been put to them, and their understanding of the procedures around voluntary assisted dying. The idea of testing retention is not novel. We do it in all forms of life. A footy coach might say to a player, “I want you to take out the full back. Did you get that? Do you know what you have to do?” We might say to kids, “We would like you to go to the shop and get X, Y and Z. Now, what are you going to get for me?” It will not be a major impost on practitioners. I would have thought it would give practitioners a lot more confidence about their assessment. As I have said, certainly in cases of dementia, retention is one of the first things that goes. It is a threshold question that needs to be addressed. I know the minister has told us that the Western Australian framework is different. I am trying to ascertain why those words were removed. I seek the minister’s response to the proposed amendment.

Mr R.H. COOK: The definition in the bill of “decision-making capacity” is consistent with the provisions of the WA Mental Health Act 2014. Medical practitioners are already comfortable with the definition of decision-making capacity in the WA Mental Health Act. The reference to “retain the information” is a reference to Victorian legislation and is not reflective of Western Australian legislation. As I assured the member earlier, those words were not removed; they were never there. This is the way in which we have described decision-making capacity in the context of the WA Mental Health Act.

Mr P.A. KATSAMBANIS: I think I have made my point on the amendment moved by the member for Girrawheen. I definitely think it will improve the test for decision-making capacity in the bill. I have not heard any explanation of why Western Australia is so different from Victoria that this proposed amendment is unnecessary. I think it is a necessary part of the protection framework for people who may or may not be on that threshold where their capacity can be questioned. I think it is a well understood test and, as the member for Girrawheen has pointed out, with respect, it improves what is already a relatively robust test. I do not know why there is such opposition to improving something in the bill. It certainly does not add any harm, nor does it weaken the provisions. It does not change the provisions in any way; it is just one more step to make things even better.

Mr S.K. L’Estrange: Safer.

Mr P.A. KATSAMBANIS: Ultimately, as the member for Churchlands points out, the whole idea here is to make things safer and to assuage the concerns of people who might be a little worried about how this test is going to be applied in practice. To me this seems like the sort of good and harmless amendment that ought to be accepted in good faith to indicate that the government is prepared to listen and is prepared to actually make things safer and better. With that, I will sit down; I cannot continue to make the same point.

Ms M.M. QUIRK: I want to ask the minister quickly: he has indicated to this chamber that this test is done routinely. I know that every individual case is different, and we are not yet at the training section so I cannot cloak our discussion in relation to training. On average, how long does the minister think it will take to do a test of capacity by working through these criteria? Can we get some sort of medical advice on how long that will take?

Mr R.H. COOK: It will really depend upon the patient, their capacity to communicate, the way that they communicate and the comorbidities that they are suffering from. In some respects, the answer is: how long is a piece of string? The assessment will take place over a period of time in a clinical setting as part of a therapeutic relationship.

Dr M.D. NAHAN: I want to make a quick statement. We are looking at issues in which there is a great deal of variability in people’s mental and physical state and their ability to communicate and think. One key thing is that people have good days and bad days. They can be in and out of comas, in and out of consciousness, and have good

Extracted from finalised Hansard
feelings and not so good feelings, so it is physical and mental. It seems to me that when people are making an assessment about whether a person can consciously make a decision about their life earlier—not real early, but earlier—we should make sure that there is enough time between asking the question and going through the process to make sure that it has sunk in and that it is their final decision.

I recognise that this has to be done twice by two medical practitioners, but it seems as though retention is an important point. I add that a large number of supporters of voluntary assisted dying in the community want it to apply to people with dementia. That is the reality. They hope that having a living will allows them to do this, but we are not doing that here. However, there is no doubt that many of them—the public—think right now that this will apply to them if they get dementia. This is a real process that we will have to deal with. Therefore, I think that a statement of retention, as the member for Girrawheen has proposed in the amendment, is a sensible approach to addressing this very important issue.

**Mr R.H. COOK.** As I said, this is part of the provisions of the Mental Health Act. In some respects, when there is already best practice, we stick with it. It is widely understood by the medical community and, as a result, we think it is absolutely adequate. To pick up on one of the member’s points, the decision-making capacity will have to be demonstrated not twice but three times, in assessments carried out by authorised medical practitioners. However, the authorised prescriber needs to be satisfied, and if the person seeks an administering practitioner, they have to be satisfied that they have decision-making capacity as well. As the member said, they might have a bad day. In this process, they have to demonstrate that decision-making capacity throughout the process. In that sense, it is a very robust framework and in that context I am sure it should provide satisfaction to the members for Riverton and Hillarys, given their concerns and anxieties around that.

**Mr Z.R.F. KIRKUP.** Just to clarify the amendment moved by the member for Girrawheen, is there already adequate capacity in the decision-making capacity clauses? Is the minister suggesting that there is no need to ensure that someone can retain the information that has been provided to them?

**Mr R.H. COOK.** That is right. There are essentially two arguments. Firstly, the person has to understand the information, the matters involved and the effect of the decision, which is essentially the definition of retention; they have to retain the information. As I mentioned to the member’s colleagues, these are also consistent with the provisions of the Mental Health Act, so they are widely understood by the medical fraternity.

**Mr Z.R.F. KIRKUP.** I appreciate that response, minister, which went to the first question I asked on this clause about trying to demonstrate that the patient has understood the information. This clause would not necessarily change the ability for a practitioner to ascertain whether someone understands the information. As the minister said, there are already a number of points at which it has to be demonstrated that the patient understands. It is important, though, to make sure that a patient fully absorbs the consequences of the decisions that they will undertake. Would the insertion of an amendment such as this help to strengthen that at all? I appreciate the consistency with the Mental Health Act, but this goes beyond that.

**Mr R.H. COOK.** I do not believe so. Essentially, this is about the person understanding that they will die if they enter the voluntary assisted dying process and that they understand the consequences of that decision. From that perspective, I think we have captured it.

**Division**

Amendment put and a division taken, the Acting Speaker (Ms J.M. Freeman) casting her vote with the noes, with the following result —

Ayes (15)

<table>
<thead>
<tr>
<th>Mr I.C. Blayney</th>
<th>Mr Z.R.F. Kirkup</th>
<th>Mr W.R. Marmion</th>
<th>Ms M.M. Quirk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs L.M. Harvey</td>
<td>Mr A. Krsticevic</td>
<td>Ms L. Mettam</td>
<td>Mrs M.H. Roberts</td>
</tr>
<tr>
<td>Dr D.J. Honey</td>
<td>Mr S.K. L'Estrange</td>
<td>Dr M.D. Nahan</td>
<td>Mrs A.K. Hayden (Teller)</td>
</tr>
<tr>
<td>Mr P.A. Katsambanis</td>
<td>Mr R.S. Love</td>
<td>Mr D.C. Nalder</td>
<td></td>
</tr>
</tbody>
</table>

Noes (38)

<table>
<thead>
<tr>
<th>Ms L.L. Baker</th>
<th>Mr M. Hughes</th>
<th>Mr M.P. Murray</th>
<th>Mrs J.M.C. Stojkovski</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr A.D. Buti</td>
<td>Mr D.J. Kelly</td>
<td>Mrs L.M. O'Malley</td>
<td>Mr C.J. Tallentire</td>
</tr>
<tr>
<td>Mr J.N. Carey</td>
<td>Mr F.M. Logan</td>
<td>Mr P. Papalia</td>
<td>Mr D.A. Templeman</td>
</tr>
<tr>
<td>Mrs R.M.J. Clarke</td>
<td>Mr M. McGowan</td>
<td>Mr S.J. Price</td>
<td>Mr P.C. Tilley</td>
</tr>
<tr>
<td>Mr R.H. Cook</td>
<td>Mr J.E. McGrath</td>
<td>Mr D.T. Punch</td>
<td>Mr R.R. Whitby</td>
</tr>
<tr>
<td>Ms M.J. Davies</td>
<td>Ms S.F. McGurk</td>
<td>Mr J.R. Quigley</td>
<td>Ms S.E. Winton</td>
</tr>
<tr>
<td>Ms J. Farrer</td>
<td>Mr D.R. Michael</td>
<td>Mr D.T. Redman</td>
<td>Mr B.S. Wyatt</td>
</tr>
<tr>
<td>Mr M.J. Folkard</td>
<td>Mr K.J.J. Michel</td>
<td>Ms C.M. Rowe</td>
<td>Ms A. Sanderson (Teller)</td>
</tr>
<tr>
<td>Ms J.M. Freeman</td>
<td>Mr S.A. Millman</td>
<td>Ms R. Saffioti</td>
<td></td>
</tr>
<tr>
<td>Ms E.L. Hamilton</td>
<td>Mr Y. Mubarakai</td>
<td>Ms J.J. Shaw</td>
<td></td>
</tr>
</tbody>
</table>

Amendment thus negatived.
Mr Z.R.F. KIRKUP: I refer to clause 6(3), which states —

For the purposes of this Act, a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity.

If I am reading that right, the onus is to prove that a patient does not have capacity.

Mr J.E. McGrath: I cannot hear, Chair.

Mr Z.R.F. KIRKUP: I am sorry; can the member not hear me? I am sorry, I do not know what is happening. Just to clarify for the member for South Perth, I just want to understand that subclause (3) shows that the onus is not reversed, but on the practitioner to assume that the person has capacity unless otherwise proven. Is that correct?

Mr R.H. COOK: Yes, that is a WA standard. As I think I have explained to the chamber before, the definition acknowledges that a person is presumed to have decision-making capacity unless there is evidence they do not. In Western Australian law, there is a presumption that a person has capacity to make decisions about their own life. This is reflected in the presumption in the legislation.

Mr Z.R.F. KIRKUP: The way that a practitioner assesses that is against all the other parts of that clause as well as the eligibility and things like that, as defined in the legislation. Is that right? That is how the practitioner would practically come to any conclusion one way or the other. Is that basically right?

Mr R.H. COOK: As the member knows, there is a range of tests. The person has to be eligible to start with, and we will go into some detail on that in the first place, but this is obviously the test by which the assessment would be made that the person has the capacity to make the decision.

Dr D.J. HONEY: The minister knows that I have a concern about undue influence and coercion. I wonder whether it would not be prudent to specifically mention that in this clause. I am not suggesting an amendment, but I am asking the minister perhaps to consider a form of words—for example, that the patient is not subject to any undue influence or coercion. The reason for highlighting it is to make sure that that is specific consideration by the practitioner. I appreciate that there are references later in the legislation, but the reason to include it in this clause is to especially highlight that because that is one of the particular risks in this legislation.

Mr R.H. COOK: That is a different test or requirement of the act. It comes later in the act. In particular, I draw the member’s attention to clauses 99 and 100, which deal with the offences committed under the bill. This clause is specifically related to decision-making capacity.

Dr D.J. HONEY: I am not trying to drag this out or frustrate the progress of this legislation in any sense. My concern is that if someone is subject to coercion or undue influence, they do not necessarily have the capacity to make an informed decision.

Mr R.H. COOK: If someone has decision-making capacity, they can understand the decision that they are making and the consequences of that decision. But if that decision is considered to be taken in the context of coercion, they would not be eligible for voluntary assisted dying.

Mrs A.K. HAYDEN: In case I have missed it, is there an obligation for the doctor to seek the medical history of a patient when determining the decision-making capacity of that individual?

Mr R.H. COOK: It is not a subject of this clause, but it is obviously a significant part of a medical practitioner’s clinical and legal obligations as a clinician.

Mrs A.K. HAYDEN: Before we move on from that, can we ask this question in another part of the legislation? Is the minister prepared to answer that now or does he want us to come back to it? I do not want to move on from this clause if it cannot be discussed later.

Mr R.H. COOK: It is not part of the bill. It is part of good clinical practice and, of course, the obligations that medical practitioners are required to practise under, in relation to the law and registration with the Medical Board of Australia.

Mrs A.K. HAYDEN: So that I have it right—I do not want to misquote the minister—under the decision-making capacity provision in clause 6, the doctor is not obliged to seek the medical history of a patient to determine whether they have the capacity to make that decision. I want to clear that up.

Mr R.H. COOK: A medical practitioner is required to draw upon their medical practitioner training, experience and skills to make that assessment. Obviously, they would take the full range of information available to them, including the medical records of the patient.

Mrs A.K. HAYDEN: I have one last question because I know the member for Cottesloe wants to ask something on this clause as well. Is it in the Victorian legislation?

Mr R.H. COOK: I am advised that it is not.
Dr D.J. HONEY: I want to clarify that, because I was not reassured by those words. We have these general words that it would be good practice, but the question that was very specifically asked is whether there is an obligation under this act for them to do that. We have heard the member for Girrawheen talk about a patient with dementia or some other degenerative illness that may not be readily apparent to someone, even a medical practitioner, when talking to or meeting that patient for the first time. It is all right saying that it is good practice or it is good clinical practice but, specifically, is there an obligation under this bill for a doctor to do that? I guess a corollary of that is—I will not draw this out into 20 questions—how would anyone know whether they had done that? The very specific question is not, “Is it good practice?” but “Is there an obligation under this bill, and how would anyone know whether they had done that?”

Mr R.H. COOK: As the member knows, we rely upon medical practitioners to make decisions and conduct themselves in specific ways as a matter of Australian law under the conditions associated with their Australian Health Practitioner Regulation Agency registration. They have ethical, legal, professional and moral obligations to undertake all these practices. It is not prescribed in this legislation but it is implicit in the use of a medical practitioner in this role and it is explicit in the national health professions law.

Dr D.J. HONEY: To complete the second part of the question, how would anyone know whether that had been done?

Mr R.H. COOK: In the same way that we can be assured that anyone receiving clinical care receives that care within the appropriate legal framework.

Dr D.J. HONEY: I do not wish to verbal the minister at all but that response was general and generic. We either have a mechanism to know that that has been done or we do not. I do not think we can ever say that we know because we assume it would be done as best practice. I take it from the minister’s answer that we do not have any way of knowing whether that has been done. We can only assume that it was done.

Mr R.H. COOK: A medical practitioner will have to make declarations on the authorised forms throughout the voluntary assisted dying process. They might lie on those forms.

Dr D.J. Honey: I’m not worried about lying.

Mr R.H. COOK: That is right. All those declarations and authorisations on the authorised form will obviously take into account that they have discharged their duties and there would have to be a declaration around that. That is how we would know, and obviously the Voluntary Assisted Dying Board will see those as part of the voluntary assisted dying processes. Yes, there will be declarations and certifications and they will be part of the assessment process.

Mrs A.K. HAYDEN: I apologise that we keep asking the same question. I know that it can get a bit frustrating but this decision-making capacity will enable an individual to access voluntary assisted dying. This is one of the most critical clauses in the legislation. Having heard that there is no obligation for a doctor to seek the medical history of a certain patient, red flags are going up at 100 miles an hour. If a person’s capacity deteriorates over time, is there a test for that capacity? Are there existing legal tests or things such as estate management decisions about medical treatment and so forth? The minister just said that we do not have any way of knowing whether that has been done. We can only assume that it was done.

Mr R.H. COOK: Yes, there are multiple assessments throughout the process, as I explained to the member for Riverton in my answer just a short while ago. There are multiple assessments throughout the process based upon the written requests, the final review, the prescribing and the handover; and, if the patient uses an administering practitioner, at that stage as well. If someone of standing is of the view that that process is incorrect, they can appeal to the State Administrative Tribunal. As the member can see, I think all members share the concerns that this process is robust and is enduring throughout the process, and that is why we have these measures in place.

Clause put and passed.

Clause 7: Voluntary assisted dying substance —

Mr P.A. KATSAMBANIS: Clause 7 provides —

(1) The CEO may, in writing, approve a Schedule 4 poison or Schedule 8 poison … for use under this Act for the purpose of causing a patient’s death.

It goes on to define the approved poison as a “voluntary assisted dying substance”. I would like to know, firstly, why was the decision made that the CEO would do this in writing, rather than have this prescribed in regulations, as would ordinarily be the case? Secondly, what process will the CEO follow in making this approval? Thirdly, once the approval is made in writing, to whom will it be communicated? Will it be a publicly available document; and, if so, under what process?

Mr R.H. COOK: The answer to the member’s first and third questions is no, it will not be in regulations, because we do not want it to be public. The answer to the third question is no, it will not be public. To answer the member’s second question, the choice of lethal medication will be a clinical decision made by the coordinating practitioner.

Extracted from finalised Hansard
from the approved list of schedule 4 or 8 poisons that the CEO of the Department of Health approves or authorises. As part of the implementation of the bill, it is intended that a clinical panel will be convened to determine the schedule 4 and schedule 8 medication protocols suitable for voluntary assisted dying in Western Australia. The clinical panel will also inform the operational requirements for the supply, dispensing and safe management of these medications. It is expected that the clinical panel will include appropriate representation from pharmacy, medical and nursing experts from both a Department of Health and clinical perspective. The recommendations of the clinical panel will inform the CEO’s approval under clause 7.

Mr P.A. KATSAMBANIS: This will not be communicated to the public; I think the minister has alluded to that in previous discussion in consideration in detail. The CEO will make a determination in writing. Who will the CEO communicate that decision to? Who are the people or the groups of people who will find out what this determination is? Clearly, the public is not going to know.

Mr R.H. COOK: Obviously, the trained medical practitioners will be informed, because they are the people who will undertake the prescribing, and the chief executive officer will be informed by the clinical panel. From that perspective, it is essentially a closed loop to make sure that the public is not made aware of what those substances are, the make-up of those substances or the way that they are combined, because that would be very dangerous information to have out in the public domain.

Mr P.A. KATSAMBANIS: I understand that we do not want a circumstance in which a formula might become publicly available and people start making the stuff at home, even if it is from a well-meaning perspective. But I assume that at some point the substance considered to be the voluntary assisted dying substance will need either to be purchased from the manufacturer in its entirety or otherwise to be compounded by a compounding pharmacist. I assume the list of people who will eventually find out the formula will go beyond those whom the minister has articulated in his answer. I would ask the minister to reflect again and give me a fuller answer as to the range of people who will find out what this substance or range of substances will be.

Mr R.H. COOK: I apologise. I misunderstood the member’s question. I thought he was talking about oversight. The clinical panel will have oversight, and only those medical practitioners that have had the training for voluntary assisted dying will have access to that information. The authorised supplier, which will be a pharmacist, will have access to that information as well because they will receive the prescriptions. To pre-empt a potential question the member might have, that prescription will not be handed over. It will be communicated directly from the medical practitioner to the pharmacist so that the person for whom the prescription is made available, or their representative, will not find out what the substance is.

Mr P.A. KATSAMBANIS: I have a range of questions about that. Will the pharmacist be a pharmacist in private practice or a pharmacist in the Department of Health system in Western Australia? I ask because in Victoria the substance is compounded in one place. I hesitate to name it because I am not sure whether it is publicly known, but I know where it is. It is a public facility, and I will leave it at that. If the minister understands that it is publicly known where the Victorian facility is, I will leave it for him to name it. At this stage, I will not. That is how I understand it works in Victoria, but how will it work in Western Australia? Will the health system purchase the voluntary assisted dying substance from a pharmacist in private practice or will it be compounded in the public system?

Mr R.H. COOK: It will not necessarily be compounded. That will depend on the substance itself. A proposed central pharmacy service will have governance over the training requirements and certification of any authorised suppliers—for instance, pharmacists at regional hub pharmacies who are involved in the supply of voluntary assisted dying medications. It is not anticipated that that will be pharmacists in a commercial setting.

Mr P.A. KATSAMBANIS: Can the minister clarify that last bit? Did he say that it is not anticipated that it will be pharmacists in the commercial framework?

Mr R.H. Cook: No. That is correct.

Mr P.A. KATSAMBANIS: It will be somehow contained within the Department of Health. Will the government at some point create a series of guidelines for how the substance will be delivered to the far-flung parts of the state that it must be transmitted to? In that case, who will create the guidelines? Will it be the CEO, the central pharmacy authority or the minister? Will that be prescribed in the regulations? How will that work?

Mr R.H. COOK: That will be subject to the implementation phase. It will certainly be the CEO, who is responsible for everything that goes on in the Department of Health. The CEO will have to authorise the process. The member will understand that, consistent with my previous answer, the proposed central pharmacy service will be responsible for the training and auspicing of the process and advising the CEO of the appropriate ways that the substance can be efficiently delivered to the patient.

Mr P.A. KATSAMBANIS: I have further questions about this. It is important that we get into the minutiae of this. I want to cover a number of areas. The first is confidentiality. The minister has clearly articulated that it will be important to maintain confidentiality to control the manufacture of the substance. I think it was mentioned earlier that it will also help control the price. I accept that that might be a factor that needs to be taken into account.
A range of people will become aware of the formula of the substance and will have some knowledge of what comprises the voluntary assisted dying substance. What confidentiality requirements would they be under; where in the bill are they contained; and what are the penalties for breach of any of those confidentiality requirements right across the chain, from the trained doctors to the central pharmacy authority to all the other distributed parts of the network that may end up receiving knowledge of this substance?

Mr R.H. Cook: Clause 102 creates a specific prohibition with regard to the advertising of a schedule 4 or schedule 8 poison as a voluntary assisted dying substance. The penalty is imprisonment for three years and a fine of $36,000. That is under clause 102.

Mr P.A. Katsambanis: That relates to advertising, and I can understand that we do not want anyone putting up their shingle and saying, “Come and buy the medicine from me”, but that does not cover disclosure. It does not cover someone who has received information that the minister and the people who are putting this bill together clearly want to be kept confidential. It does not in any way cover disclosure, whether it is disclosure done for malfeasance or simply inadvertent disclosure. That is why I ask again: what is the protection against disclosure; where is it contained; and what are the penalties for breach of any of those confidentiality requirements?

Mr R.H. Cook: It is clause 105, under “Recording, use or disclosure of information”.

Mr P.A. Katsambanis: I will just have a look.

Mr R.H. Cook: Perhaps I can take a question from some others while you are doing that.

Mr P.A. Katsambanis: I have another area that I want to canvass on the same clause, whilst the advisers might look at that.

Mr R.H. Cook: No, you're looking at that, and I’ll take another question from perhaps the member for Cottesloe while you familiarise yourself with that clause. That was my suggestion.

Mr P.A. Katsambanis: No. I just wanted to go through those provisions. I am okay to go through that. The minister referred to clause 105. I am happy to deal with that when we get to that clause, but I have another question on clause 7 that just fits in.

I do not want to sound like I am getting into the minutiae, but as the minister understands, this is actually important and I am sure he will grab this straightaway. When dealing with schedule 8 poisons, we know that there are medical practitioners out there who have had their right to prescribe schedule 8 poisons restricted or removed by medical boards for various reasons, which we do not need to get into. We know that happens on not infrequent occasions. What happens, both legally and practically, in a circumstance in which a practitioner who otherwise fits all the requirements of this legislation is willing to participate in the scheme provided for under the legislation but is prohibited from prescribing a schedule 8 poison? I think the minister understands that I am not dealing with a hypothetical here; I am dealing with a circumstance that would exist out there right now in Western Australia, on more than one occasion.

Mr R.H. Cook: There are severe penalties under the Medicines and Poisons Act in relation to the abuse of schedule 8 drugs by either someone who is not a medical practitioner, or a medical practitioner who is seeking to prescribe them. In that sense, there are very harsh penalties associated with that. Under section 14 of the Medicines and Poisons Act, a person who manufactures a schedule 4 or 8 poison, including a voluntary assisted dying substance, will commit an offence, unless that person does so under, and in accordance with, an appropriate licence or a professional authority in accordance with that act.

Mr P.A. Katsambanis: Sure. But it does not cover off the question that I asked. It is not in relation to the manufacturing of drugs. We have a medical practitioner who has gone through this process. They are ready to go; they are ready to write out the prescription and the patient has asked them to do so. However, at that stage, having covered all that, the medical practitioner is not able, through a prohibition placed on them by the medical board or others, to fill out that prescription because it contains a schedule 8 poison. In that circumstance, what happens? Do they refer them to another practitioner simply for the prescribing? Does that practitioner then have to undertake all the other tests and checks and balances that are contained in this bill? What happens in that circumstance?

Mr R.H. Cook: If the medical practitioner is not eligible, under their qualifications, to manage a schedule 8 poison or medication, they would not therefore be eligible to be a coordinating or consulting practitioner and so would not be involved in the process. They have to have the capacity to participate under the Voluntary Assisted Dying Bill—or act, if it passes—in order to play those roles. If they are not able to play those roles, they would not be eligible to be either a coordinating or a consulting practitioner.

The ACTING SPEAKER (Ms J.M. Freeman): Member for Girrawheen.

Mr P.A. Katsambanis: I just wanted to finish on this.

Ms M.M. Quirk: Good. I will let the member do that then.

The ACTING SPEAKER: Member for Hillarys, finishing on this!

Extracted from finalised Hansard
Mr P.A. KATSAMBANIS: I have two questions on this. The first one is just to follow up on that. Is the system robust enough to eliminate a person who has already been qualified through the system to be a practitioner in this space and has subsequently lost their right to prescribe schedule 8 poisons? That is the first question: is our system here in Western Australia robust enough to quickly pick that up and remove them from the list of eligible practitioners?

Mr R.H. COOK: The answer to the member’s first question is yes, the system is robust in the first instance. If they are not qualified, they would not be able to register. In the second, if they lost that registration, they would not be eligible to continue to be a coordinating or a consulting practitioner.

The ACTING SPEAKER: Do you want to do it by way of interjection, member for Hillarys?

Mr P.A. Katsambanis: No, not at all.

Mr R.H. COOK: Let us take it to an extreme scenario. Maybe they are halfway through the process or they have just about completed the process under voluntary assisted dying; they could delegate that function to a medical practitioner who was qualified to do it, but, clearly, they would come off the register thereafter.

Mr P.A. KATSAMBANIS: That was the sort of answer I was looking for. My final question on this clause is: What will the prescription look like? When a medical practitioner writes out a prescription, does he or she write out the actual substance that is approved in writing, or do they write out a prescription that simply says, “Please prescribe this patient an approved voluntary assisted dying substance”? Is the practitioner actually writing a script for a generic term or for an actual pharmaceutical or brand-name product?

Mr R.H. COOK: It is anticipated that the prescription will be communicated through a secure means, probably through a portal of some form. Obviously, that would include information about the medical protocol that is required for the specific patient and the limited range of substances.

Mr P.A. Katsambanis: So it would be the substance; it would not be a generic?

Mr R.H. COOK: That is correct. It would obviously be a very specific request, but also it would not be on a piece of paper that someone could wander down the street with. It will never get into the patient’s hands; it will be communicated by secure communication.

Ms M.M. QUIRK: I have two fairly prosaic inquiries about clause 7. Clause 7(1) says that the CEO may, in writing, approve a schedule 4 poison. Should that not say “must”? If he is approving a drug, surely he should commit that approval to writing?

Mr R.H. COOK: Again, this is a drafting convention. The reason that the expression “may” is used is that it authorises the CEO to do so in the event that the CEO undertakes these actions consistent with clause 7.

Ms M.M. QUIRK: Does that not give the CEO carte blanche to approve a schedule 4 poison without doing so in writing?

Mr R.H. COOK: The concept of the term “the CEO may” is attached to the concept of the term “approve a schedule 4 poison or schedule 8 poison”. The term “in writing” describes the means by which the CEO would create that authority.

Ms M.M. QUIRK: Would we not then get into problems about whether there is a record of whether approval was made, when it was made and so on? How do we get over that?

Mr R.H. COOK: If the CEO makes an approval, it will be in writing, and that is what that clause expresses.

Ms M.M. QUIRK: Clause 7(1) confers the CEO with power to approve a schedule 4 poison. Can that power be delegated to another person under the Interpretation Act or is that power limited solely to the CEO?

Mr R.H. COOK: I am advised that it can be delegated and would likely be delegated to the Chief Pharmacist.

Ms M.M. QUIRK: Is it likely that it will be delegated to any other individuals or will there be a list of positions that will be permitted to be so delegated? Will that delegation occur only when the CEO is on leave or away?

Mr R.H. COOK: My understanding of the way that this will operate is that the CEO will create a schedule. The Chief Pharmacist has agency in relation to the provisions of the Medicines and Poisons Act, so in that context may have a role to play. This is another example of the interplay between this bill and the Medicines and Poisons Act.

Ms M.M. QUIRK: This is my last question, minister. Will there be some formal instrument of delegation under the Medicines and Poisons Act?

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: Thank you.

Dr D.J. HONEY: Some of this was touched on in yesterday’s debate. I refer to clause 7(2). I will not labour it, but could the minister please explain why there was seen to be a need to create the term “voluntary assisted dying substance” and not simply continue to use the word “poison”? This states clearly that one is the other. Why is there a necessity to use another form of words for that?

Extracted from finalised Hansard
Mr R.H. COOK: In the same way that in another context we have something called pain medication, this is simply a way in which we can describe the substance in the context of the bill. We have a voluntary assisted dying decision, and, in this context, we have a voluntary assisted dying substance.

Mr Z.R.F. KIRKUP: I am conscious of the question that I asked the minister previously. I appreciate the comments that the minister provided to the member for Cottesloe, or it might have been the member for Hillarys, about correspondence about CEO decisions. If the CEO were to write to the minster or write some sort of executive order, is it possible that that would be captured under freedom of information? I imagine that it would be.

Mr R.H. COOK: No, I do not believe it would. Let me take specific advice, but, obviously, the intent is that the information will not become public. The answer is no.

Mr Z.R.F. KIRKUP: I agree with all the sentiments of the bill. We would not want details about the use of a schedule 4 or schedule 8 drug to be published. The minister might need to clarify, when we get to the implementation phase, what that will look like. However, given my previous life and my knowledge of the FOI act, I am concerned. As I read the legislation as it stands, I do not think there is any clause under which that information could be exempted from being provided, unless there was some commercial-in-confidence information, or it was, perhaps, covered by cabinet confidentiality. I am conscious that although the intent of the bill is to ensure that that information is not made public, it might be possible to access that information through FOI.

Mr R.H. COOK: We will come back to that.

Clause put and passed.

Clause 8: When request and assessment process completed —

Dr D.J. HONEY: What capacity will there be for a third party to raise concerns at the stage at which the request and assessment process has been completed? Let us imagine that, for whatever reason, a passionate euthanasia advocate has gone around the process in some clever way and is pushing ahead, and a third party becomes aware of that. Could a third party intervene in the process at that stage to raise a concern and in fact stop the process from going forward?

Mr R.H. COOK: I am advised that if someone had a special interest in the context of the operations of the State Administrative Tribunal, they might be able to intervene, and the State Administrative Tribunal would determine whether they had a special interest in the context of that request to appeal to SAT.

Dr D.J. HONEY: I take it that a person will have to approach the State Administrative Tribunal. If that were the case, would the State Administrative Tribunal be able to consider anything outside the principles outlined in clause 4 of the bill and the administrative steps? We will come back to this point a number of times, but if there is coercion or undue influence, for example, would the SAT be limited to consider the principles—we were told that the court would look at this as part of the sequence of administrative steps—or would that be initiated on other grounds?

Mr R.H. COOK: My understanding of these things, which is not extensive, is that we are not in a position to tell the SAT what it can and cannot do. We can lend from its framework in the context of its normal jurisdiction, but ultimately it will test whether someone can appeal to the SAT and the grounds upon which they can appeal. For the sake of completeness, the Supreme Court also has parens patriae over the provisions of the bill so, ultimately, the SAT can have oversight of any aspect of the person’s interest.

Dr D.J. HONEY: Thank you, minister. That was very clear. As I outlined in my second reading contribution, going to the SAT is daunting and going to the Supreme Court is only for the well-heeled and well-informed. Would it be possible for a person to raise a concern with the board or, in fact, is the only available mechanism through the SAT or going to the Supreme Court?

Mr R.H. COOK: I am advised that there is capacity for a member of the public to draw a matter to the attention of the CEO, who has powers under the Health Act and this bill to undertake investigations. I accept the point the member is making about the Supreme Court. That is why there is the administrative tribunal system.

Mr P.A. KATSAMBANIS: I understand the genesis of why this clause has been included. Effectively, we are dealing with a process whereby the coordinating practitioner will self-assess whether the request and assessment process has been completed. If other actions took place after that stage was reached without that stage being completed, what will be the remedy and what penalty will the coordinating practitioner who breached this section be liable for?

Mr R.H. COOK: It would ultimately depend upon the nature of the shortfall, for want of a better description, in terms of their assessment and review of the process. In general terms, I refer the member to part 6 of the bill, which refers to offences under the act. Ultimately, it would depend upon the nature of the transgression in that context.

Mrs A.K. HAYDEN: This clauses states the request and assessment process will be complete if the coordinating practitioner for the patient has completed and certified the final review. Why was it decided that a medical practitioner would determine this process?

Mr R.H. COOK: They will have the central responsibility from the beginning of the process through to the end of the process. They are the clinician in this case—that is, the coordinating practitioner.
Mrs A.K. HAYDEN: Is there any reason the board will not get involved at this level?

Mr R.H. COOK: The board will be involved at every stage of the process. At each of the points that the person goes through to access voluntary assisted dying, it will be the responsibility of either the coordinating or consulting practitioner to lodge authorised forms with the Voluntary Assisted Dying Board throughout the process.

Mrs A.K. HAYDEN: Just to clarify, clause 8(b) states that the coordinating practitioner “has certified in the final review”. Will that certification of the final review get ticked off by the board?

Mr R.H. COOK: It certainly will be sent to the board straightaway, yes.

Mrs A.K. HAYDEN: It will be sent to the board. Will it be up to the board to review that finding, or is it just a tick and flick that gets filed away? Will the board go over the information sent, or is it just a self-review by the medical practitioner with no real oversight? Is there an obligation for the final review to be sent or for the board to review the decision and the process?

Mr R.H. COOK: It is the responsibility of the board to make sure that all those assessments have taken place. It is not the responsibility of the board to second-guess the accuracy of the assessments, but it needs to be satisfied that each of the assessment processes have been followed.

Mrs A.K. HAYDEN: Obviously, this line of questioning is about safeguards. If it is not up to the board to assess whether the review has been done and the final report has been ticked off by the coordinating practitioner—again, I am not condemning the majority of coordinating practitioners by any means, but we are here to legislate for the element of doubt—how do we know whether a practitioner is not maybe doing it to the board’s expectations of the intent of this legislation? How would that be picked up? What is the safeguard for that?

Mr R.H. COOK: The assessment process will take place between the coordinating and consulting practitioners; they will both have come to their decisions and undertaken the assessment process. They are required to lodge authorised forms throughout the process as the patient undertakes their journey. The board itself can authorise police, the chief executive officer of the Department of Health or other investigating authorities to make inquiries into that. There is oversight through checks and balances around the assessment process, and the VAD board will be responsible for overseeing the whole process.

Clause put and passed.

Clause 9: Registered health practitioner may refuse to participate in voluntary assisted dying —

Dr D.J. HONEY: I want to explore this clause generally, because I have concerns about it. The title of this clause is “Registered health practitioner may refuse to participate in voluntary assisted dying”. My concern is that a registered health practitioner does not have any option to refuse to participate, at least in part, in the voluntary assisted dying process. I am happy for the minister to correct me, and I have read the clauses, but it is my understanding that if a person says to a medical practitioner that they wish to participate in the voluntary assisted dying process, that medical practitioner is then formally required to respond and will be required to submit a report to the CEO within 48 hours. Let us assume that the medical practitioner, as many do, has a fundamental conscientious objection to voluntary euthanasia and wants nothing to do with the process whatsoever. They will still be required to submit a report to the CEO within 48 hours outlining the details of the patient and why they are refusing to participate. Furthermore, they will be required to give the person information provided by the CEO. We do not know what the information is at this stage, but we assume it is information that will direct the patient to another source to assess them for voluntary assisted dying. Does the registered practitioner have the right to completely refuse to participate in the process and say they do not wish to be involved at all, and that is the end of it, or is the registered practitioner forced to go through the process I outlined?

Mr R.H. COOK: I think the member is referring to clauses 19, 21 and 30. I am happy to discuss those issues when they come up. This simply sets out the voluntary nature of the voluntary assisted dying process. It is voluntary for the medical practitioner as well.

Dr D.J. HONEY: I am happy to explore this in more detail on debate on those clauses. I just want to be clear because the statement at the top of the clause is that a registered health practitioner may refuse to participate in voluntary assisted dying, which to me would imply not having to participate in that process at all, but when we go further on, it seems they have to at least go to the extent of providing information to a person, and if they do not, they potentially could be fined $10,000.

Mr R.H. COOK: I apologise for my earlier statement. I used the words “medical practitioner”. This clause applies to a health practitioner, so it casts the net much wider. This clause states in general terms that a health practitioner is not required to participate in the voluntary assisted dying process. There are obligations set out later about the specific requirements of a medical practitioner when confronted with the initial request, but this clause states in general terms, for the purposes of this bill, that health practitioners are not required to participate in the voluntary assisted dying process. I apologise for my earlier answer.

Extracted from finalised Hansard
Dr D.J. HONEY: This is the problem with having extended sitting sequentially: we get tired. If we want to do this properly —

Dr A.D. Buti interjected.

The ACTING SPEAKER (Ms S.E. Winton): Thank you!

Dr D.J. HONEY: Let me tell the member that I take this deadly seriously. Anyone who has been to hospital would know that there is a strict hierarchy of medical professionals and specialists who walk around in a godlike manner and general practitioners are loath to do anything that would upset a specialist. Equally, many of the other medical staff in the hospital, such as nursing staff, are very loath to do anything to deny the request of a more senior doctor.

In a hospital setting, all the staff will be employed by the hospital, so it is not an employer–employee relationship. However, a doctor who is more senior to, for example, a nurse, may say to a nurse, “I want you to come and help me with this.” Does the minister think there is a realistic chance that in some cases someone may feel compelled to be involved in the voluntary assisted dying process even when they have an objection to the process?

Mr R.H. COOK: I do, member. Obviously, I am the Minister for Health so I have to at least have faith in the capacities and the lines of command in the health system. Further to the member’s point and to provide the member with some comfort, I draw his attention to clause 10, which provides further protections for a health practitioner who does not wish to participate in the voluntary assisted dying processes.

Dr D.J. HONEY: I believe I understand clause 10, minister, but again people may not feel as though they can complain as they may feel that it could affect them professionally. I have some indirect experience of the hospital environment. A little bit like law firms, hospitals are anachronistic in the sense that they are strictly hierarchical, unlike most other workplaces I know of. The specialists are treated in a godlike fashion, as are the senior doctors in the hospital. The junior medical staff do not wish to disobey a request that they are given and they may feel compelled to be involved. I guess to that end, is there another reassurance in reinforcing that with staff? I imagine that this could potentially affect any health professional. The bill refers to a registered health practitioner and a medical practitioner. It can affect any of those and it can be in any hospital or hospice setting. Particularly in remote communities, there may be only two professionals—one a medical practitioner and the other a health practitioner. I wondered what other protection there is to make it clear to all those parties that this is purely consensual and there is a clear right not to participate.

Mr R.H. COOK: I do not think we can get more explicit than to have an explicit clause that is backed up by the following clause, which is also explicit! It is explicitly voluntary. To contravene the act in relation to this issue is explicitly considered an act of professional misconduct or unprofessional conduct for the purposes of the Health Practitioner Regulation National Law. I think the member should take some comfort from that. I also assure the member that the 18-month implementation period will require an awareness-raising exercise right across the health system about what everyone’s obligations may or may not be under this legislation. Obviously, we will make it very clear to everyone that voluntary assisted dying is just that—a voluntary process.

Dr D.J. HONEY: I guess we are taking it on face value that that will cover that. I appreciate the minister’s genuine intent. I am not questioning his sincerity in any sense whatsoever. I do not think I need a response, but the trouble is that I see clause 10 applying when there is an overt act. It is effectively bullying if someone says, “You do this or else.” That is very rare in the case. More often than not it is simply that the other person does not feel that they have the ability to object because they think it will subsequently affect their career or there is a strict hierarchy in hospitals, which, as I have said, is usual, in my vicarious experience. It does not exist in other workplaces but it seems to be a very strong characteristic in many hospitals. I will not labour the point anymore.

Mr P.A. KATSAMBANIS: I note that the term “registered health practitioner” is defined in clause 5 by reference to “a person registered under the Health Practitioner Regulation National Law (Western Australia)”. I seek some clarification. What types of health practitioners are covered under that specific national law? Does the list include doctors, nurses, pharmacists and pharmacy assistants? Who is included in the national law, so that we are all on the same page?

Mr R.H. COOK: I am advised that this definition of “registered health practitioner” means —

… a person registered under the Health Practitioner Regulation National Law (Western Australia) to practise a health profession (other than as a student);

Those covered by the national law include— I refer to the list taken from the Australian Health Practitioner Regulation Agency website—Aboriginal and/or Torres Strait Islander health practitioners; Chinese medicine practitioners, including acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers; chiropractors; dental practitioners, including dentists, dental hygienists, dental prosthetists, dental therapists and oral health therapists; medical practitioners; medical radiation practitioners, including diagnostic radiographers, radiation therapists and nuclear medicine technologists; nurses and midwives; occupational therapists; optometrists; opticians; osteopaths; paramedics; pharmacists and pharmaceutical chemists; physiotherapists; physical therapists; podiatrists; chiropodists; and psychologists. The list only goes up to “p”!

Extracted from finalised Hansard
Mr P.A. KATSAMBANIS: That is pretty comprehensive. Given that it includes medical practitioners, clause 9 effectively creates an absolute right to conscientious objection. Subclause (1) reads —

A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —

I am interested in paragraph (a) —

participate in the request and assessment process;

It is an absolute right. Clause 9(2) indicates that there is no intention that subsection (1) limits the circumstances in which that right can be exercised. In relation to medical practitioners, is that not a direct and inherent contradiction to the obligations that medical practitioners have, if they have a conscientious objection, to inform the board and provide a form to the patient in the form that is approved by the CEO, which, in actual effect, requires them to participate in the request and assessment process in some way as articulated in clause 19? Why is there this inherent contradiction and which of the two clauses would apply?

Mr P.A. KATSAMBANIS: As the list suggests, medical practitioners are health practitioners but not all health practitioners are medical practitioners. “Health practitioners” casts the net more widely. I explained this to the member for Cottesloe a short moment ago. This goes to the issue in general terms about the rights of a health practitioner not to participate in a voluntary assisted dying process. Later in the bill, it goes to the specific way in which a medical practitioner must respond in order to make sure that they can exercise this right. The member for Hillarys is a lawyer; I am not. My understanding is that it is widely accepted that the general gives way to the specific; therefore, in this context, a medical practitioner has a general right not to participate in the voluntary assisted dying process. Clause 19 prescribes the way that they exercise that right; however, as a medical practitioner, I guess there are parameters or frameworks to the way they do that.

Mr P.A. KATSAMBANIS: I am not sure that proposition is tested under this legislation. I think it is a general proposition. I am prepared to accept it and move on. Of course, it highlights that the conscientious objection rights under this legislation for registered health practitioners who are not medical practitioners are broader, better and stronger than the rights of a medical practitioner, because, for other registered practitioners, those rights are not limited by the limitations contained in subsequent clauses, including clause 19. I can ask the question here or I can ask it at clause 19: why has the decision been made to limit the conscientious objection rights for medical practitioners in a way that they are not limited for other registered health practitioners?

Mr R.H. COOK: Because, as the member is aware, medical practitioners have a specific role within this legislation, particularly when playing the role of a coordinating, consulting or administering practitioner. From that perspective, it is obviously important that we describe their rights and interests and, indeed, their obligations. By virtue of the seniority of their position in the medical field, medical practitioners have extra obligations that set them apart from other health practitioners, which is perhaps the hierarchy that the member for Cottesloe described. In that context, it is important that we clearly enunciate the way a medical practitioner would discharge their duties under this bill.

Mr P.A. KATSAMBANIS: I understand that is the minister’s position; let us just accept that there is a philosophical difference between the minister and me on this. I have to say, I do not think that someone’s conscientious objection right should be limited in the way that it is in this bill. I highlight that under this bill some health practitioners have greater rights than others in relation to conscientious objections. That is obviously a direct policy decision of the government and the minister who is responsible for the bill. As I pointed out in my second reading contribution, I think that is a significant failure of the bill. Obviously, it is a failure that is drawn from that direct policy choice, and I will leave it at that.

Mr S.K. L’ESTRANGE: Following up the questions by the member for Hillarys, I, too, was interested in this clause, particularly how it relates to clause 19(4)(b). This is where I seek clarification. Clause 9 states, in part —

(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —

(a) participate in the request and assessment process;

Clause 19(4)(b) states that the medical practitioner must —

give the patient the information approved by the CEO for the purposes of this section.

I know the minister has more or less addressed that with the member for Hillarys. The member for Hillarys and I think there is a problem in that the medical practitioner has to provide information approved by the CEO. My question is: what information approved by the CEO do they have to give?

Mr R.H. COOK: That is set out very clearly in clause 19 itself. It is detailed under subclause (4)(b).

Mr S.K. L’ESTRANGE: The minister says it is detailed under clause 19(4)(b). I am asking the question about clause 19(4)(b); that is my question. Clause 19(4)(b) states —

give the patient the information approved by the CEO for the purposes of this section.

I am asking what type of information approved by the CEO must the medical practitioner give the patient?

Extracted from finalised Hansard
Mr R.H. COOK: It would be standardised information regarding the voluntary assisted dying process, eligibility criteria, access points, supports, and that a patient’s request for assisted dying may be withdrawn at any time. It is important that they communicate with the Voluntary Assisted Dying Board to make sure that the patient’s rights have been observed.

Mr S.K. L’ESTRANGE: Based on that answer, does that not contradict clause 9(1)(a), which states they have the “right to refuse to do any of the following”. Doctors may say that they are a conscientious objector and will not give a patient any further information about voluntary assisted dying, but under clause 19(4)(b), they will be obliged to do so.

Mr R.H. COOK: This is the same answer I gave the members for Cottesloe and Hillarys: it is not a contradiction. In drafting, the general gives way to the specific. This clause specifies how a medical practitioner will discharge their rights under clause 9.

Mrs A.K. HAYDEN: I wish to follow on from the line of questioning raised by my colleagues. I believe that Victoria has the extra safeguard of health practitioners having the right to refuse to give out information about voluntary assisted dying. We have talked about this a couple of times. The government has followed a lot of the guidelines from the Victorian legislation. Can the minister explain why that right was removed and the government did not choose to have that additional safeguard?

Mr R.H. COOK: We are striking a balance between the rights of the patient and the obligations of the medical practitioner. This clause reflects the position that a medical practitioner is professionally obliged not to unduly delay a person’s access to voluntary assisted dying. They should make a decision and inform the patient as quickly as possible.

Mr Z.R.F. KIRKUP: As part of the request and assessment process, a medical practitioner might have a conscientious objection. I appreciate that we have explored that quite thoroughly.

The ACTING SPEAKER (Ms S.E. Winton): I think we have too. I am looking forward to a new question.

Mr Z.R.F. KIRKUP: I am underlining that. Thank you for your endorsement, Madam Acting Speaker.

What will happen if a medical practitioner does not believe a patient has the cognitive capacity to make the first request or assessment? I imagine the practitioner would form a conscientious objection to proceeding with the rest of the process. How would that occur? What is the mechanism by which they would inform the patient that the process would not continue? Will the board be informed of that?

Mr R.H. COOK: There are a number of ways a medical practitioner may not participate in the process. Conscientious objection is one that we are particularly focusing on. They may not be registered as a coordinating practitioner or done the training and all that goes with it. They just might not be eligible. Upon receiving a request from a patient to access voluntary existing dying, there are specific clauses. Clause 21 specifically states what that practitioner must do. That includes saying to the patient within a specific period of time, “Sorry, I’m not your dude” or “I’m not your dudette”. Then a very specific set of information is required to be handed on to the Voluntary Assisted Dying Board. That medical practitioner will then have discharged their obligations.

Mr Z.R.F. KIRKUP: In that case, the practitioner would not form a conscientious objection to refuse to participate based on their view of the patient’s inability to access it. If they believe the patient is ineligible to continue with the process, will they go through the requirements that are spelt out in the legislation?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: That is, inform them in two business days and the rest of it. Will they inform the board? I want to clarify whether the board will be informed.

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: I realise that this might be covered in the implementation, but I am getting to this because it is a refusal to participate in some way, shape or form. Is there a way for the board to track that refusal to stop the patient going a number of times to a number of different practitioners to try to find a practitioner who does not choose to refuse?

Mr R.H. COOK: There is no prohibition on doctor shopping or on seeking second or third opinions; that is an inherent part of our system. Obviously, the board would see that as an emerging pattern taking place and would then be able to inform the Department of Health, the hospital or whoever else is responsible for providing the service, be it palliative care or whatever, about what is going on. It would say, “We see this pattern; clearly something’s not working here. What do we need to do to respond to it?”

Dr M.D. NAHAN: This relates to the medical practitioner, but what about the institution within which the practitioner potentially works—the hospital? The practitioners are employees of the hospital and the hospital might be a Catholic hospital, for instance, and might want to be a conscientious objector to voluntary assistant dying. Is there a facility for the institution to be a conscientious objector, or does it go right down to the individual employee, the medical officer?

Extracted from finalised Hansard
Mr R.H. COOK: No; faith-based hospitals are able to object to participating in the voluntary assisted dying process for any reason, including, but not limited to, conscientious objection. The bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of individuals and organisations who do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility.

Dr M.D. NAHAN: If someone is in a hospital that has decided to be a conscientious objector, is there a requirement on employees of the hospital to inform the board, as there is for medical practitioners? In other words, if a doctor is a conscientious objector, the request is passed on and facilitated by the board. Is there something else in place if it relates to an institution?

Mr R.H. COOK: The medical practitioner might be working at—let us call a spade a spade—St John of God, and a patient says to them, “I wish to access voluntary assisted dying and I make my first request.” The onus is on that medical practitioner to then inform the Voluntary Assisted Dying Board. There is no obligation on the organisation.

Dr D.J. HONEY: Just to follow up on that line of questioning, although the minister says that the institution is not required to participate, if a person comes to that hospital to make that request, would that medical practitioner not still be required to hand the information to the person? In fact, that is making provision for the distribution of information to access voluntary assisted dying within an institution that is fundamentally opposed to voluntary assisted dying.

Mr R.H. COOK: Yes, that would be duty of care to the patient.

Dr D.J. HONEY: Where would that information be kept? Would the hospital have to keep that information in the hospital to make it available for practitioners to distribute? Would the medical practitioner have to have the information? The minister can see where I am going with this. It is a fundamental concern. I know there are people who think that this is something that should be everyday, but there are individuals, institutions and medical and health practitioners who are utterly opposed to it and want nothing to do with it whatsoever. But it seems as though even an institution that is fundamentally opposed to voluntary assisted dying is still going to have to carry information that promotes it.

Mr R.H. COOK: The member would see that ordinarily there would not be stands around the corridors of a St John of God hospital displaying standardised information. One could imagine that the standardised information would be a printout from a website and that the medical practitioner would say, “No, not only can I not help you but you’re in the wrong place. Why did you come to St John of God if you wanted to access voluntary assisted dying?” In that instance they would say, “No, I can’t help you. Under the act, I’m required to provide you with some information.” Print: “Here’s the information and I will inform the board of your request. Have a great day.”

Dr M.D. NAHAN: What about Midland hospital that is operated as a public hospital by St John of God?

Mr R.H. COOK: Yes, that issue! As the member knows, there are a range of things that St John of God Midland Public Hospital does not provide, and this is another one. We cannot compel St John of God to do something that it, in good faith, cannot carry out.

Dr M.D. NAHAN: We are picking on a certain institution in St John of God, but I think it might apply to aged-care homes and others where these types of activities would take place. Some of them are religious based, and I assume have the same concerns.

Mr R.H. COOK: I am not using St John of God to be judgemental; it is just by way of example. I know of other organisations involved in palliative care that are not mad keen on this stuff either.

Mr Z.R.F. KIRKUP: As part of the ability for a registered health practitioner to choose not to participate or to be a conscientious objector in any step of the process at clause 9(1)(a), (b) or (c), is it envisaged that as part of the first request stage a practitioner might have to inform the patient up-front, “I’m happy to proceed with the first request and the first assessment, I’m happy to agree to be your coordinating practitioner, but I won’t be your administrating practitioner”? Is there an obligation on them to inform them at that stage or will they have to get to the end of the stage where they come to the administration decision before the patient is informed by the practitioner about how they wish to proceed, if the patient opted for an administration practitioner to provide the substance?

Mr R.H. COOK: There is a bit of a misunderstanding about what the member is asking, so I will get him to clarify that in just a second. The member used the language, in the first instance, of “health practitioner”. A health practitioner would not be required to do so; a health practitioner who is also a medical practitioner has obligations under this bill. A health practitioner obviously does not need to worry about this aspect of it. Could the member ask again what he is looking for so that we can be completely clear?

Mr Z.R.F. KIRKUP: I appreciate that; thank you, minister. I am trying to assess whether a health practitioner has the right to refuse to do any of the following. Firstly, clause 9(1)(c) states—

be present at the time of the administration of a voluntary assisted dying substance.

If they choose to be a conscientious objector to that part of the process, are they obliged to inform the patient at the earliest possible opportunity? Is there any requirement on the practitioner to inform the patient or do they get
through the entire process and then say at that point, “I’m not going to participate here”? Is there a requirement on them to state, if they have already formed the view, for example, that they will not be there when the administration decision is made?

Mr R.H. COOK: It would be at the first request stage.

Clause put and passed.

New clause 9A —

Dr A.D. BUTI: I move —

Page 10, after line 5 — To insert —

9A. Registered health practitioner not to initiate discussion about voluntary assisted dying

(1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person —

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

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

(2) Nothing in subsection (1) prevents a registered health practitioner from providing information about voluntary assisted dying to a person at the person’s request.

My proposed amendment follows, in the main, section 8 of the Victorian legislation. The amendment that I am seeking to insert in this bill does not have subsection (3) of the Victorian legislation, which states —

A contravention of subsection (1) is to be regarded as unprofessional conduct within the meaning and for the purposes of the Health Practitioner Regulation National Law.

The reason it is not included is that clause 10 of the Western Australian bill already includes that offence. No new offence would be generated by the insertion of this new clause, but any contravention of the new clause would be covered under clause 10 of the bill, which relates to the contravention of the legislation by a registered health practitioner.

The proposed new clause refers to a person and states —

A registered health practitioner who provides health services or professional care services to a person …

The term “person” is deliberately used rather than “patient”, because a patient for the purposes of our bill means someone who has made a request for access to voluntary assisted dying. The new clause refers to the situation prior to requesting information about voluntary assisted dying, so that is why “person” is used rather than “patient”.

The new clause refers to a registered health practitioner who provides health services or professional care services. In a previous answer to a question from the member for Hillarys, the minister went through what a health practitioner is and read out a long list of people, such as dentists, nurses, optometrists, pharmacists, chiropractors and physiotherapists. In his response to the second reading debate, he said that he did not agree with the new clause I flagged as he did not want to interfere in the doctor–patient relationship. The fact is that it may not be a doctor. A lot of people with disability have longstanding relationships with physiotherapists, chiropractors, occupational therapists et cetera. By not accepting this new clause, the minister is saying that a chiropractor or physiotherapist who may have a long-term relationship with a patient could initiate discussion on voluntary assisted dying with that patient. It is not necessarily a medical practitioner–patient relationship; it could be a wider relationship with another health professional.

The minister mentioned that he does not want to interfere with the medical practitioner–patient relationship. Why should that necessarily be sacrosanct when we are trying to prevent the possible abuse of the vulnerable? As the Premier has rightly said, the government is looking at introducing legislation to break the confessional seal between a priest and a confessor—I do not know what the person would be called—and I agree with that. Sometimes we need to look at reasons why we may need to break the autonomy or independence of that relationship. In any case, the new clause goes to not just medical doctors but also health professionals. As the minister said, there is a long list of people. If we do not include this new clause, which is in the Victorian legislation, we will be saying that there will be no protection from a situation in which any health professional forms a close relationship with a patient who may easily be swayed by what they say.

Dr D.J. HONEY: I would like to hear more from the member.

Dr A.D. BUTI: The Joint Select Committee on End of Life Choices, chaired by the member for Morley, looked at this issue in its report “My Life, My Choice”. At paragraphs 6.78 and 6.79 on pages 199 and 200 of its report, the committee said that it looked at it but did not agree that the section in the Victorian legislation should be included. Paragraph 6.79 states —

To that end, the prohibition contained in the Victorian legislation should not be a feature of Western Australia’s legislation. Assisted dying should be considered as one of many clinical options available to patients for responding to terminal illness.

Extracted from finalised Hansard
I do not disagree that it should be considered as one of the clinical options—I am in favour of the bill—but it is not a normal clinical option. It is quite a significant clinical option. If someone gets it wrong, there is no reversal. It is not like recommending paracetamol. It is quite an important clinical option that may need to be treated differently. Surely for most clinical options, we do not have 102 safeguards. The reason we have 102 safeguards is that the government, and, I presume, this Parliament, recognises that this is an incredibly important issue and we need to get it right.

The Ministerial Expert Panel on Voluntary Assisted Dying also considered this issue. It states at page 29 of its final report —

Victoria is the only jurisdiction that prohibits health practitioners from starting a conversation about voluntary assisted dying.

Many health practitioners are reluctant to discuss end-of-life care with people. It is also known that up to 60% of Australians have low levels of individual health literacy.

That may be so. However, members continue to quote in this Parliament, and I may have mentioned it in my second reading debate speech, that 88 per cent of Western Australians support voluntary assisted dying. If we say that most Western Australians support VAD, that means they must know about it. It has been said that people will not know about VAD after we pass this bill—I think we will pass it—and it will allow the doctor to initiate the discussion. I do not agree with this. It has been put to me that of course educated people will know about it, but people who are not well educated will not know about it. I do not know that that is true. I do not want to stereotype Armadale, but I can assure members that a lot of people in Armadale know about this legislation. It is stereotyping to say that people in Western Australia who are not well educated will not know about VAD.

People from all over Australia are listening to this debate. This morning, I received an email from Professor Lindy Willmott, professor of law at Queensland University of Technology, who I quoted during the second reading debate. I make full disclosure: she does not agree with the amendment that I have moved. She included in her email two papers, one written by Professor Willmott and various colleagues, and another paper, “Discussing Voluntary Assisted Dying”, by Carolyn Johnston and James Cameron. The “Discussing Voluntary Assisted Dying” paper refers to other jurisdictions, in particular Oregon, and to the likely implications of the prohibition that I am seeking to have included in the bill. Victoria is the only jurisdiction that has the prohibition. Oregon does not have it.

Dr D.J. HONEY: I would like to hear more from the member.

Dr A.D. BUTI: This paper states, in part —

The limitation in Victoria on health practitioners initiating discussions is likely to further limit access for those with limited literacy.

It also states —

Data showing a lower use of assisted dying among low socioeconomic status groups might reflect unequal access rather than a less of a preference among these groups.

As I have said, Oregon does not have this prohibition. Therefore, we cannot say that this prohibition will prevent people from low socioeconomic groups from accessing voluntary assisted dying. There may be other reasons that those people do not access voluntary assisted dying. The government may need to look at providing a better education program, and I will get to that.

It was put to me when I flagged this proposed amendment that the government has looked at the Victorian legislation, and that is why the government will not agree with this prohibition.

That could not have been done on the basis of the Victorian legislation because it has just become operative. Both the report of the Joint Select Committee on End of Life Choices and the final report of the Ministerial Expert Panel on Voluntary Assisted Dying were tabled prior to the Victorian legislation coming into operation. It was not on the basis of any empirical evidence that it was determined that section 8 of the Victorian legislation had been causing a problem. I have also been told that section 8 of the Victorian legislation was introduced because of a compromise. That is not true either. I refer members to the Victorian “Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report”. At page 87 is the heading “Initiating a request for voluntary assisted dying”. Then on page 89 it states —

During the consultations a range of stakeholders raised concerns that people may seek access to voluntary assisted dying because they feel like a burden. The most common reason for accessing voluntary assisted dying in Oregon is loss of autonomy, with 91.4% of people reporting this as a reason.

It talks about that and then it states —

The Panel is of the view that the additional safeguards —

That is, the additional safeguard of the prohibition, which is what I seek to introduce —

it has recommended will ensure decisions in relation to voluntary assisted dying are voluntary.
That is key. That is why I am a big supporter of this bill: it is voluntary and we should ensure that it is voluntary. It continues—

These safeguards and the assessment process also provide a further opportunity to identify potential abuse; even if a person does not meet the eligibility criteria for voluntary assisted dying, the assessment process will still provide an opportunity to alert health practitioners and services to the situation so they can address any abuse. The Panel notes that while legitimate concerns about elder abuse and coercion must be taken into account in assessing requests for access to voluntary assisted dying, most people who are dying have loving and supportive families and it is important that these relationships are maintained throughout the request and assessment process.

The report then refers to elder abuse and abuse of people with disabilities. Before I go into that, I will read what it says at page 91. It states—

In 2016, a Victorian Parliamentary Committee Inquiry into abuse in disability services identified widespread abuse and neglect of people with a disability in disability services in Victoria. Concerns about a lack of respect for people with a disability or different treatment of people with a disability were also raised during consultations. The Panel recognised the importance of addressing these concerns when considering its recommendations.

The Panel supports the Government’s ‘zero tolerance of abuse of people with a disability’ and notes the measures taken by the Government in response to the Inquiry, including strengthening oversight of disability services. This includes the creation of a new code of conduct for disability workers and greater support and training to identify and respond to abuse of people with a disability. Recent steps to clarify the roles of Victoria Police and the Disability Services Commissioner will also assist in responding to instances of abuse effectively.

Dr D.J. HONEY: I would very much like to hear more from the member.

Dr A.D. BUTI: The report continues—

The framework recommended by the Panel does not allow people to make judgments about the lives of others. The framework allows people who are already at the end of their life to make a choice about how they will die. This decision must always be made by the person themselves. The Panel is confident that the process recommended will identify any coercion or undue influence, and ensure that this is dealt with appropriately.

**Ministerial Advisory Panel Recommendation 7**

That a request for access to voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others, including family and carers.

Then I come to recommendation 8 of the Victorian ministerial advisory panel, which is the one that I am seeking to follow. It states—

That a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

Policy intent

To ensure a person is not coerced or unduly influenced into accessing voluntary assisted dying and to demonstrate the request for voluntary assisted dying is the person’s own voluntary decision.

I have just referred to the issue of the abuse of people with disabilities. I must say that in the minister’s response to the second reading—I will stand corrected because I have not read that speech—I did not hear him once mention disability. He may have, but I did not hear disability mentioned by the minister once. When one is looking at the history of euthanasia, the concerns of the disabled are very important. We are, of course, not seeking to engage in eugenics et cetera, but once upon a time we did. The minister can understand how people with disabilities may be fearful of that. My drive for this prohibition is not just for people with disabilities; it could also be for older people or anyone, in fact, because it is understood under law that there is a presumed undue-influence relationship between a doctor and a patient. That is one of the presumed relationships of undue influence. We do not have to prove actual undue influence; we start off from a presumption of undue influence.

The responses that I have received since I wrote my op-ed are interesting. Some people approached me and asked why I want to do this, because I will be affecting people’s ability to access VAD or I will prevent a doctor from giving all the clinical options. That may be so, but what about the protection of the vulnerable? Surely that is also very important. One reason I am a member of the Labor Party is that I want to protect people who are vulnerable. We always seem in this place to forget the people who have disabilities. We very rarely talk about people with disabilities in this chamber. It is interesting that when I became a member of Parliament in 2010, we very rarely
talked about domestic violence. I will take some responsibility for this, because I think as a result of me pushing that in 2010, we now have a fantastic Minister for Prevention of Family and Domestic Violence. I hope that we might improve the profile of people with disability. It is interesting that in a debate on VAD, with the history of people with disabilities, it has not been mentioned in this debate, or if it has, very rarely. It is also interesting that I mentioned my daughter, and some people have made an assessment that my daughter would not have the mental capacity to make this decision. I do not know how people made that assessment, because they do not know my daughter. I can tell the minister that a person with an intellectual disability can still have the capacity to make a decision. If we look at the decision-making capacity under clause 6, I can tell members one thing: my daughter can understand information. She can process information and she can make a decision, but what I am fearful of is that she wants to please. After I made my contribution to the second reading debate, a constituent contacted me.

Dr D.J. HONEY: I would like to hear more from the member for Armadale.

Dr A.D. BUTI: She wrote me an email. This is, in part, what she said —

When I think of my own daughter, I get emotional. When I read Hansard the other day, I think you feel similarly about Alkira …

Who is my daughter. She then mentioned her daughter’s name, which I will not mention. She continues —

… has a communication disorder (among other things) and trusts people implicitly. Consequently, she is very easily led and that makes her vulnerable in all sorts of ways. Right now, my husband and I are here to care for her, but that won’t always be the case. If this law is enacted, then I have to trust future, unknown politicians to make laws that are safe for my daughter.

I cannot emphasise enough that this is a major concern for people with disabilities. Malcolm McCusker contacted me after my op-ed and we had a very civil discussion, as you would with Malcolm. He mentioned that there was a person on the expert panel who represents people for disabilities. That might be the case; that was one person. I am not sure, but Samantha may have a disability. Does she have a physical disability?

Mrs L.M. Harvey: Not an intellectual disability, a physical disability.

Dr A.D. BUTI: Okay, a physical disability. I looked back at the people who were consulted. I think four or five organisations that deal with people with disabilities were contacted, but I wondered what sort of consultation that was. I wonder whether there was consultation with people who live with disabilities, like my daughter. This is not only about my daughter; this is also about that constituent who emailed me. This is about my daughter’s best friend, who would be very competent, but has an intellectual disability. People with Down syndrome can have normal intelligence. I am on the board of the Armadale special education centre, and I reckon 50 to 60 per cent of those kids would have mental competence under this legislation to make a decision. As I said in my contribution to the second reading debate, I do not want to deny people with disabilities the right to be involved in VAD, but I want to ensure that they have not been coerced at all. I am very fearful about that. I use my daughter as an example. She wants to please, and I know, because I have manipulated her a lot of times as a parent! If I ask her something or say X, she will want to do it. It has been said that the reason this amendment will not be accepted is that it will prohibit the doctor from giving a pamphlet and that does not mean they are engaged in the process, but if there is a pamphlet at the doctor’s surgery, the doctor has initiated the discussion about VAD. That could be done. People could go to the doctor’s surgery and they would know about it. I find it hard to believe, with all the attention we have had for a long time on VAD, that most Western Australians would not know about it. We have a role as the government to educate them—not to tell them they should do it, but to educate them that it is legal. I am very, very disappointed that the objection to my raising of this issue is that —

Dr D.J. HONEY: I would like to hear more from the member for Armadale.

Dr A.D. BUTI: — it is going to affect the ability of a doctor to give the full range of clinical options. It will not once the patient raises the issue. Is that more important than protecting people who are vulnerable to abuse or engaging in something that they would not have engaged in? Under this legislation, somebody could go to a doctor with a terminal illness—I gather with six months to live on the balance of probabilities—and not even be thinking about VAD. If they are easily led by a medical practitioner, within two weeks they could be dead. I think that is something we should try to prevent. We are reviewing this legislation in, I think, three years. If we find that it is causing such a limitation on the doctor’s ability to provide information to a patient, we can review it, but just to blankly disregard this new clause is a failure. I am very supportive of this bill, but I will be even more supportive if we include this new clause.

Extracted from finalised Hansard
Mrs L.M. HARVEY: I rise to support this new clause. I had a similar amendment drafted, but the member for Armadale pipped me at the post in putting it on the notice paper. I concur with everything he has so eloquently put about protections for vulnerable people. He talked about people with disabilities, who are one category of vulnerable people. The other category of vulnerable people I am particularly concerned about is our seniors and the elderly. I know from dealing with elderly people in my constituency and also elderly grandparents who are sadly no longer with us that they absolutely revere the medical profession and will do whatever medical practitioners tell them. I can recall one story of an elderly lady who was nearing 90 years of age. Her GP put pressure on her for two years to have a knee replacement because once she got over 90 years of age, she would not be able to have it for free. She followed the doctor’s advice, against family advice at the time, went in and had the knee replacement. She ended up with a massive infection and was in hospital for six months. The titanium knee had to come out, so she had no knee for another year. She had to go back in and have further surgery once she got on top of the infection, and, sadly, it shortened her life. These are the sorts of decisions that people can be talked into. She thought that she was getting a bargain because her GP wanted her to have that free medical treatment and said to her that she would not be able to get it later because of her age. That is the vulnerability of some elderly people in the community; a power imbalance exists in the relationship between vulnerable people and their GP.

I believe that most doctors are great, but doctors are representative of our community and we find doctors who do the wrong thing. We will find doctors who will approach voluntary assisted dying with an air of zealotry. There might be only one, but if we have one, it is one too many. I will use some examples of when doctors do the wrong thing so that members can understand where I am coming from. I am not saying that the broad suite of GPs and medical professionals in Western Australia are like the examples I will mention. However, I will mention these examples because I think it is important that we consider that some individuals in the medical profession do not act in the best interests of their patients.

I have one case here of a French doctor charged with killing nine patients by poisoning them during surgery. The article reads —

An anaesthetist in the French city of Besancon is suspected of poisoning patients during surgery to trigger heart failures and then heroically bring them back from the brink of death.

Investigating magistrates have found evidence linking Frederic Pechier to 24 out of 66 suspicious incidents that happened during surgical proceedings at the clinic where he practiced, according to Besancon prosecutor Etienne Manteaux.

Several members interjected.

Ms S.F. McGurk: What’s this got to do with anything?

Mrs L.M. HARVEY: I am trying to illustrate that some doctors lose their way and become obsessed with issues. I have another story here from the universities. The article is titled “US doctor charged with murdering 25 patients using fentanyl overdoses” and states —

A US doctor has been charged with the murders of 25 hospital patients who Ohio authorities said were killed with deliberate overdoses of painkillers, many of them administered by other medical workers on his orders.

Several members interjected.

Mrs L.M. HARVEY: Just wait. Everybody has an opportunity to put their opinion in this place. It continues —

… Dr William Husel was accused of ordering excessive doses of the powerful painkiller fentanyl.

Mrs A.K. HAYDEN: I would like to hear more from the member.

Mrs L.M. HARVEY: This is where it is pertinent and this is why I raise it. It continues —

Many of the patients who died were on ventilators and receiving palliative care. The deaths occurred between 2015 and 2018.

These two doctors completely lost their way. Two individuals—49 lives. I put to members in this place that without a protection to prevent doctors from initiating a conversation with a patient about going down the pathway of voluntary assisted dying, there is a real risk that one of these doctors may be a psychopath—I do not know; I am not a clinical psych to make the diagnosis. We might get that one doctor who is a psychopath, and if they decide that they want to initiate conversations with terminally ill people in palliative care to encourage them down the voluntary assisted dying pathway, they will be able to do it without that protection.

Mr F.M. Logan: They have done it without it.

The SPEAKER: Members, this is a very important debate. You might have an opinion but the member is on her feet and her opinion counts at the moment.
Mrs L.M. Harvey: I agree with the member for Armadale that this is a very important protection for vulnerable people, people who can be easily influenced. They may not necessarily always be influenced but when they are talking to their doctor, what their doctor says is right. We all know who those people are. Members will have people in their lives, like I do, who have a suite of medical options available to them but unless they go to the doctor and get a prescription for some pills, they do not think that they are going to get better. They rely on the doctor’s information and if that doctor says, “You are looking at a couple of pathways here. You’re looking at a world of hurt. Your health is deteriorating and your cognitive function might deteriorate. You had better access voluntary assisted dying now”, people may take that course without necessarily having contemplated it. If their doctor suggests it, they might do it. I do not in any way, shape or form say that every doctor is going to do this. I do not believe that to be the case. There are other checks and balances with the reporting requirement et cetera to catch doctors who behave in that way. However, there is an element of risk. We are debating legislation in this place, which, in the minister’s own words, will cater for a very small number of people who will want to access it—a very small number of people who will fit the criteria and whose circumstances are so dreadful that they will want to access voluntary assisted dying—and that is the choice that this legislation will provide them. But in introducing this legislation, we do not want to open it up to a very small or potentially large number of people who may be guided into voluntary assisted dying without necessarily initiating it themselves because that will then not be their choice. That choice will be influenced by somebody else whom they trust, somebody whom they hold on a pedestal and think is smarter than them, knows more than them, has more experience than them and understands what is best for them. For those individuals, we cannot take the risk. This amendment has a precedent because it is in the Victorian legislation. I do not believe that it will fundamentally affect access to voluntary assisted dying for the people who want to access it for the various reasons that they do. I think it will be a small number of people. But even if one vulnerable person is talked into voluntary assisted dying after a doctor initiates that conversation, we in this place will have failed. If members think about the conversations about the death penalty, they are all predicated on the one innocent person who was put to death and subsequently found to be not guilty. We need to view this legislation and this amendment through the prism of the one individual, the one vulnerable person who may be influenced by a doctor, even if that doctor thinks that they are doing the best thing for their patient.

Mrs A.K. Hayden: I would like to hear more from the member.

Mrs L.M. Harvey: They may influence vulnerable people into a choice not of their initiative—a choice that they would not contemplate until the person they trust tells them that it is their best option. We cannot allow that to happen. It is one amendment. I one hundred per cent support it. I thank the member for Armadale for putting it on the notice paper.

Dr A.D. Buti: After speaking to my friend the member for Kimberley, I forgot to add one part to my presentation, which I do not want to miss—that is, the issue of Aboriginal people. The Ministerial Expert Panel on Voluntary Assisted Dying heard mixed views about doctors initiating the conversation. Page 30 of its report states —

Discussions that took place in the Kimberley raised issues in relation to self-harm and suicide and noted that even discussing palliative care with patients can be challenging in this context. There may be complexities surrounding concepts such as blame or ‘pay back’ in Aboriginal communities and potential implications if the family has a negative perception of the practitioner or health service because of involvement in voluntary assisted dying.

I refer to a quote from Kimberley Palliative Care Service at the consultation stakeholder meeting, which states —

High turnover of staff and GPs is a huge issue. For people to establish a relationship with their GP to even have a discussion about voluntary assisted dying is hard.

The report continues —

The complexity of medical terminology and the balance of power between health practitioner and patient was also identified as potentially challenging and would require thorough consideration during any implementation planning (including being part of practitioner education and training).

There is then an excerpt from a submission of the Aboriginal Health Council of Western Australia —

‘Clinicians often use complex medical terminology when discussing treatment options with Aboriginal people ... This results in the real risk that Aboriginal people may consent to something they don’t fully understand. There is also the issue of the disparity of power between a doctor and Aboriginal people; Aboriginal people will often agree with a doctor’s advice even if they are not happy with it as they can feel overpowered in the doctor–patient relationship’.

Mr Speaker, when I was working at the Aboriginal Legal Service, it was during the time that Marshall Perron introduced the Northern Territory legislation. I remember reading that and speaking to Aboriginal clients. They were so fearful of voluntary assisted dying, or euthanasia, whatever one wants to call it, because they thought that the state was coming after them. They said, “We always have to do what people tell us to do”, and they were very fearful. The state is not coming after Indigenous people, but one can understand that in some remote communities,
the relationship between the only doctor in the community and Aboriginal people is a very strong relationship, and there is a power imbalance. I think Aboriginal people should be able to access VAD if they want to, but we should guard against the possibility that they would not have done so but for the initiation by the medical practitioner.

I believe that there is no evidence at this stage that this section in the Victorian legislation is causing any prohibition. I went to Melbourne about two months ago and spoke to people in the Minister for Health’s office and other people. There was no concern from what I gathered, and I was surprised it was not in our bill. Even in the articles that Professor Willmott sent me there is no evidence. It is saying that it may inhibit. Yes, it may, but I am more concerned with protecting the vulnerable. I do not believe that the VAD legislation that we are debating in this Parliament, which is a very good piece of legislation, will be detrimentally affected by the inclusion of this clause. If anything, it will protect it. Surely, in the Labor Party, our number one commitment is to protect those who are vulnerable; that is much more important than maybe one or two doctors who may have a hard time in dispensing some information to a patient. I do not understand why there is this hesitancy to introduce this. There is no evidence anywhere that it has affected the ability of the VAD legislation to operate.

Mr R.H. COOK: I would like to acknowledge the member for Armadale on this amendment. We heard from him in the second reading debate. This is clearly a matter and a subject about which he is greatly passionate, and I think it is important that we as a chamber acknowledge that. However, I do not support the amendment that the member has proposed. There is no prohibition in the Western Australian bill. This is different from the Victorian act, which expressly prohibits registered practitioners from initiating a discussion with the patient about voluntary assisted dying. Victoria’s prohibition was not supported by the Joint Select Committee on End of Life Choices or by the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying. The reason for this is there should not be an attempt to censor the conversation health practitioners have with their patients. They should be able to raise and discuss voluntary assisted dying in the same way as other serious health medical decisions and care options, so that the patient is making fully informed decisions, particularly at the end of life. I think the scenario the member for Armadale described of the special relationship between a health practitioner and patient in this particular instance would amount to coercion, in the way he characterised and described it, which, of course, is expressly prohibited under the bill.

Victoria is the only jurisdiction in the world that prohibits health practitioners from starting a conversation about voluntary assisted dying. I am drawn to comments made by Dr Linda Sheahan, who is an Australian palliative care physician and a Churchill Fellow, in her report dated 30 May 2013. She stated —

… it is highly reassuring to review the data and find no evidence of increased risk to vulnerable groups …

Further, a submission that People with Disabilities WA and the Australian Federation of Disability Organisations made to the Joint Select Committee on End of Life Choices in 2018 stated —

There is no evidence to suggest, from either Oregon or the Netherlands data, that people with disabilities are at heightened risk of assisted dying. Vulnerable groups generally including women, ethnic minorities, people from lower socio-economic circumstances, children, people with a psychiatric disability or dementia were not found to be at any heightened risk of assisted dying. People with psychiatric disability … constituted 20% of referrals to the Netherlands assisted dying process, but none progressed.

In Western Australia, a registered health practitioner may commence a discussion related to voluntary assisted dying with a person to whom they are providing health services or professional care services. This may include the provision of written information by the practitioner to the person. That the patient’s decision is well informed is fundamental to the proposed model of voluntary assisted dying in Western Australia. Indeed, I believe there is an obligation on medical practitioners, in dispensing their professional obligations, to inform patients of all their treatment options. In order to allay concerns about a health practitioner coercing or inadvertently encouraging a patient to seek access to voluntary assisted dying, at least two medical practitioners, the coordinating and consulting practitioners, must independently assess the patient. If an assessing medical practitioner is unable to determine whether the person’s condition meets the eligibility criteria, whether they have decision-making capacity or whether their decision is voluntary and without coercion, they must refer them for further assessment. Furthermore, if the patient wishes to proceed, they are required to make a written declaration of their request to access voluntary assisted dying. That must be witnessed by two adults. The witnesses must not be members of the person’s family or stand to benefit financially or otherwise from the person’s death, nor can the coordinating or consulting practitioner be a witness. If the person has completed a written declaration and makes a further final request, the coordinating practitioner must undertake a final review.

Mr J.E. McGrath: I would like to hear more from the minister, Mr Speaker.

Mr R.H. Cook: In the final review, the coordinating practitioner must confirm that the process has been undertaken in accordance with the requirements of the act and that the patient has decision-making capacity to request voluntary assisted dying, that they are acting voluntarily and without coercion and that their request is enduring.

I believe the process by which someone will access voluntary assisted dying has ample safeguards. Evidence from overseas and other jurisdictions suggests that vulnerable patients are no more at risk under voluntary assisted dying.
legislation than any other medical process. It is important that we get the proper balance between the rights of the patient and the need to protect and provide safeguards. That is what we have done. We are not saying that the issue of voluntary assisted dying should not be raised with a patient. It is the patient’s right to be fully informed of all the treatment options that are available to them.

Mrs L.M. Harvey: It is not a treatment! Death is a treatment option?

The SPEAKER: Excuse me, members, I will hear this in silence.

Mr R.H. COOK: Options at the end of life.

The cases that the member for Scarborough outlined in her speech were, quite frankly, extreme and inflammatory. Several members interjected.

The SPEAKER: Members!

Mr R.H. COOK: She essentially described overtly criminal activity, which is not the way to enter this debate and characterise the relationship between medical practitioners and their patients. It is important that we understand, in respect of what the member for Scarborough described, that nothing in this bill will protect patients from someone who has decided to become a serial murderer—nothing—so to try to provide protection by way of explanation or defence of the member for Armadale’s amendment is absurd.

I respect the member for Armadale; I think he comes to this debate with a very considered position—one that, as we all witnessed, was born of his own personal circumstances—and he has our utmost respect. I think this place is the better for him having raised those issues, and we really appreciate it. He is right; we had a member from the disability sector on the Ministerial Expert Panel on Voluntary Assisted Dying, Samantha Jenkinson, who considered the issues along with the other members of the ministerial expert panel. The panel stated, in its final report —

The Panel carefully weighed the outcomes of the consultation and knowledge of other jurisdictions, with the unique cultural circumstances of Western Australia in its deliberations on this matter.

The Panel believes that health practitioners have a professional obligation to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying.

The Panel acknowledges the position of the Joint Select Committee and agrees that health practitioners should not be restricted in their ability to have comprehensive end of life discussions with patients, including that there be no prohibition on health practitioners appropriately raising the subject of voluntary assisted dying.

I greatly respect the member for Armadale and the issues that he brings to this place on not only this occasion but also other occasions. But on this particular point, I respectfully disagree with him that we should restrict health practitioners from raising this as one of the many issues that will confront someone at the end of life. There is no evidence from overseas to suggest that their having the capacity to do so will create an extra level of vulnerability for patients.

Mr S.K. L’ESTRANGE: I think this is an eminently sensible amendment to make because it is there to give the medical profession and our society the capacity to protect the weak, the sick, the ageing and the demoralised when they front a professional about their illness. When they are sitting in that room, discussing their illness and discussing a way forward, there cannot be a presumption that they want to die early. It must be up to the patient to decide whether they want to have a conversation around that topic. If they are, in good faith, in front of a medical professional seeking the advice of that professional to help them deal with an illness, to have them actually being told that an early death brought on by a substance is an option for them would go against all the principles that I understand the Hippocratic oath to encompass. I would be amazed if the medical fraternity at large would agree with what the minister has just said. The minister has spoken about his expert panel. Let us be frank: the panel was put together to help the minister write the bill. The medical fraternity at large has opposing views to the bill; the Australian Medical Association has said that.

Several members interjected.

The SPEAKER: Members, please. Just let him speak.

Mr S.K. L’ESTRANGE: This is not political banter; this is a serious matter that the member for Armadale has raised in the context of personal lived experience. The minister may not like what he is hearing from me, but he should show some respect to one of his own who has moved this amendment.

We have a duty to protect the weak, the sick, the ageing and the demoralised who are standing in front of a medical professional to seek advice. We have a duty in this bill to protect them. We have a duty to control whether coercion occurred. Coercion can be very overt or it can be very subtle. Outside of a doctor’s room with him or her and their patient there is absolutely no way of knowing whether coercion has taken place. There is no way of knowing that
unless the patient comes out and says it. If they say nothing, there is no way of knowing that. To suggest that coercion can or cannot be controlled is irrelevant, because it can occur. We know that. That is a risk. I find it most unusual, to be polite, to actually consider euthanasia as a treatment in the context of health care: “Doctor, I’ve got an illness. What can you do to support me with my illness?” “Here’s a treatment. You can have voluntary euthanasia, which is essentially voluntary suicide assisted by a physician. There’s a treatment.” How is that possibly medical treatment? It is not. When the minister said that he thinks it is a medical treatment, he cannot have his cake and eat it too. He has said in this context that it is a medical treatment, but earlier when we asked why do we not put “palliative care” into the definitions part of the bill, the minister said, “No, because that is separate from this.” He is trying to shape his argument around a very sensible amendment. The minister’s argument will not stack up. To coin that classic old phrase, it simply would not pass the pub test.

Dr D.J. Honey: Mr Speaker.

The SPEAKER: Had you finished, member for Churchlands?

Mr S.K. L’Estrange: No.

Dr D.J. HONEY: I would like to hear some more from the member.

Mr S.K. L’ESTRANGE: That explanation given by the minister would not pass the pub test. That is straight up. This is not a treatment. This is absolutely an option for a patient, if the patient wants to explore that option. That is what this bill should be about. What all the people in this chamber are saying we are most concerned about is if the patient did not go in to seek that type of information, they should not be presented with it. That is all—nothing more than that. I would be very interested to know what the Australian Medical Association of Western Australia would have to say, given this is Western Australian legislation, about the comments the minister made tonight on the proposed amendment. I really would like to know what it would have to say on this.

Dr D.J. HONEY: Someone said the Premier would be answering questions. I am extremely disappointed in the minister’s response to this proposed amendment. This is a crucial amendment to make this bill the proper and reasonable bill that the government and the minister are presenting. I wish to dwell on a point. I am not a lawyer, but I am aware of the doctrine of presumed undue influence. To explain to members what the doctrine of presumed undue influence is, the doctrine presumes that if a doctor gains any benefit from a patient, it is presumed that there was undue influence. In fact, there is a considerable burden of proof required for that medical practitioner to prove that they did not influence that decision. That is profound. If a doctor gains some benefit, it is presumed that there was undue influence because of the imbalance of power. I am not going to rearticulate the excellent speech made by the member for Armadale on this matter. It is presumed that there is undue influence. This is not about someone doing some extreme thing. This is not about someone who is doing this out of any malice or for any other purpose. It may well be that a doctor has a particularly strong view about things. As we have discussed, some doctors are vehemently opposed to voluntary euthanasia—it makes them feel sick. Some medical practitioners are absolute advocates of voluntary euthanasia and, in fact, think that this bill is weak and does not go far enough. That is just because doctors reflect the breadth of views in this room and in the broader community. It may be that a doctor does not have any particular view. However, if the doctor said, “Maybe you could leave the house to me”, and the person left the house to them, the presumption under law would be that that was undue influence, because the law has recognised for a long time that doctors have special power in a relationship.

Let us equate voluntary euthanasia with a commercial benefit to the doctor. If a patient who has no thought of this and is not considering terminating their life comes in to see a doctor and the doctor looks at the patient and believes that the patient’s case is hopeless and they ask the patient, “Have you considered the range of options? We can give you the treatment but, by the way, you can also access voluntary euthanasia”, the law would say that the doctor has undue influence per se. The doctor would have to presume that they had not unduly influenced that decision. In this case, the minister is saying, “No, I don’t presume that.” It is in complete contradiction to a principle in law that has existed for some considerable time. I am astounded that Malcolm McCusker has not raised this as a concern, because every lawyer I have spoken to about this topic has raised this. That is true. I know of many lawyers, both personally and otherwise. It is true, members. I do not know why members are pulling faces and laughing about this matter. Every lawyer I have spoken to has expressed this concern; that is, the imbalance of power between a doctor and a patient is such that if a doctor were to simply discuss this with a patient, that could unduly influence the patient to take this decision—a decision that they would not otherwise take.

Mrs A.K. HAYDEN: I would like to hear more from the member.

Dr D.J. HONEY: I see this in a number of bills that are brought before this place and I heard it in the discussion today; that is, we assume that in the best possible circumstances, everyone is of goodwill, everyone will do things in the best possible way, everyone will receive the information in the best possible way and we will have the best possible outcome. Members, we know that is simply not true. Again, the member for Armadale outlined very eloquently the simple reality. It is in not just remote Aboriginal communities but also country communities. In country towns, the doctor is an esteemed and revered figure. Doctors have enormous influence in country towns.
Members who represent regional areas will know that in many communities, the doctor is not just a leader in the medical field, but a civic leader. When the doctor raises an issue or a concern or suggests something, per se the community takes that to be an important matter and something that it should consider and do. Members know that for many patients, a doctor is a revered figure. It is absolutely certain that if a doctor suggests to a patient that they consider voluntary assisted dying, some patients—members—can debate how many patients until the cows come home, but that is speculation—will go through that process, and nothing will pick that up. How will that possibly be picked up? We hear about these checks and balances, but nothing will pick that up. There is not a specified question. There is not a deemed provision in this legislation that says that one of the questions that must go onto the checklist is: did the doctor suggest this before you asked? Nothing in this legislation will pick that up.

I want to dwell on one point. The minister used the example of Oregon a few times to say there is no evidence that vulnerable people access voluntary euthanasia more than other people do. Of course they do not in Oregon. I can tell the minister that most vulnerable people are poor. In fact, it goes exactly the other way. Poor people are less likely to access voluntary euthanasia. That is because in Oregon, if people do not have insurance, it costs a heap of dough. The minister has not given us one skerrick of evidence that doctors will not influence a person who is in that position. I am not talking about a person who is mischievous or criminal. I am talking about a doctor who is well meaning and believes this is an option that the person should consider. The minister has not told us anything that proves that will not be the case. In fact, all the evidence indicates that doctors have a special position and a special power, and that, simply by discussing something, doctors can unduly influence a person to make a decision that they otherwise would not make. I know that there seems to be some sort of dogmatic position that not one skerrick of this bill will be changed. The minister may say I am saying this because of politics, religious belief, or extremest belief, but I strongly urge every member to support this amendment. This amendment is absolutely crucial to make this the proper, reasonable, fair and balanced bill that I know the minister intends. I will finish on that. I strongly urge members in this house to support the outstandingly ideal amendment put forward by the member for Armadale.

Mr R.H. COOK: I want to clarify a couple of points. Member for Churchlands, I did use the word “treatment”, but I then corrected myself in my comments. It is end-of-life options.

Several members interjected.

Mr R.H. COOK: A number of members drew it to my attention, and I said options at end of life.

Mr S.K. L'Estrange: You are correcting it now, of course.

Mr R.H. COOK: Indeed.

Mr S.K. L'Estrange: If I may make an interjection —

The SPEAKER: No interjections, please. You had your chance to talk.

Mr R.H. COOK: I said that people should be familiar with all the end-of-life options.

Mr P.A. Katsambanis: It was a flourish. It was a slip of the tongue. I accept that.

Mr R.H. COOK: I want to go to the issue that everything a doctor says, a patient does. That is simply not the case. In fact, doctors are already entrusted with a range of life and death medical decisions that are made without the safeguards that are contained in the Voluntary Assisted Dying Bill. For example, death may occur as a consequence of a decision to remove assisted ventilation, cease medical hydration and nutrition, or cease renal dialysis. Such decisions are routinely made by doctors, in collaboration with patients and their families, whether they come from high socioeconomic backgrounds or, as the member for Cottesloe described, are vulnerable people because they come from low socioeconomic backgrounds. We are all, from time to time, confronted with having to work with our doctor to make these sorts of decisions. These decisions are routinely made, in collaboration with patients and their families, and are also open to the possibility of coercion and abuse, yet we trust that process, because medical practitioners have a trusted role within our medical framework. They make these decisions all the time, in conjunction with patients and patients’ families. We recognise, as a number of members have commented, that this is a particularly important decision. That is why these added safeguards are baked into the Voluntary Assisted Dying Bill. From that perspective, we believe we have achieved the best balance between the right of patients to be informed about all their end-of-life options, and the safeguards that are needed to protect vulnerable patients who might be coerced, by either someone within the medical or health fraternity or someone in the community, such as a friend or relative. That is why we have put these safeguards in the bill.

Mr P.A. KATSAMBANIS: I rise tonight to congratulate and commend the member for Armadale for the contribution he has made to this debate. I do not say the following words lightly at all. I was first elected to Parliament in 1996 and have been around parliamentary chambers a long time. I have heard a lot of debate. The amazing contribution I heard tonight is almost certainly the one contribution that has profoundly moved me as a legislator—hearing the comments of the member for Armadale tonight and hearing how he spoke lucidly and knowledgeably, with a great

Extracted from finalised Hansard
amount of research and a lot of personal lived experience. He incorporated that into his contribution because he fundamentally cares about the rights of vulnerable people. He also fundamentally supports the principles and provisions of the bill before us. It was an astounding contribution from a learned individual who truly and utterly believes that what he is proposing will make a better bill, in particular, because it provides protections for the most vulnerable in our society. Through his own lived experience, he highlighted how some sections of the community might be particularly vulnerable to suggestion because they want to please or because of cultural backgrounds—for instance, in Aboriginal communities.

In my contribution to the second reading debate, I spoke about the vulnerability of some people to suggestion from medical practitioners because of their cultural background. I can tell members that in many culturally and linguistically diverse and non-English speaking communities, the doctor, the medical practitioner, is revered. They are held up to a higher standard. Their word is taken almost as gospel. If you want, members should come to my parent’s church group, which comprises almost totally elderly first-generation migrants from southern Europe, most of them from Greece. The mere suggestion by a medical practitioner about almost everything, from direct health to broader health, including diet, to perhaps ways that they might communicate with their children or grandchildren, is elevated to a status well beyond what it would have if it was a suggestion from another person—perhaps a child, a grandchild or a sibling.

In that way, when we talk about that power imbalance—as the member for Armadale rightly put it, that power imbalance between a medical practitioner and a client is rarely recognised—it may be something that is not obvious to the medical practitioner. It may not be obvious at all. A medical practitioner may not deliberately act in a wrong way or in a pernicious way. They may even not have a clear understanding of the unusual and coercive impact that their words have on that individual, particularly if they do not have an overly longstanding relationship with them.

Mrs A.K. HAYDEN: Can I hear more from the member?

Mr P.A. KATSAMANIS: It covers a lot of cultural groups, a lot of vulnerable groups in the community. That is why it is important to provide the strongest possible protections for vulnerable people. I want to pick up on the commentary of the Leader of the Opposition, who rightly said that an objection to capital punishment is often couched by many people, including myself, on that one rare case—that is, the one rare case that you want to avoid. The one wrongful death must be avoided. That is how we should view this provision that I believe would rarely come into play. The heartfelt plea from the member for Armadale gives voice to the voiceless. It gives voice to the vulnerable and it ought to be heard by all of us here tonight. It ought to be heeded and it ought to be enacted, because if we do not do it, we are condemning the most vulnerable in our society to a risk that is not worth imposing upon them. It is not fair to impose that risk upon them. I do not think there was a person in this chamber or anyone listening to this debate who was not moved by the personal story that the member for Armadale related. But I also think not too many people cannot extrapolate that personal story out to circumstances that they are aware of through their interaction with their family members, other community members or, in the case of us as legislators, our constituents. We know it is the case. This new clause will not obliterate the provisions of the bill, it will not be a victory for opponents of the bill and it will not even bring into question the learnedness of the body of people who have spent time putting this bill together. It will simply add one more protection, one more safeguard, which is why I implore members to support it.

When I heard the minister’s response, initially I was shocked that he mentioned that assisted dying was a treatment option. However, as I sat here before he got up to set the record straight, I thought: “Long time, long night. The minister is there in the chair on his own with a lot of us talking to him. It was a bit of rhetorical flourish, he got a bit carried away and I think he meant it is an available option—it is a choice at the end of life if this bill becomes law.” I am glad that I did not have to broach it with him directly and that he got up and put on the record that that is the case, because it never should be considered a treatment option. If it comes into law, voluntary assisted dying will be an available option, but it is certainly not treatment. I digress from the main point of the amendment before us. Again, member for Armadale, congratulations from the bottom of my heart. It will take an extraordinary contribution in whatever time is left for me in parliamentary life into the future for his contribution to be topped. He deserves the plaudits, but in particular the people he is voicing concern for today deserve support for his amendment, and I intend to give that support.

Dr A.D. BUTI: I thank everyone who has contributed to this motion that I put forward. Although I am disappointed with the minister’s response, I appreciate him giving me a full hearing. I would like to bring it to a vote, to divide. I move that the vote be put.

Point of Order

Mrs M.H. ROBERTS: My point of order is that that member is not able to move the vote be put, because he has already spoken.

The SPEAKER: We just realised that.

Extracted from finalised Hansard
Debate Resumed

Mrs M.H. ROBERTS: I would like to speak on this new clause put forward by the member for Armadale. I have been in the chamber for part of the time and the rest of the time I have listened to the debate on this clause. I think the amendment moved by the member for Armadale is excellent. I am very keen that someone in his own party supports him on his amendment in this chamber, because it is a very good and appropriate amendment. It is not asking the world; it is part of the legislation in Victoria. It is an additional safeguard for people who are vulnerable—the disabled, Aboriginals. I have no idea why it is being opposed in this chamber. I am quite confident that this amendment will get up in the other house. We have wasted a lot of time tonight debating an amendment that will no doubt succeed in the upper house, and, on that basis alone, it should probably have been accepted here so we could move on. There is a big differential between a professional medical doctor and an ordinary person. So many of my constituents are quite intimidated by doctors. They have enormous respect for doctors. There is a huge power imbalance, and members here have reflected on the imbalance between the doctor and an individual, but particularly a vulnerable individual such as an Aboriginal. The Attorney General has taken up the cause for Aboriginal people in remote communities, and I have seen in my portfolio Aboriginal people pleading guilty to crimes that they did not commit. They can be very open to suggestion. On that basis alone, I think if people just reflected on that, they would see this new clause is probably more important in Western Australia than in any other state.

I do not want to delay the house. I have spoken for about two minutes. The member for Armadale has my full support with this amendment and I hope it is successful in the upper house. I have no doubt it will be brought back to this house again.

Mr A. KRSTICEVIC: I would very quickly like to pass on my congratulations to the member for Armadale for moving this amendment, because I spoke about this issue in my contribution to the second reading debate. I also spoke about the possibility, especially for people with non–English speaking backgrounds, whose son or daughter could —

Withdrawal of Remark

Mrs A.K. HAYDEN: Point of order, Mr Speaker. I would like you to apologise to me, without me having to say why, for what you just did.

The SPEAKER: It is a good point of order, but you were continually having a go at me. I gave one of your own members the point. I just asked your Whip to go and explain to you.

Mrs A.K. HAYDEN: Point of order, Mr Speaker. I am asking you to apologise without me having to tell the chamber —

The SPEAKER: No. I am not. I was talking.

Mrs A.K. HAYDEN: I am the Whip.

The SPEAKER: Manager of opposition business—sorry. You withdraw that remark.

Mrs A.K. HAYDEN: I will withdraw that or I will name you.

The SPEAKER: I call you to order for the first time. It is not about you; it is about the person on their feet.
Debate Resumed

Mr A. KRSTICEVIC: I again reinforce importance of this amendment. I concur with the member for Midland. I think the rational heads in the Legislative Council will listen to the debate in this house and understand that a number of members have some valid concerns and amendments, which for whatever reason are not being accepted in this place. I have no doubt that we will be debating this legislation again in this chamber. The member for Armadale’s amendment is very critical because, as I said, when people from non-English speaking backgrounds go to the doctor, they sometimes take their son or daughter with them to discuss things. I used to do that with my late father. I would go to the doctor, interpret for him and talk him through what the doctor was suggesting. Nothing would stop a son or a daughter from encouraging the doctor to raise the topic and to discuss it with the father. Again, the son or daughter may well be supportive of the doctor’s view and encourage a vulnerable parent who holds the doctor in high regard to go down the path of voluntary assisted dying when they otherwise would not have considered it. This could occur in many circumstances. This area could become a problem.

I do not see anything wrong with the patient raising this as an issue. At the end of the day, we are talking about someone terminating their life and it is probably something they should decide to raise themselves. I do not think they necessarily need someone else to look at them and say, “Hey, have you thought about ending your life as a good idea?” I am sure people who want to go down that path would think about it themselves and raise it with the doctor. I note that some people in this chamber are not listening to rational and intelligent suggestions from the member for Armadale, but I think most people are, and I think it is fair to say that we should give them serious consideration. If this amendment is not passed in this place, I implore the other house to do its best to try to get this amendment through.

Mrs A.K. HAYDEN: I rise to thank the member for Armadale for his bravery in putting forward this amendment. I also thank the member for Midland for her bravery for standing up and speaking to this amendment. I know how difficult it is to stand and talk to an amendment against one’s own government. Minister, this is exactly what everybody has raised. I raised this issue in my second reading contribution. If one vulnerable person is not treated respectfully and slips through the cracks, that means this legislation is not worth it.

I simply do not understand. We have had all the debate and I do not need to go through it all again. I do not understand why the minister is so adamant about not including this additional safeguard for the most vulnerable people in our community. I do not understand. It has been put in the Victorian legislation for a reason. I do not understand why the minister is so adamantly opposed to it. I would like an explanation from the minister of why he is so adamantly not to insert this new clause. If the government were to put in this new clause, what adverse effect would it have on the legislation? The only effect I can see this amendment having is to assist and put in another safeguard for our vulnerable and the people in our community who need it the most. I would really like an explanation of why the minister so adamantly does not want to put it in the legislation. What adverse effect would it have on the legislation?

Mr R.H. COOK: I think I have made my position very clear and I have explained all the issues, but I thank the member for her contribution.

Dr D.J. HONEY: I wish the minister to correct something he said earlier. My understanding is that the minister said that I referred to people from lower socioeconomic groups. I certainly did not refer to those. I referred to people from Aboriginal communities and then I said that the concerns for those communities were the same concerns I had for other isolated communities where a doctor is an esteemed figure in the town. I believe the minister should reflect that I did not refer to lower socioeconomic groups.

Mr R.H. COOK: I apologise if I misrepresented the member’s position. I referred to the comments the member made about Oregon and low socioeconomic and therefore vulnerable groups there. If I mischaracterised those comments, I apologise. It is true that doctors have a lot of power, and the member raised that issue. Doctors already make suggestions around a range of end-of-life decisions such as whether to continue to ventilate or keep someone on life support or whether a patient should withdraw from chemotherapy or dialysis. The logical extension of what the member is suggesting is that they should not have those discussions either. Everyone in this place would agree that doctors need to have the full range of these discussions. I thank everyone for their contributions this evening and, once again, I thank the member for Armadale. It has been a good ventilation of the issues and from that perspective, Mr Speaker, I think we should move forward.

Question to be Put

Dr A.D. BUTI: I thank everyone for their contribution. After checking with the Clerk, I move —

That the question be now put.

Question put and passed.
Division

New clause put and a division taken with the following result —

Ayes (17)

Dr A.D. Buti
Ms J. Farner
Mrs L.M. Harvey
Dr D.J. Honey
Mr W.J. Johnston

Mr P.A. Katsambanis
Mr Z.R.F. Kirkup
Mr A. Krsticevic
Mr S.K. L’Estrange
Mr R.S. Love

Mr W.R. Marnion
Ms L. Mettam
Dr M.D. Nahan
Mr D.C. Nalder
Ms M.M. Quirk

Mrs M.H. Roberts
Mrs A.K. Hayden (Teller)
(71)

Mrs L.M. Harvey
Mr A. Krsticevic
Dr M.D. Nahan
Mr D.C. Nalder
Ms M.M. Quirk

Noes (34)

Ms L.L. Baker
Mr J.N. Carey
Mrs R.M.J. Clarke
Mr R.H. Cook
Mr M.J. Folkard
Ms J.M. Freeman
Ms E.L. Hamilton
Mr M. Hughes

Mr D.J. Kelly
Mr F.M. Logan
Mr J.E. McGrath
Ms S.F. McGurk
Mr D.J. Honey

Mrs L.M. O’Malley
Mr P. Papalia
Mr S.J. Price
Mr J.R. Quigley
Ms D.R. Michael

Mr R.H. Templeman
Mr P.C. Tinley
Mr R.R. Whitty
Ms S.E. Winton
Ms C.M. Rowe

Mrs R.M.J. Clarke
Ms L.L. Baker
Ms L.M. Harvey
Ms L.M. Harvey
Ms M.J. Davies

Mr M. McGowan
Mr J.N. Carey
Mr R.H. Cook
Ms M.J. Davies
Mr R.H. Cook

Mrs L.M. O’Malley
Mr D.J. Kelly
Mr J.N. Carey
Ms L.M. Harvey
Mr M. McGowan

Mr C.J. Tallentire
Mr D.A. Templeman
Mr P.C. Tinley
Mr R.R. Whitty
Mr B.S. Wyatt

Mrs L.M. Harvey
Mr A. Krsticevic
Dr M.D. Nahan
Mr D.C. Nalder
Ms M.M. Quirk

New clause thus negatived.

Clause 10: Contravention of Act by registered health practitioner —

Mr Z.R.F. KIRKUP: Clause 10 states —

(1) A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Western Australia).

Does that restrict any other criminal charges that might apply, or anything like that? Does it restrict any other criminal matters?

Mr R.H. COOK: No, it does not.

Mrs L.M. HARVEY: Could the minister please advise what the penalty for professional misconduct or unprofessional conduct would be?

Mr R.H. COOK: There are a range of penalties under the Australian national law. It may come down to sanctions from the professional body associated with it. Ultimately, it may come to essentially forming a view that that person is no longer fit to remain in that profession. As the member will understand, the regime that the Australian Health Practitioner Regulation Agency works under is extensive. We could come back to a range of contraventions that could typically be contemplated, and how they are typically dealt with under that law, but, as I said, each of them is dealt with under their own professional bodies.

Mrs L.M. HARVEY: Clause 10(2) states —

Subsection (1) applies whether or not the contravention constitutes an offence under this Act.

Can the minister explain that clause?

Mr R.H. COOK: This clause provides that where a registered health practitioner contravenes a provision of the act, that contravention, as one would expect, is capable of also constituting a professional misconduct or unprofessional conduct. Professional misconduct or unprofessional conduct will be ascertained pursuant to the Health Practitioner Regulation National Law (WA) Act. A contravention may be an act or an omission of an act, but even where the act or omission is found not to be a criminal offence—that is, it does not trigger those offence provisions under this act in terms of criminality—the act or omission may still be considered professional misconduct or unprofessional conduct. It may not trigger the criminal sanctions associated with this act; however, ultimately, it may still trigger regulatory framework for the medical profession.

Mr Z.R.F. KIRKUP: I am keen to understand: With the contravention of any provision, who would assess that a contravention has been made? Under the existing practices of the Health Practitioner Regulation National Law (WA) Act, is it the practices as they stand? How would a contravention be assessed and a conclusion arrived at?

Mr R.H. COOK: I am advised that AHPRA would be the responsible enforcement agency. AHPRA’s attention may be drawn to it by either the CEO or potentially the Voluntary Assisted Dying Board.

Mr W.J. JOHNSTON: I said to the minister that I would ask a couple of questions to get matters on the record. I just want to confirm, if we look at clause 10(1), we see that an example of a contravention might be a failure by a medical practitioner to provide the information required by clause 19(5)(b). Clause 19(5)(b) directs the medical practitioner to give the patient the information referred to in clause 19(4)(b), that being the information approved by the CEO. If a doctor fails to give the information prescribed there, is that an example of something that would be in contravention of the provision and could be capable of constituting professional misconduct?
Mr R.H. COOK: Yes.

Mr P.A. KATSAMBA VIS: I seek a little clarification. In the absence of this provision, would a contravention of this bill not be capable of constituting professional misconduct or unprofessional conduct for the purposes of the national law? My understanding is that it would be unaffected because this bill will not amend the national law. I do not have any objection to this provision being in the legislation. I think it is good for completeness. But does the minister have any advice about what the ill would be if this clause did not exist?

Mr R.H. COOK: The member is right. It is to provide clarity.

Dr D.J. HONEY: I have a question following on from the Minister for Mines and Petroleum. If a medical practitioner who has a profound objection to voluntary euthanasia refuses to pass on information to a person so that they can access voluntary euthanasia, could they be charged with professional misconduct or unprofessional conduct?

Mr R.H. COOK: As the member said and the member for Cannington observed, that potentially could be found to constitute professional misconduct or unprofessional conduct. Whether there would be sanctions or any implications of that is entirely the purview of the Australian Health Practitioner Regulation Agency.

Dr D.J. HONEY: I know this might sound obvious, but if a medical practitioner refused to participate by submitting a form to the CEO rejecting being involved in the process, would that apply as well?

Mr R.H. COOK: It could. I think the member means that the form had been sent to the Voluntary Assisted Dying Board, but it could. It would not automatically trigger that process. Whether there is a sanction is entirely up to the national law.

Mr S.K. L’ESTRANGE: Picking up on the contravention of the act, if a mistake is made, what remedies would be available to a patient or, in the worst-case scenario, a family that is left, after a malpractice has occurred with wrong advice or whatever?

Mr R.H. COOK: The remedies under this bill, as the member would be aware of, are detailed in the relevant clauses. The remedies, as the member has said, under the national health practitioner law would, essentially, relate to the way that AHPRA views the severity of the offence.

Mr S.K. L’ESTRANGE: Is the minister intending to establish some sort of redress scheme attributed to any contraventions of the legislation?

Mr R.H. COOK: No.

Ms M.M. QUIRK: I am curious about how this contravention or allegation of misconduct gets to the various medical boards. Is it referred by the board? I am not quite sure about the process and who investigates it.

Mr R.H. COOK: There is a range of ways that the Australian Health Practitioner Regulation Agency might be made aware of the issue, including through its own observation of circumstances. An individual could refer to AHPRA an accusation of misconduct or otherwise by a medical practitioner. Ordinarily, one would expect the chief executive officer or the Voluntary Assisted Dying Board to refer to AHPRA, and of course the Health and Disability Services Complaints Office would be another such entity. Once they have undertaken their own investigations, they would refer their evidence on to AHPRA.

Ms M.M. QUIRK: What are the procedures for referring it to one of those bodies? For example, is material disclosed to the practitioner before the findings? It is not clear from here whether it is a different process from what is normally adopted for medical negligence or misconduct.

Mr R.H. COOK: What is referred to AHPRA in that particular instance is the conduct of the medical practitioner, so that would not ordinarily require disclosure in relation to the actual patient. AHPRA, of course, has authority to undertake its own investigations, make findings as a result of those investigations, and provide sanctions and penalties commensurate with its legislation.

Ms M.M. QUIRK: By way of interjection, this is expanding the nature of conduct that can be regarded as being professional misconduct; is that correct?

The SPEAKER: Can the member talk up a bit, or get a bit closer to the microphone?

Ms M.M. QUIRK: I will stand up, then. This clause is effectively expanding the categories of conduct that may well lead to charges and adjudication or allegations that there has been professional misconduct or unprofessional conduct.

Mr R.H. COOK: Technically, yes, but ultimately it simply draws a ring around the full range of clinical practices that a medical practitioner undertakes and, in any sort of clinical setting, the rules and regulations of their profession that they are obliged to follow.

Clause put and passed.

Debate adjourned, on motion by Mr D.A. Templeman (Leader of the House).
VOLUNTARY ASSISTED DYING BILL 2019
Consideration in Detail

Resumed from 4 September.
Debate was adjourned after clause 10 had been agreed to.

Clause 11: Voluntary assisted dying not suicide —

Mr Z.R.F. KIRKUP: The term that is being defined in this clause is that voluntary assisted dying is not suicide. Obviously there is some contention, especially in relation to a self-administrative decision, and the perspective that might be. Can the minister provide some insight into why the government has decided to define voluntary assisted dying as not suicide?

Mr R.H. COOK: This clause provides that, for the purposes of the law in Western Australia, a death that results from the administration of a prescribed voluntary assisted dying substance is not considered to be a death resulting from a person committing suicide. This clause reflects the tenor of the bill, and the views of the government, that voluntary assisted dying is not suicide. Suicide occurs when a person takes their own life in circumstances outside those permitted by this bill. Voluntary assisted dying must be viewed as completely separate to and distinct from suicide. Suicide connotes a loss of life of a person who is typically not dying, and in circumstances that are often tragic, and a person feels socially or emotionally isolated. Voluntary assisted dying, however, involves a person’s choice about their mode of death, when they are already dying—a process that is requested and led entirely by the person, in which they are given the support and care they require in the end-of-life stage.

Concern was raised in the committee’s minority report that there is an artificial distinction between assisted dying and suicide generally. Whether one construes such a distinction as artificial is a matter that depends solely on a person’s opinion, based on personal views, including political and religious beliefs on the ethics, morality and psychology behind the choice to take one’s own life. The bill reflects the views of a significant proportion of people in Western Australia, and addresses a genuine choice. This is one of the provisions that brings into sharp focus the philosophical issues within the bill. It is what it is. As the member can see, it is a fairly simple, straightforward clause, and it may be that we simply will not be able to provide comfort for folk who have a philosophical opposition to this.

Mr Z.R.F. KIRKUP: I am assuming, as well, that this clause has some relationship with the death certificate. Because we are defining, at this point, that voluntary assisted dying is not suicide, obviously that will not be reflected on the death certificate either. Can the minister confirm that?

Mr R.H. COOK: That is correct. There are obviously a range of reasons of clarity for having this clause included in this bill, but it is certainly our intention that the death certificate would not include voluntary assisted dying or suicide in its outcomes.

Mr Z.R.F. KIRKUP: Given the lack of language in relation to the word “suicide” throughout the rest of the bill, why was it considered necessary to include this definition? Why was it considered necessary to insert this clause into the bill if it was not referenced anywhere else?

Mr R.H. COOK: Because it reflects the policy intent of the bill, it is therefore an important clause to clarify.

Mr Z.R.F. KIRKUP: The policy intent is that someone can access voluntary assisted dying. Is that what the suggestion is?

Mr R.H. COOK: We want to make it absolutely clear to those perusing the legislation, and also to the general community, that this is not a question of advising suicide. This is a very distinct act, and to provide clarity in the bill is an appropriate way to go.

Dr D.J. HONEY: I am absolutely perplexed by this clause. It is a clause saying that in this bill, we say black is white, or orange is pink, because we do not like the colour black or the colour orange, and we do not want people to think. I see a theme going through this bill; clearly, the ministerial committee and the people who wrote this bill are strident advocates for euthanasia. We saw that in the briefings. When I went along to the briefings, any discussion from the expert panel that suggested anything other than this bill was appropriate was, I will not say attacked, but vigorously put down. The tenor of the bill is that anything considered uncomfortable or irksome is defined away, hidden or redefined. We do not talk about a “poison”; we talk about a “voluntary assisted dying substance”. We do not want to use the word “poison” because the community does not like it, so we hide it and use another phrase to describe it.

Extracted from finalised Hansard
If a person takes their own life, it is suicide. I am dumbfounded. I am not a hardline zealot on this issue, but I do have considerable concerns about the protections in this bill—or the lack of protections in this bill. I am extremely concerned why the government, if it is so certain that this is the right thing to do, is trying to hide anything that has negative connotations or is irksome. It is perverse. The idea that someone is not committing suicide because they are going to die anyway is a nonsense. We are all going to die. To be really frank, the minister has no idea whatsoever and a doctor has no idea whatsoever when a person is going to die. They are making an estimate about it; they are making a guess about it. They say that voluntary assisted dying is different because it is a considered process assisted by someone else. Many suicides—I would say nearly all suicides—are a considered process, and many suicides are assisted by another person. If someone takes it upon themselves to commit suicide and they are assisted by another person, it is clearly a considered process. Do we say that is not a suicide?

To say that this is a philosophical issue is really dumbfounded. This is not a philosophical issue; this is a simple matter of a common English definition. It does a disservice to this bill that the government continues to try to hide or obfuscate anything that could put this legislation in a bad light. It gives me great concern about the motives behind the bill. It is not an open discussion or an attempt to have an open discussion; it is an attempt to hide the facts behind it. I do not know why this provision needs to be in the legislation. This goes further, because when we talk about the death certificate, it will not recognise that a person has gone through this formalised process at all. Again, the fact that this has occurred at all is hidden. I do not know why that has to be; there is no shame in a person accessing this process. I disagree with this bill, but I understand there are people who want access to voluntary assisted dying and there are people who support it. Again, we see this constant thread through this bill of trying to hide any single thing that could have any negative connotation whatsoever. In this case, it is trying to fundamentally redefine a term that is well understood and well accepted in the English language.

**Dr M.D. Naham:** I assume that this clause means that there are accepted definitions of “suicide” in the various acts. Could the minister provide me with some accepted definitions of “suicide” in the various acts relevant to this legislation?

**Mr R.H. Cook:** I am advised that there are references to the concept of suicide in the Criminal Code, but we are not sure whether it is actually defined in the legislation. Certainly, we could check that for the member. We are going to be in consideration detail on this bill for some time, as the member knows, so we can provide that feedback to him in due course. I am happy to provide that information.

As I said in my earlier remarks, I understand that members find this particularly confronting, because people feel strongly about this issue. From that perspective, it is important that members take care when they are making remarks about this particular clause. At the moment, in some instances, as members would be aware, a patient’s death can be hastened under a clinical environment. As a rule, we do not describe that as suicide, and we certainly do not describe it as taking one’s life. What we are doing here is legislating for particular activities around someone’s end-of-life experience. We are doing this from a legislative point of view rather than it simply taking place in the community unregulated, unobserved and unmonitored. It means that we need to proceed carefully and make sure that we are accurate in both the intent and the structure in the drafting of the bill.

I reject the member for Cottesloe’s contention that doctors are guessing—they are not. They are trained, paid, and under the great history and regulation of their occupation. On behalf of all the community, they provide calculated and scientific judgements, which are exercised every day. To say that doctors are guessing is, quite frankly, a little sad. This clause provides clarity in relation to the intent of the bill. It has not been put in through some ideological perspective, which the member for Cottesloe might be suggesting. The clause is there to make sure that we have competent and appropriate legislation.

**Mr A. Krsticvic:** In the minister’s answer, he indicated that there are other procedures or processes that are akin to suicide that are currently undertaken. I beg to differ on that point, because those procedures are not about suicide; they are about pain relief and management. Someone may pass away as a result of those procedures, but the purpose is not to take a person’s life. Obviously, looking at the definition of “suicide”—it does not matter where one looks—we see that it is the act of someone intentionally taking his or her own life. In regard to this clause, which states that voluntary assisted dying is not suicide, how is that concept—that idea—going to get prominence to be understood in Western Australia, Australia and internationally? I am sure if a person were to google it and look at all the international research, they would see that the definition of “suicide” would not change just because clause 11 of this bill states that suicide is no longer a person intentionally taking his or her life if it comes under VAD legislation. Apart from the suggestion in clause 11, what will this mean to people? Is the government going to have a major advertising campaign to tell people that VAD is not suicide? Is the government going to change the definition of “suicide”? When I google “suicide” it is very clearly defined, and this bill will allow what is currently defined as suicide. I want to know the minister’s thinking in that realm.

**Mr R.H. Cook:** With regard to the member’s earlier remarks, I certainly never used language like “it is akin”, so please do not verbal me. The member’s following remarks lay bare just how complex this issue is and the fine line we tread. I thank the member for his support. The government is trying to clarify the issue to make sure that
the intent and approach of this bill is clear in the public’s mind. I do not have any further remarks to add beyond those that I made to the member for Dawesville, except to say that I appreciate that this might go to the heart of a lot of the philosophical differences on this bill, but it is an appropriate clause to have in the context of the intent and approach of the bill.

Mr Z.R.F. KIRKUP: Is there a need to reiterate that voluntary assisted dying is not suicide for the purpose of trying to ensure that we are not caught under the commonwealth communications act on the use of a carriage service to incite suicide? Is that a reason to reiterate why this is not?

Mr R.H. COOK: As the member knows, the issues with the commonwealth act have been a fairly contemporary or recent development. This clause predates those considerations. As he knows, we have cited this clause as being material to that issue.

Mr P.A. KATSAMUNIS: This clause particularly troubles me. It troubles me philosophically, but it also troubles me legally. As I understand this clause—this has not really been canvassed so far in the debate that I have heard; I missed the opening parts of it, so the minister can correct me if I am wrong and it has been canvassed—it has nothing to do with the person whose life is being ended. This is really a protection. A clause such as this is necessary to protect those people involved in the process from the application of the parts of the Criminal Code that relate to aiding and abetting and assisting suicide. At the genesis of it, a clause such as this that provides protection for those people would make eminent sense if we were to embark on this sort of regime. However, it could be achieved in other ways that do not try to tell the public of Western Australia that black is white, which is what this is attempting to do.

I will put it in context. If somebody chooses to end their life by taking a cocktail of drugs outside of the operation of this regime, that is suicide. If someone chooses another, more fatalistic, method—jumps off a bridge, hangs themselves or slashes their wrists—that is suicide. If someone undertakes a process whereby they access a medication that is approved by the state to end their life, the outcome will be absolutely no different. The outcome is that they will take their life by ingesting a poison. That is suicide. Whether or not it is deemed to be suicide under this legislation, it is—in the ordinary use and the well understood meaning of the word. If there are other participants in that process, they need to be protected from the application of the Criminal Code, as I said.

A different formulation for this clause that would not incite the concerns that this clause incites would exempt those people who are involved in the process of the ending of a life in accordance with this legislation from the operation of those sections of the Criminal Code. Why was that formulation not considered? Why was it deemed necessary to essentially put in a clause that tries to convince the public that the deliberate taking of one’s life is not suicide, despite thousands of years of understanding that that is exactly what it is? From a legal point of view, I understand why a clause such as this ought to be in this legislation for the purposes of the law of this state, but it could have been formulated in a much better and much more appropriate manner than this ham-fisted way that turns our language upside down.

Mr J.E. McGrath: Mr Acting Speaker.

Mr P.A. Katsambanis: I would like a response.

Mr R.H. Cook: I am happy for the member to speak, but I will address the member’s issues.

Mr J.E. McGrath: I have concerns with the way this is going. I will tell members what suicide is. I knew a young fellow at Brightwater who was almost totally incapacitated. He was in a wheelchair. His father was killed in a plane crash in the Congo. His stepmother loved him dearly. He could come and go at the facility, and one day he got a cab to take him to the Garratt Road jetty. He had a bottle of Jim Beam and a ghetto-blaster. He drank the bottle of Jim Beam and then wheeled himself off the jetty and committed suicide. That is committing suicide.

I want to avail himself of this legislation—I do not think he would have because he was not near death—and if he met the conditions of the legislation that we are trying to put through this place, he would have had to go through a process. Going through those hoops is completely different from someone just saying, “I’ve had enough”, and a family member coming home and finding them hanging in the garage, with all the distress that that causes to the people who arrive at the scene first, such as paramedics and police. That is suicide. This is not suicide.

My worry is that a lot of people who do not want this in the legislation are the same people who want this bill to be called the voluntary suicide bill. I think there is an ulterior motive here and we have to be very careful. I am not sure, and I will be guided by the minister, but does the Victorian legislation spell out that it is not suicide? I need to know. I understand that there is a problem with the commonwealth legislation. We have to spell out everything for all those people members have been talking about who are disadvantaged and who might not understand the legislation. It has to be spelt out that if a person’s life has become unbearable, they are in such pain that it cannot be managed and they want to go through that process, what they are doing is not committing suicide; they are deciding that they want to take a different path, and make a different choice, at the end of their life. They might want to do that surrounded by family and friends, not in a lonely way on their own in a garden shed, by driving their car into a tree or jumping off a boat in the middle of the ocean. We have to support this. It is very important that this clause is in the legislation.

Extracted from finalised Hansard
Mr R.H. COOK: I thank members for their commentary. This is an important aspect of the bill. To answer the member for South Perth’s question, it is not in the Victorian legislation, but it was a clear message that came through in all the consultation by the Ministerial Expert Panel on Voluntary Assisted Dying, and I have Mr McCusker sitting next to me and providing me with this feedback. In all the community consultation, people were very clear: “Do not call this suicide; this is not suicide.” They wanted us to make that distinction within the legislation, because they are saying that this is not suicide; this is the relief of suffering at one’s own hand.

The ministerial expert panel said —

Suicides are potentially avoidable; ‘every effort should be made to prevent these deaths’ and there is a ‘range of critical work being undertaken to prevent suicide’. By contrast, the people ‘who are the focus of voluntary assisted dying face an inevitable death as a result of an incurable disease, illness or medical condition. It would not be appropriate to use the same terminology to describe’ their choice about the circumstances of their impending death. For these reasons, the Panel agreed the word ‘suicide’ should not be used in relation to voluntary assisted dying. It is wrong to confuse these two very different kinds of deaths.

From that perspective, the very clear call from the community—we all know that the community wants this legislation, that it is widely supported and that in the community’s mind this is not suicide—is that this is an important addition to the legislation. I reiterate that this was not put in for ideological reasons; it was put in to make sure we have clear and competent legislation, and it was put in before the issues with the commonwealth were raised. I made this comment before the member for Hillarys came into the chamber: I do not expect to be able to convince him of this because it goes to the deep, fundamental and philosophical issues inherent in the bill. I know many members, both in front and behind me, find that difficult, but we do have to grasp the moral nettle to take this on.

The member for Cottesloe said that it is like saying that the sky is pink when he believes it is blue; the member for Hillarys said that it is like calling something black when we all know it is white. I am not sure I can convince those members about this. I do not mean that disrespectfully and I do not say that the arguments are not pronounced; however, this goes to the deep philosophical aspects of the bill. It is an important clause to create clarity in both the minds of lawmakers and the community that we are doing something that is very distinct from suicide. We are prescribing very carefully the circumstances in which voluntary assisted dying will take place to create that distinction that, as the clause says, “For the purposes of the law”, it is not suicide. For that reason, it is important to make that distinction. If a death takes place outside the framework of this law, it will become subject to the Criminal Code and it is suicide. We are providing absolute clarity around what the community’s intent is on this—this was screamed from the rafters in the community consultation process—and the legal aspects of it; that is, to make very clear the intent and scope of it in the minds of people who are observing this law.

Mr S.K. L’ESTRANGE: I want to pick up on some of the minister’s remarks. I am still keen to understand why we need to ignore what is a fundamental definition. An equivalent to clause 11 is not contained in the Victorian Voluntary Assisted Dying Act 2017. Before I go on, can the minister explain why it has been deemed necessary to include such a clause in this bill when it was not deemed necessary in the Victorian bill?

Mr R.H. COOK: I think Oregon probably looks at the Victorian legislation and thinks, “Wow! We wish we’d included some of the elements they have in their bill.” I think that Victoria might be looking at our bill and saying, “Wow! I wish we had that insight before we drafted ours.” Each time a jurisdiction legislates for these issues, we modernise and make more contemporary, sound legislation. Before the member for Churchlands joined us, I provided a lengthy explanation to the member for Dawesville about the background and thinking on this. I do not want to go into those arguments again, but it is there for reasons of clarity and to assure people in the future what the intent of the legislation is. It is not an ideological flight of fancy; it is about creating modern, competent and appropriate legislation.

Mr S.K. L’ESTRANGE: I have some further questions. If suicide is not recorded on a death certificate, what will be recorded? A lot of researchers and universities undertake research into the causes of death to track the health of our society over time. That certainly is being done at the University of Western Australia where researchers are going through all the coroner’s reports to look for markers on the cause of youth suicide. It is quite a big study that is going on at the University of Western Australia that will take some time. Going back through all the documentation on a person’s death to understand exactly how and why they died can be very informative and helpful for our society in the future because it results in better health outcomes. I am very interested to know how that information will be captured, if suicide will not be recorded as the cause of death for people who take their lives prematurely through the Voluntary Assisted Dying Act, and how will we as a society be able to assess in time how many people have taken this option? I think it is important to know that.

I now turn to the comments the minister made when he referred to the ministerial expert panel. I understand an assumption was made in the Ministerial Expert Panel on Voluntary Assisted Dying discussion paper that suicide involves the tragic loss of life of a person who is otherwise not dying. The premise of that is straight-up wrong. The committee’s report states that it was provided data from the State Coroner that demonstrated that as many as 10 per cent of suicides in Western Australia each year are carried out by people who are suffering from terminal,
chronic or neurological conditions; that is, people who are dying are committing suicide. In the government's own committee report, the minister's statement that suicide is not about people who are dying has been found not to be true. The need to remove the word "suicide" from voluntary assisted dying does not make a lot of sense to many of us, and the minister has heard why. Fundamentally, it comes back to the definition of the term, which is the action of killing oneself intentionally. That is what it is. It is not pleasant. It is not something that any of us want to have to see a member of our families go through. It is tragic. We are simply denying that fact.

Last night we heard in debate on, I think, clause 10, how people will receive advice from a doctor. An amendment moved by the member for Armadale was seeking to include a clause in the bill to make it illegal for a doctor to initiate a conversation around voluntary assisted dying—essentially, a conversation about ending life early, which is suicide by definition. We cannot mince words here. We have to be honest about what we are dealing with and the whole premise of society. If society is saying, as the minister points out, that it is in favour of the bill, that is fine. But that does not negate a responsibility for the legislation to accurately reflect what is happening by using correct definitions.

Mr P. A. KATSAMBARIS: I am sure the minister will address that. I listened to the minister's explanation, in which he suggested that this was a moral divide. The point I made in my contribution, which the minister has not answered, and I understand that we will be poles apart on this, is that it was unnecessary to frame this clause in a way that creates that moral divide. This is not a clause that I believe has been included in this bill for some sort of moral purpose or to define the relative morality that has been balanced here. It ought to have been a very simple legal protection clause, and it could have been drafted in a way that it was. Unfortunately, as we discovered last night with the very good new clause moved by the member for Armadale, it is quite clear to me that the minister and the government are simply not prepared to consider any suggestion made in good faith to make this legislation better and safer. I will not continue on that path, but I would like to interrogate the operation of this clause, because it will be critically important for people who are participating in this space. Obviously, I am not a supporter of this type of regime, but there are people out there who are and who will be engaged in this, either as medical practitioners, other health practitioners, pharmacists, nurse practitioners and the like. This clause says —

For the purposes of the law of the State, —

Just for the state, not for the commonwealth —

a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not commit suicide.

I emphasise “in accordance with this act”. What if there is a death under this legislation that is committed by the self-administration of a substance that would, in the ordinary course of language, not under this bill, be considered suicide, and it is later found that some of the requirements of the legislation were not complied with—a form was not filled out, a step was not taken, perhaps a capacity decision was wrong? All those individuals exposed in the chain would then be exposed to the operations of the Criminal Code, would they not, minister?

Mr R. H. COOK: I thank the member. I will go back to a number of those issues that the member for Churchlands raised. I think he described what would be on the death certificate. Again, I already answered that question from the member for Dawesville earlier in the day, but for that purpose, that is covered later in clause 51. I am happy to discuss that when we get there.

In relation to the other comments the member made about the reports and the oversights and so forth, that is covered in the clauses dealing with the Voluntary Assisted Dying Board. The board will be required to prepare an annual report, and within that annual report it will address issues to do with its oversight of the legislation. That report will obviously be a public report, and will provide clarity and information on the functioning of the legislation.

I come to the point that the member for Hillarys raised around the issues of morality. As I said before, this clause provides clarity and signals clear intent in relation to the law from that perspective. The member might think that it uses confronting language, but from that perspective, this clause does both those things and provides important insights.

In terms of the second part of the member's question, there are offences under the bill. Some of those offences may be considered at the minor end of the process, and some at the very extreme end of the process. That is why the penalties under the bill range from fines of up to $10 000 to life imprisonment. We are dealing with difficult and serious issues here, and that is why there are 184 clauses in this bill to ensure that we have safeguards in place to ensure that this takes place. In its oversight, the Voluntary Assisted Dying Board will be able to have reference to the coroner, the Australian Health Practitioner Regulation Agency, the police and the chief executive officer, and from that perspective we will have every opportunity to examine whether the law is not working. But as the member can see, in every aspect of this bill there is a capacity to review to make sure that we have safeguards in place. From that perspective, and on the point the member for Churchlands made, the annual reports of the Voluntary Assisted Dying Board will show this at a forensic level and we will be able to understand what is going on.

Extracted from finalised Hansard
Mr P.A. KATSAMBANIS: I do not find that answer satisfactory, and I put on record right now that anyone involved in this regime should be fully aware that if, after the event, it is found that there was a failure of process to comply with all aspects of this legislation, they may be liable to penalties under the Criminal Code. This clause does not say “in substantial compliance with the act” or “in accordance with the really important parts of the act rather than the less important parts of the act, or the less critical parts of the act”; it says “in accordance with this act.” If a pharmacist prescribed a substance to an individual who then took it and ended their life, and it was found that further up the chain one of the practitioners had not complied with every step along the way, that pharmacist would not have the protections that this clause purports to deliver. They would then be liable for penalties under the Criminal Code for assisting suicide. If a delivery person delivered the substance, the same thing would apply. If an intermediary were involved, it may apply to them. In actual fact, if the second of the two medical practitioners signing off did things in good faith but the coordinating practitioner did something wrong, perhaps they might be liable under this sort of framework. Despite the language used, I believe this clause is drafted to provide protection in good faith; I just think it fails that test and is unsafe for the practitioners involved and for all the parties involved along the chain. If we took off our ideology blinkers and treated this as legislation that can be improved, then I think the minister would be providing better protection for those people he wants to empower with this legislation. This is not me standing up and saying, “I have a philosophical objection to this bill”, which I have; this is me standing up and saying, “You’re not actually achieving what you ought to be achieving with this clause.” It is a flawed clause; the minister can do better. If he wants to let it go through, let it go through, but he cannot say he was not warned.

Mr R.H. COOK: This clause is informed by advice that we have received within government from the Solicitor-General, the Department of Justice, the Director of Public Prosecutions and the State Solicitor’s Office. The member has made a number of remarks and comments in this debate. Most of them are very insightful and helpful; this is not one of them.

Mr V.A. CATANIA: I carry on under clause 11. At the start of consideration in detail I spoke to the minister about his conversations or his department’s conversations with the commonwealth Attorney-General and the Attorney-General’s Department. If my memory serves me correctly, the minister said that he would provide me with some information on that correspondence. I think the member for Hillarys has a point about section 474.29A and 474.29B of the commonwealth Criminal Code Act. Has the minister sought clarification from the federal Attorney-General? The minister said that the Western Australian Attorney General wrote to his federal counterpart seeking clarification. When was clarification sought by the Attorney General? It is my understanding that the state Attorney General sought advice from the federal Attorney-General on this very matter as little as seven days ago. The member for Hillarys asked a very important question—one that members of the chamber need to ask: has the commonwealth Attorney-General’s Department corresponded with the minister, his department or the Attorney General to give confidence that this does not go against the commonwealth Criminal Code Act 1995 in any way? This is a very important point if we are to move forward with the legislation. Perhaps the minister can table the correspondence that the Western Australian Attorney General sent to the federal Attorney-General and any advice that the minister has sought through the State Solicitor, the minister’s department or any other means to clarify this point. Potentially, people may breach the commonwealth Criminal Code Act. I do not think anyone wants that to happen. We are questioning the legislation in good faith. Members may or may not agree with the legislation, but we will hit a brick wall in furthering this legislation if we cannot clarify the situation or the minister does not table the correspondence to show exactly how this provision will not breach the commonwealth Criminal Code Act. The minister said at the start of consideration in detail that he would provide that evidence.

Mr R.H. COOK: I cannot table the letter because it is a letter between the Attorney General and the commonwealth Attorney-General and, from that perspective, it would be inappropriate to make that correspondence public. I can confirm that this issue was first brought to our attention on 26 June after it was raised in the media and public discussions. Conversations have been ongoing since that time. I can confirm that the Attorney General wrote a letter to the commonwealth Attorney-General dated 28 August in response to the conversations that were taking place between the state Department of Health and the commonwealth Attorney-General’s Department. It is not an impediment to the bill. But certainly as I confirmed privately to the member for North West Central, and I am sure I have talked about it in the chamber in the course of the debate, this is material to the issues associated with the commonwealth act. The drafting of the legislation did not come subsequent to the discovery of the issue. The drafting is there for our own purposes, although it is material to that discussion. What it means, as the member knows, is that it comes down to the issue about a carriage service—I think that is the expression—such as telecommunications, the internet and so forth in relation to the provisions of the Voluntary Assisted Dying Bill 2019. We are very confident that there is no conflict between the commonwealth act and this legislation. If we have to get around it because that is not the case, we will get around it. In the context of the member’s constituents, that will mean that we will have to get out on the ground. That will be more expensive and more difficult, but it is the right of the member’s constituents to receive that service.

Mr V.A. CATANIA: I sort of accept the minister’s explanation. However, the government found out about this in June and the Attorney General wrote to the federal Attorney-General only on 28 August. There is quite a time...
between first finding out about the issue and writing a letter. The minister may not want to disclose the letter but I think that either he or the Attorney General should disclose it to members in the chamber because that will give us clarity about what the Attorney General asked. Did he ask for advice about whether this clause breaches the commonwealth Criminal Code Act? Did the letter that the Attorney General sent to the federal Attorney-General ask for clarification about whether clause 11 will breach the provisions of the commonwealth Criminal Code Act? That is a very important question. Alternatively, did the Attorney General write to the federal Attorney-General to say, “There’s nothing to see here. Our advice says it’s okay”? They are two very distinct and different questions. It is important that the minister table the Attorney General’s letter to provide clarity and remove any uncertainty that someone may commit a crime.

It does not matter whether members think this bill is right or wrong. As I said, I support this legislation but we want to make sure that it is as tight as possible so that no-one breaks the law. Will the minister table the advice sought on this matter about whether the bill breaches the provisions of the commonwealth Criminal Code Act? Did the Attorney General seek advice on whether that is the case or did he provide advice to the federal Attorney-General on this issue? They are two very different but very important questions. If the Attorney General wrote to the federal Attorney-General and said, “Look, we believe that we are right. Our advice says that we are right”, that is not asking the federal Attorney-General whether this will breach the commonwealth Criminal Code Act. Given that the Attorney General wrote the letter on 28 August—we are now seven days or so down the line—and we are debating this clause today, has the minister picked up the phone and spoken to the federal Attorney-General and said, “We really need your advice on this matter urgently to ensure confidence in the chambers of the Parliament of Western Australia that no-one is going to break the Criminal Code Act”? That is a fair question. There is urgency in this matter. The Attorney General sent a letter several months after the government found out that this clause could potentially breach the commonwealth Criminal Code Act. I do not think that is good enough. There should have been a phone call to, or a meeting with, the federal Attorney-General, who happens to be from Western Australia, to determine whether this clause is in breach of the commonwealth Criminal Code Act. Minister, I have asked two questions. Is the minister able to clarify what was in the letter if he is not prepared to table it? It is important that we receive the advice that the minister received to give peace of mind to not only those members who support the legislation, but also those who do not support it but are working to ensure that it is workable and watertight so that people who go down this path will not break any commonwealth laws.

Mr R.H. COOK: The member will appreciate that we will not waive privilege. There has been communication between the Department of Health and the commonwealth Attorney-General’s Department. The government is consulting with the commonwealth to ascertain its position with a view to seeking an undertaking that the commonwealth will not prosecute or that it will take steps to amend the Criminal Code Act 1995 to make it clear that the provisions do not apply to voluntary assisted dying. There has been a lot of activity within the department. We do not seek advice from the commonwealth. We seek advice from the Solicitor-General and other counsel within government. That process takes time and there has been a lot of discussion around that. That clarifies the two points the member made.

Mr V.A. CATANIA: It is interesting that the minister says that this letter is privileged. If he wants to claim privilege on this letter, perhaps he may look at ways in which members on the other side have foregone privilege of the house in other parts of Parliament when it comes to emails of members of Parliament. This is about people who want to end their life because they are terminally ill. The minister is now saying that he is hiding behind privilege on a letter that the Attorney General has sent to the federal Attorney-General. Minister, is the letter asking for advice and clarity on the issue or is the Attorney General telling the federal Attorney-General that there is nothing to see here? I think it is a pretty honest approach to try to make sure that we flush out these things. If the minister is hiding behind privilege for a letter about something that is so important, that tells me he has something to hide. He is not being forthcoming with the members in this place who are trying to ensure—I keep repeating myself, because I think this is important enough to repeat myself—that this legislation is watertight, and that no-one will breach the commonwealth Criminal Code. I think it is important for members to know. This debate has been conducted in good faith, to make sure that we uphold the standards that the community expects of us as members of Parliament in debating this extremely important legislation, probably one of the most important bills that we will ever debate. People out there expect us to do our job—to scrutinise and make sure that we cover every possibility. We have to dot our i’s and cross our t’s. I am sure that all members of Parliament, whether they support the legislation or not, want to ensure that no-one is breaching the commonwealth Criminal Code.

In order to move on from this clause, it is important that the minister provides the evidence to show that anyone who goes down this path will not breach the commonwealth Criminal Code. That is all we are asking. Provide us with the knowledge and safety that the work has been done to ensure that no law is being broken. I cannot see how that letter is privileged. I have been passed a letter—where did that come from? Anyway, I cannot see how this letter is privileged, given the debates that are occurring in this place on other matters that are considered not to be privileged. This is about dealing with people’s lives. This is about ensuring that no-one goes to jail for doing something that this state says is right but the commonwealth says could be wrong. That is the important thing. Will the minister table the Attorney General’s letter? As I said, I want clarity on whether the Attorney General has said,
“There is nothing to see here! We are right. Our advice says that we are right.” We would like to see that advice. Alternatively, has the minister sought advice from the federal Attorney-General on whether the commonwealth Criminal Code will potentially be breached? Those are two very important questions because there are two very different answers.

Mr R.H. COOK: If the member sits down, I can clarify.

Ms A. Sanderson: Sit down, member!

Mr V.A. CATANIA: Hang on. Member, do not be like that! We are being open and honest, and having a debate in this house to ensure that no-one is breaking the law. Yes, we are, member, so do not be pushy. I will keep standing on this clause until we get the answer, because I think we deserve to have the answer to the questions I have raised.

Mr R.H. COOK: Thank you, member. I have been receiving subsequent advice while the member was on his feet—confirmation that it is okay to table the letter, but also confirmation that the member has actually been provided a copy of the letter. I do not have a copy here. I see that there was an exchange of documents between the member for North West Central and the member for Warren–Blackwood. I think the member for Warren–Blackwood has a copy of that letter.

Mr V.A. CATANIA: The minister should still table it so that we all have a copy. I did not have it while I was speaking.

Mr R.H. COOK: I understand that letter has been with members for some time. I hope we can move on now. I do not have a copy of the letter. Obviously, I have seen the letter. It is not mine to table, but if the member can hand it to me, I can table it. I appreciate the member’s spirited speech. It was a classic Catania, and from that perspective, I am happy to assist the member. If he gives me the letter, I am happy to table it for members. Perhaps the member could tell us, given that he now holds a copy of that letter, what it does. Obviously, he can see what it does.

Member, this is not something about which the Victorians are worried. They think they can work with it. They do not believe it is suicide, but from the perspective of clarity, they are getting on with the job, as would we. We do not believe it is suicide either and do not think it contravenes the commonwealth Criminal Code, so we will continue to move forward.

As the member said, this legislation is about important issues to do with life and death. It does not go to the nub of the issue of voluntary assisted dying; it goes to the issue of how we implement the act. We are determined to implement the act. The member is right: this particular issue relates to how we do that, but it will not stop us from doing it. I appreciate the spirit that the member brought to his contribution this morning, but this is not about whether we move forward. We are moving forward. This is about how we move forward.

Mr Acting Speaker, with your indulgence, I table the correspondence.

[See paper 2693.]

Dr M.D. NAHAN: If someone goes through the process, takes the substance and ends their life, and under this clause it is not defined as suicide, what is it? I know that we will deal with the coroner and the death certificate later. We can deal with that; that is a formal process. But what is it? We are prematurely ending life—maybe not very early, but potentially a year early in the case of somebody with an autoimmune disease. That is the purpose of this legislation. I am not questioning the purpose of the taking of the substance, but experience shows that if someone has a terminal disease, they do not necessarily die from that disease. They can often die from something else, such as a complication from the disease or the failure of another organ, or it might be something completely extraneous. I have personal experience on this one. If someone took the substance, that would be the cause of death. In the absence of the substance, if the person has a terminal illness or autoimmune disease, that might not be the cause of death. What is the cause of death in this case? Will the death certificate indicate that they went through the voluntary assisted dying process? Therefore, it is open to question. What is it?

Mr R.H. COOK: Member, again, the notification on the death notice is dealt with substantially under clause 81, so we will come to that in due course. That is the specific. In general, this legislation is about voluntary assisted dying. If someone dies, the underlying cause of that death is put on the death certificate. For instance, if a patient’s feeding tube was removed as they slipped away, the death certificate would not record that they died of starvation. If, as takes place in palliative care settings at the moment, people are encouraged in their departure—I had a very close relative who recently left us last week and this was the case—terminal sedation is not recorded. The underlying cause of the death is recorded. We will come to that issue under clause 81, but that is the general approach.

Dr D.J. HONEY: I think we have explored this issue pretty thoroughly and there are other important matters to consider, but I want to touch on a couple of topics that have been raised in the debate. Firstly, I thank the minister for pulling me up on the use of “guess”. My only excuse is tiredness. It is an estimate. That was a fair comment. It is an estimate that is made. My concern is, and there are many examples, when those estimates are wildly inaccurate. We will debate that later on. In reference to a couple of the comments that the member for South Perth
made, I suspect that everyone in this place has had some contact with suicide, as the minister clearly has. There is no shame in suicide. There is sadness, sorrow and heartbreak. It is not something that anyone should be ashamed of. As for defining suicide as a violent death, I have a close relative who committed suicide—someone I dearly loved—and their death was a gentle and considered death. It was not violent.

For my contribution and, I am certain, the contributions of my colleagues, this is not a contrivance for some other purpose. This is the most important bill that I have had to deal with in Parliament and probably the most important bill any member has had to deal with. This bill requires great consideration. We are not debating a concept. I know that some members are very keen on the concept and want this bill to go through now. They would be happy to vote on it now and for it to go through Parliament. We are debating a bill that has clauses in it. Our job is to make sure that there are not unintended consequences. We are respecting the process and we are respecting the Parliament in doing that. There is not some contrivance to change the title of this bill. For my part, and, I am certain, the part of everyone I have heard speak this morning, there is genuine concern about issues they have with the bill.

Ms M.M. QUIRK: I apologise if I am engaging in tedious repetition, but I have been paired this morning so there are a couple of things that I want to clarify about this clause. The minister has probably already told our colleagues this, but can the minister confirm whether the phrase “for the purposes of the law of the state” has any specific meaning or is it included to avoid unintended conflict with commonwealth laws?

Mr R.H. COOK: I am advised that for this legislation it is “for the purposes of the law of the state” because we cannot make laws for other states or extend that jurisdiction.

Ms M.M. QUIRK: That is a given, so I am a bit perplexed about why it needs to be there. If we proceed, the letter from the Attorney General dated 28 August this year to federal Attorney-General, Christian Porter, has kindly been distributed. Although, on its face value, the letter seems to suggest that people will not fall foul of sections 474.29A and 474.29B of the commonwealth Criminal Code, in the ultimate paragraph, Attorney General Quigley states — Officers from my Office, the Department of Justice, and the Department of Health would welcome discussions with officers from the Commonwealth … to explain the clauses in the Bill that deal with any potential interaction with the … Criminal Code.

I have two questions. Firstly, have any discussions taken place; and, secondly, has federal Attorney-General Porter responded to the letter?

Mr R.H. COOK: As I have already reported to the chamber, conversations have been going on between departmental officials since 26 June. I am not aware that the federal Attorney-General has responded, but that is, obviously, with the state Attorney General.

Ms M.M. QUIRK: The state Attorney General has written that he has — … taken advice at the highest level and it is my view that communications about voluntary assisted dying by a carriage service do not contravene the Cth Criminal Code.

He says that is his view. Was it the view of the people who gave him the advice, and who were those people?

Mr R.H. COOK: I am advised that our view was informed by the Solicitor-General, and the Director of Public Prosecutions in conjunction with the State Solicitor’s Office and the Department of Justice.

Ms M.M. QUIRK: Is it possible for legal professional privilege to be waived and that advice to be tabled?

Mr R.H. COOK: The member will appreciate that it is not.

Ms M.M. QUIRK: What is the reason it would not be?

Mr R.H. COOK: Because we do not waive privilege in these circumstances. We are monitoring the situation very closely.

Ms M.M. QUIRK: This probably has been repeated by other people, but the minister will excuse me if I repeat myself. Is clause 11 purely to obviate the issues that have arisen in Victoria that conflict with the commonwealth Criminal Code?

Mr R.H. COOK: I have spoken to this already. It is not. The drafting of this legislation predates the issues that have come up. This is about the clarity and intent of the law.

Ms M.M. QUIRK: One of the regimes that is heralded as being successful is the one in Oregon, where I think it is referred to as patient assisted suicide. I am trying to get some clarity about why there is the issue with suicide here. Is it a question of the stigma or are there some broader issues?

Mr R.H. COOK: I cannot provide insight about the lawmakers of Oregon. I know that no jurisdiction legislating in this area since 2009 has used the word “suicide”.
Division

Clause put and a division taken, the Acting Speaker (Mr R.S. Love) casting his vote with the ayes, with the following result —

**Ayes (45)**

<table>
<thead>
<tr>
<th>Ms L.L. Baker</th>
<th>Mrs L.M. Harvey</th>
<th>Mr D.R. Michael</th>
<th>Ms J.J. Shaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr I.C. Blayney</td>
<td>Mr T.J. Healy</td>
<td>Mr K.J.J. Michel</td>
<td>Mrs J.M.C. Stojkovski</td>
</tr>
<tr>
<td>Dr A.D. Buti</td>
<td>Mr M. Hughes</td>
<td>Mr S.A. Millman</td>
<td>Mr C.J. Tallentire</td>
</tr>
<tr>
<td>Mr J.N. Carey</td>
<td>Mr D.J. Kelly</td>
<td>Mr Y. Mubarakai</td>
<td>Mr D.A. Templeman</td>
</tr>
<tr>
<td>Mr V.A. Catania</td>
<td>Mr Z.R.F. Kirkup</td>
<td>Mrs L.M. O’Malley</td>
<td>Mr P.C. Tinley</td>
</tr>
<tr>
<td>Mrs R.M.J. Clarke</td>
<td>Mr F.M. Logan</td>
<td>Mr P. Papalia</td>
<td>Mr R.R. Whitby</td>
</tr>
<tr>
<td>Mr R.H. Cook</td>
<td>Mr R.S. Love</td>
<td>Mr S.J. Price</td>
<td>Ms S.E. Winton</td>
</tr>
<tr>
<td>Ms M.J. Davies</td>
<td>Mr W.R. Marmion</td>
<td>Mr D.T. Punch</td>
<td>Mr B.S. Wyatt</td>
</tr>
<tr>
<td>Ms J. Farrer</td>
<td>Mr M. McGowan</td>
<td>Mr J.R. Quigley</td>
<td>Ms A. Sanderson (Teller)</td>
</tr>
<tr>
<td>Mr M.J. Folkard</td>
<td>Mr J.E. McGrath</td>
<td>Mr D.T. Redman</td>
<td></td>
</tr>
<tr>
<td>Ms J.M. Freeman</td>
<td>Ms S.F. McGuirk</td>
<td>Ms C.M. Rowe</td>
<td></td>
</tr>
<tr>
<td>Ms E.L. Hamilton</td>
<td>Ms L. Mettam</td>
<td>Ms R. Saffioti</td>
<td></td>
</tr>
</tbody>
</table>

**Noes (7)**

<table>
<thead>
<tr>
<th>Dr D.J. Honey</th>
<th>Mr A. Krsticevic</th>
<th>Dr M.D. Nahon</th>
<th>Mrs A.K. Hayden (Teller)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr P.A. Katsambanis</td>
<td>Mr S.K. L’Estrange</td>
<td>Ms M.M. Quirk</td>
<td></td>
</tr>
</tbody>
</table>

Clause thus passed.

**Clause 12: Inherent jurisdiction of Supreme Court not affected —**

**Mr P.A. KATSAMBAHIS:** I note that the Premier is the minister at the table at the moment; welcome, Premier.

Clause 12 states —

Nothing in this Act affects the inherent jurisdiction of the Supreme Court.

Why do we need this clause? We are dealing with the inherent jurisdiction of the Supreme Court. If it is inherent, this bill would not necessarily do anything to that inherent jurisdiction. I do not have a problem with it being there, but why do we need it?

**Mr M. McGOWAN:** The advice of my learned colleagues is that it is to make it clear that the jurisdiction of the Supreme Court is not impacted in any way. This has often been raised as an issue for matters related to assisted dying, so an express provision will avoid all doubt. The Supreme Court may, in the exercise of its parens patriae jurisdiction, make orders for the protection of vulnerable people such as children, the mentally ill and the elderly. The parens patriae jurisdiction may be invoked in respect of persons who have mental capacity but whose autonomy has been compromised because they are under constraint or subject to coercion or undue influence. It provides an additional protection, if you like, which I thought members would support.

Clause put and passed.

**Clause 13: Relationship with Medicines and Poisons Act 2014 and Misuse of Drugs Act 1981 —**

**Mr P.A. KATSAMBAHIS:** This clause deals with conflicts or inconsistencies between the provisions of this bill and provisions of either the Medicines and Poisons Act 2014 or the Misuse of Drugs Act 1981. It states clearly that when there is any conflict or inconsistency, this legislation will prevail to the extent of the conflict or inconsistency. Clearly, that is important and, clearly, it is drafted on the understanding that conflicts or inconsistencies may be present. Some practitioners will grapple with this issue. For the avoidance of any doubt and for further clarity, can the Premier put on the record examples of the sorts of conflicts and inconsistencies that have already been determined between this legislation and those two other acts and, therefore, highlight to people the things from which they will be protected by this clause?

**Mr M. McGOWAN:** This clause provides that if there is a conflict or inconsistency between this legislation and the other acts, this legislation will prevail to the extent of any conflict. The Medicines and Poisons Act applies to poisons, including a voluntary assisted dying substance, and regulates and controls the manufacture and supply of medicines and poisons. It also contains offences related to the manufacture, supply, prescription and possession of schedule 4 and schedule 8 poisons, and poisons more generally. For example, there are provisions relating to unlawfully obtaining poison by wholesale; fraudulent behaviour to obtain supply of poison; storage, handling, transport and disposal of poisons; and record keeping and reporting. The voluntary assisted dying legislation will prevail over the Medicines and Poisons Act in the event of a conflict or inconsistency. The Misuse of Drugs Act applies to schedule 8 poisons and some schedule 4 poisons and also contains offences relating to the manufacture, sale, supply or possession of prohibited drugs and drug paraphernalia. The voluntary assisted dying legislation will prevail. I think this is to ensure—maybe I will be corrected—that there is not a provision under those other acts...
that prevents this legislation from operating. Obviously, under the voluntary assisted dying legislation there will be substances that people will need to consume, as awful as that is, in order to access voluntary assisted dying. If there is an inconsistency, this legislation will prevail in order to allow the intent of the legislation to operate.

Mr P.A. KATSAMANIS: I take it from the last part of that answer that this clause is really about covering off in case, at some point in time, there is a question about the processes undertaken in the compounding, sourcing and supply of the poisonous substance. It is in case the multiple operations of the provisions come up with a conflict or inconsistency rather than having identified a specific conflict or inconsistency between those two acts and this legislation. In the ordinary course of events, I imagine that a practitioner, be it a medical practitioner or a pharmacist, would not be in contravention of either the Medicines and Poisons Act or the Misuse of Drugs Act if they were following the provisions of this legislation.

Mr M. McGOWAN: My understanding is that there are consequential clauses further on in the bill, which will be dealt with later, that narrow the scope of who can prescribe the schedule 8 poisons for the purposes of voluntary assisted dying. In effect, this clause is saying that this bill narrows the way in which those substances will be prescribed, supplied and used, and that if there is a difference between this legislation and the other acts, what that might be for. When it is for therapeutic purposes, this legislation will prevail.

Mr P.A. KATSAMANIS: That last answer is very helpful because it tends to indicate that this legislation will provide a narrower regime for these particular drugs than may otherwise be deemed through those other acts. Was any consideration given to the necessity to make direct amendments to those acts in drafting this bill, or was it considered better to simply put in this clause and deal with it that way rather than directly amend those acts?

Mr M. McGOWAN: As I understand it, the member is correct. Further amendments in part 11 of the bill amend those acts in the way the member is suggesting.

Clause put and passed.

Clause 14: When person can access voluntary assisted dying —

The ACTING SPEAKER (Ms S.E. Winton): Thank you, Premier. You were a great bench man.

Dr D.J. HONEY: I congratulate the Premier on the speedy progress of the clauses.

Mr R.H. Cook: Member for Cottesloe, we will be having words later.

Dr D.J. HONEY: Clearly, the elder statesman of the house.

The ACTING SPEAKER: Member for Cottesloe, I am hoping to get some more clauses done while I am in the chair.

Dr D.J. HONEY: As has happened before, I am not sure whether this is the correct spot to discuss this. I am happy to have the minister’s guidance, but I thought this would be a chance to debate this point so we can perhaps avoid debating it earlier—later on, I should say. We could go back to the future! Clause 14(a) states —

the person has made a first request; …

I am interested in the form of that request. Obviously, there are overt requests when someone articulates that they wish to do this and engage the doctor as a coordinating practitioner. Some may not be able to speak, but they are able to write, so they write down that request. It is quite clear, and the legislation goes through all the other checks in that process. I wonder whether a scenario that has been put to me would also constitute a request. Imagine a mother has previously told her daughter, “When I get to this point, I no longer wish to live. I wish to end my life.” Then the mother gets to the point at which she cannot communicate—she cannot talk and she cannot write—so the daughter articulates the request. The practitioner, who may be the coordinating practitioner, says to the mother, who can hear perfectly well, “Your daughter has indicated this. Is this your request?” The mother nods or makes the daughter articulate the request. The practitioner, who may be the coordinating practitioner, says to the mother, “When I get to this point, I no longer wish to live. I wish to end my life.”

Mr R.H. COOK: The member is right; it is dealt with in detail later in the bill in clause 17. The request must be clear and unambiguous. The first request is verbal, not written, but it could be communicated by a gesture. The member outlined a scenario in which the daughter says that mum wants this, the doctor turns to mum and asks her whether it is something she wants, and mum says yes with a wave of her hand or whatever. I do not think a medical practitioner would say that scenario was clear and unambiguous. The principle here is that the request must be clear and it must come from the person. We do contemplate a situation in which someone cannot speak; the doctor in that scenario would have to have a very direct exchange with the mother. It could not be augmented, if you like, by the daughter beginning the process and mum just waving her hand to say she is going along with this. Under clause 17(2)(a), the request must be “clear and unambiguous”. It is an important step; obviously, the medical practitioner would want to satisfy themselves absolutely that it is not just someone going along for the ride.

Dr D.J. HONEY: It is clear in the minister’s mind that the request has to come directly from that person. Thank you, minister.

Mrs L.M. HARVEY: I seek clarification that a person needs to meet all the criteria to access voluntary assisted dying.
Mr R.H. COOK: Yes, member.

Mrs L.M. HARVEY: I draw the minister’s attention to clause 14(c) —

the person has made a written declaration; …

I seek a bit of information around that paragraph. Obviously, some people are incapacitated—they might have paralysis or whatever it might be—and would not be able to make a written declaration. This might also be problematic for individuals who cannot speak. Can the minister cover off on how those circumstances can be managed to satisfy the criteria for a written declaration? If the person’s language is other than English, can the written declaration be made in Italian, Greek, Arabic or whatever language it might be or does it need to be a written declaration in English?

Mr R.H. COOK: I am advised that in the event that someone makes a written declaration, protocols will already be in place about the way that that person communicates. It might be by way of iPad or something like that. They would obviously be at the end of a long journey and there would be clear protocols with their clinician about the way that they communicate their wishes, so it would take advantage of that. Division 5 of part 3 deals with how someone can make a declaration. Legally, a person can make a written declaration without putting pen to paper. It provides avenues and ways that that can be undertaken.

On the question of the language, the role of the interpreter is made clear in clause 41(6), so we can come to that in due course—hopefully sooner rather than later. The Department of Health stands by the language services policy, including using a language other than English. Yes, it would be okay for that person to make a declaration in a language other than English, but clearly the medical practitioner would need to be satisfied that they have an appropriate translation of it.

Mrs L.M. HARVEY: Drawing on my experience as a former Minister for Police, we started to tape in various different Indigenous languages the information that people need to receive when they come into the custody of police so that individuals understand exactly what is going on. Could an illiterate person who wants to access voluntary assisted dying have a voice-to-text arrangement or a recording of their wishes? Would that be acceptable in lieu of a written declaration for somebody who is illiterate?

Mr R.H. COOK: Ultimately, there has to be transcription, and there are ways that someone can transcribe what the other person has verbally communicated and then make a written declaration in that instance. The member raised the issue of the language barriers in Aboriginal communities. I think she is absolutely right to raise that as an issue. I know the Attorney General has been working on its interaction with the justice system. We are looking at a range of ways that we can engage people from an appropriate cultural background to translate not so much for VAD, because that will come with the implementation, but certainly around palliative care.

Mr Z.R.F. KIRKUP: Clause 14(b) refers to the coordinating practitioner and the consulting practitioner. I note and entirely accept the definitions of both those terms. I think this has come up a number of times and certainly the Australian Medical Association has stated its position on the level of commerciality that might exist between the coordinating practitioner and the consulting practitioner. I note that there is nothing in the requirements for people to access voluntary assisted dying to stop the level of commerciality that might exist between the coordinating practitioner and the consulting practitioner. Can I get some understanding from the minister about whether the ministerial expert panel or the minister looked at that? If my reading of the legislation is correct and there is an allowable level of commerciality—that is, two practitioners from the same practice—why was that included and not specifically ruled out?

Mr R.H. COOK: As I stated in my response to the second reading debate, the issue around commerciality is not considered to be a material risk. I think in the Netherlands, where this is much more prominent, it is around four per cent and the experience in Oregon is that it is around 0.4 per cent. We are really looking at a very small cohort of patients. Ultimately, there would be slim pickings if someone decided this was going to be their core business.

Mr Z.R.F. KIRKUP: I appreciate that. The sheer volume of people who will access voluntary assisted dying, by design of the legislation, is obviously meant to be a very small number. That is the intent with which everyone has approached this. This is just my own concern. I still have a level of reservation about the ability of someone to set up a dedicated clinic in the sense that there could be a deliberately designed facility at which people might access a coordinating practitioner, witnesses and a consulting practitioner without there being an existing relationship with their own practitioner. I would be quite concerned about a dedicated facility such as that. That is probably not the intent of the legislation. I think the intent of the legislation is to ensure that there is a deliberate and good faith interaction between patients and practitioners. If a commercial arrangement such as that were set up, I would feel quite uncomfortable about it, and I suspect most people in this chamber would feel uncomfortable about it. Although I realise the market force might not be there, some people—practitioners in particular—might be quite intent on establishing a clinic such as that. I appreciate that there is a two-year review, but is there any mechanism by which the CEO, the minister or the board might be able to get involved and stop that from occurring? I genuinely think that is a real and present concern.

Extracted from finalised Hansard
Mr R.H. COOK: The member is absolutely right to identify those mechanisms. The board obviously would take a view on it. The board would refer that to the CEO, who is responsible for the management of it. Ultimately, the member is right; after some experience, we might want to put some sanctions around these things, but, as I said, it is not considered a material risk and can be managed within the administration of the legislation. As the member knows, the coordinating and consulting practitioners must make declarations. They are very solemn declarations that they, regardless of their corporate entity, are personally responsible for. We all know that most doctors in Western Australia went to school with each other—it is a small community—but they have to come to an independent view about the eligibility of the patient.

Mr Z.R.F. KIRKUP: Noting that the practitioners have to come to an independent view, would the minister believe that a clinic set up for the sole purpose of providing access to voluntary assisted dying would be in breach of the level of independence required by the two practitioners?

Mr R.H. COOK: Not necessarily. Again, the consulting practitioner cannot look at the work that the coordinating practitioner has done and say, “Oh, yes, that looks about right.” They have to come to their own independent view on that. Again, as the member knows, medical practitioners specialise from time to time and maybe that would increase the quality of the work they do under that. We are talking about such a small cohort that I do not think there is material risk in how the process might work in that context.

Mr Z.R.F. KIRKUP: I appreciate that, minister. I might just leave it on this point: obviously, this is something that we should be aware of. I appreciate that the minister will likely have custody of this, at least during the implementation phase, so there is the possibility for the department and the minister to be aware of the issue. I note that the AMA provided information that reveals 82 per cent of doctors surveyed said that they believed a commercial contract should not exist between two practitioners. All of us are aware of that issue. It is difficult to specifically state how that could be prohibited because, of course, it would be very easy for a commercial relationship to exist between two subcontracting clinicians operating within the same facility, which occurs now in our hospitals. I appreciate that it will be very difficult to adhere to that and to legislate accordingly. However, I would appreciate the minister making an undertaking about that. The clinical expert panel also would have been aware of that as part of the implementation.

I put to the minister one challenge I see in the situation he described. If a clinic is set up in which Dr Smith and Dr Johnson, for example, are the practitioners and all patients go to Dr Smith first, then Dr Johnson will know that his role is to receive all patients from Dr Smith. It will be assumed, for example, that patients will have gone through the appropriate process of appointing a coordinating practitioner. Dr Johnson’s role will be as consulting practitioner and although the relationship, or the commerciality, is not explicit, each of them will understand the role that the other plays. My best read of the legislation is that it is possible that a consulting practitioner will have a conversation with the patient about who their coordinating practitioner is. There is nothing that will rule that out. Any practitioner could assume, for example, that if a patient has gone to a coordinating practitioner—that is, Mr Smith—their role is as consulting practitioner. I appreciate that they will have to follow the provisions of the act and that these mechanisms will be in place. I just think we should be aware of that. I would appreciate some assurance from the minister that that is something we would be alive to and would be looked at as part of the implementation of the bill.

Mr R.H. COOK: The member is right. It is an issue that the board would be alive to. Obviously, it will be informed about every step of the process for every person who goes through this process. The board would very quickly pick up on what is going on and the CEO would investigate it.

Ms M.M. QUIRK: I have two questions. The first is: the minister reiterated that doctors must be independent from one another; I am not sure that I can find that in the legislation.

Mr R.H. COOK: Member, there is no express reference in the bill to the first and second assessments being independent; however, it is implicit. First, each coordinating consulting practitioner must assess whether a patient is eligible for access to voluntary assisted dying, which is contained in clauses 23 and 34. Second, the second assessment cannot take place until the patient has been assessed and is eligible for access to voluntary assisted dying by the coordinating practitioner and a referral is made to the consulting practitioner, which is contained in clause 29. Thirdly, a patient cannot be assessed as eligible for access to voluntary assisted dying by a coordinating or consulting practitioner unless the practitioner is satisfied that the patient meets all the eligibility criteria and understands the information required to be given to them, which is contained in clauses 27 and 39.

Ms M.M. QUIRK: Why is it “explicit”? It says “explicit” in the explanatory memorandum, but, ironically enough, it does not say that in the legislation.

Mr R.H. COOK: The explanatory memorandum reflects the intent and interpretation of the bill.

Ms M.M. QUIRK: The explanatory memorandum is a secondary aid when the legislation is ambiguous. It seems to me that it would have been more satisfactory to have put it in the legislation, but I know it was prepared in haste.
The second matter I want to talk about is clause 14(b), which refers to persons being assessed as eligible for access. I presume that is in the following clause, which is about the eligibility criteria. In particular I ask: will that assessment be subjective and will subjective factors be taken into account in relation to the person making the request, as opposed to an objective assessment?

Mr M. McGOWAN: The criteria and how they will be assessed are contained within clause 15.

Clause put and passed.

Clause 15: Eligibility criteria —

Dr D.J. HONEY: I would like to understand the thinking behind the age that has been chosen in this clause. I am particularly concerned about this age. I am sure other members will want to comment on this. One issue that affects a person when making such a decision is their experience of life. When I was 18 years old, I was quite fatalistic. As I recounted to another member, I grew up in the bush. I used to have a little Mini and I used to drive that car as fast as it would go on the gravel roads, oblivious of the concerns of the world, and it was only due to God’s good grace that I am here now. My concern is that someone at the age of 18 years may be predisposed to make a decision, for example, to end their life but not understand the decision they are making and what they are giving up. I appreciate this is in the context of an estimate of imminence of death, but we have heard a number of times that, although there will be some reasonable accuracy, there are many examples in which it is highly inaccurate. Was an older age considered? Why was this age chosen?

Mr M. McGOWAN: The age of 18 years is obviously the age of adulthood in our society, and has been for decades. At age 18 a person is eligible to go to war, which is the often-used example. A person can join the Army or other service and potentially go to war for the country, which has significant risk attached to it. The 18-year-old criteria was a recommendation of the joint select committee and the ministerial expert panel. It is contained within the Victorian legislation and is consistent with what occurs overseas. There was no other consideration of any other age.

Mr D.T. REDMAN: I want to ask a question which is further to a question I asked earlier. I refer to clause 15(1)(c), which states —

the person is diagnosed with at least 1 disease, illness or medical condition that —

(iii) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

When we debated the definitions clause, I sought the minister’s advice on whether he would consider including in the definitions a definition of “suffering”. The simplistic one-dimensional approach to suffering simply says it is a physical suffering—it is pain—and everyone understands that. But the definition of suffering that the minister put to me was the full breadth of suffering, including mental suffering, spiritual suffering and emotional suffering. There is a whole range of suffering. I have the view that the full breadth of suffering in a very personal and subjective sense should be explicit in the bill. I seek clarification about where in the bill the word suffering is treated in the full context of suffering and not limited to physical suffering, which is perhaps the one-dimensional thinking that the broader community understands it to be.

Mr M. McGOWAN: I thank the member for the question. Whether a disease, illness or medical condition causes suffering to a patient that cannot be relieved in a manner that the patient considers tolerable, is a subjective element to be determined by the patient. This is consistent with the person-centred approach of the bill to voluntary assisted dying. Both the joint select committee and the ministerial expert panel formed the view that a patient’s suffering was an intensely personal experience and may take a variety of forms, such as physical, mental, emotional, social, spiritual or existential, or, probably a mix of all, to be frank. It is up to the individual to determine the level or standard of suffering and how much they can withstand. It really is up to the individual to make that decision. I suspect in most, if not all, cases, the person in question will have gone through considerable suffering over an extensive time prior to making the decision to access voluntary assisted dying. Even then, it would be a decision they would make after some further consideration. By necessity, a person’s pain and suffering is subjective and the decision is on their advice. I do not know whether it is physically possible to determine it objectively.

Mr D.T. REDMAN: The concern for me is not one of trying to constrain the bill. In this regard, it is to strengthen the full breadth of it. Nothing that I read in here gives us guidance that explicitly says that suffering is considered in the full context. I am concerned that it is an eligibility criteria for access to voluntary assisted dying. A practitioner could hold a view that physical pain is easy to define—if someone is groaning in agony, it is not difficult to understand what is occurring. If it is emotional or indeed spiritual pain, it is a very different beast. A practising practitioner will have been through training and whatever else in order to take on those particular roles. A person could present to them with spiritual suffering, and that might be something deep in their spiritual beliefs causing them significant concern. I understand it is a subjective issue, but I would be very concerned if that practitioner chose not to put the person into the eligible category because they defined suffering in a narrow sense, and therefore the person was not able to access the opportunities that this bill provides. I recognise there is a long way

Extracted from finalised Hansard
to get to that point, such as having an advanced progressive illness that will cause death in six or 12 months. I recognise that, but it concerns me that the last hurdle is a doctor or practitioner making judgement, and because it is an eligibility criteria, if it does not meet that threshold, they are not in the game. We need to be explicit about the breadth of that. I think a practitioner should be given a bit more scope and direction in the assessment of someone meeting a threshold of suffering, in the full breadth of that sense.

Mr M. McGOWAN: I agree with the member and that is why the explanatory memorandum is very clear that it is a subjective decision based on the patient’s consideration of their suffering. If the member has a look at clause 15(c)(iii), it is qualified by the words “that the person considers tolerable”. In effect, that explains that it is a subjective test by the person.

Mr D.T. REDMAN: Just for a little guidance, the Premier referenced the explanatory memorandum. If these matters come up as a challenge, in a legal sense, is the explanatory memorandum relevant in giving clarity to legislative intent?

Mr M. McGOWAN: My recollection of statutory interpretation is somewhat rusty, but under the Interpretation Act, the explanatory memorandum is used by courts in determining what the bill means.

Dr M.D. NAHAN: This a very important area and I think there is a lack of clarity in the community. I might ask some questions, and the purpose is to explore this a bit on behalf of the public. Under clause 15(1)(c), I accept paragraphs (i) and (ii). The issue I want to explore and get a response from the Premier about is building on the discussion he just had with the member for Warren–Blackwood. I want to clarify that pain has many dimensions. Indeed the evidence overseas, particularly in Canada, is that the majority of people taking up VAD are not necessarily suffering physical pain, but have what they call “existential trauma”. They get a death notice and they respond to it. There might be an amalgam of dimensions of pain, I am not arguing that, but the perception out there is that this act will be restricted to people who have a terminal illness, as defined in the bill within a certain period, and when palliative care is not working any longer or is not working to address the pain the VAD will overwhelmingly be used in that restrictive sense. That might be the case. As I think the minister made particularly clear, the desire to live is profound. I expect that to be the overwhelming case. However, people have asked me whether it will be restricted to people with just physical pain, and I want to get clarification for people who meet the criteria otherwise. For those who simply do not want to avoid the imminent painful death that has been the prognosis, will they be able to act pre-emptively on the basis of existential pain?

Mr M. McGOWAN: As I think I indicated before, suffering does not necessarily mean physical pain, when someone is writhing in agony; it can be other forms of pain as well. As I said before, I outlined a range of suffering, including physical, mental, emotional, social, spiritual or existential, or a combination of all of them. Some people do not want to go through palliative care. They might have seen it, they might have a religious objection, they might have a conscientious objection to taking drugs or something of that nature. It is all qualified under section 15(1)(c)(iii), which states —

is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

The person makes the decision based on their own circumstances.

Dr M.D. NAHAN: I am not an expert in this, but the restrictions are, “cause death within a period of six months”. My experience is that doctors usually give people an expectation and a range. How is that six months determined? Let us say a doctor gives someone a prognosis of six to 12 months? Does that fit? The doctor does not necessarily give a median or a mean, or a single quote, because there is a lot of uncertainty in it. What is the cut off?

Mr M. McGOWAN: It is six months or less, except in the circumstances of a neurodegenerative illness.

Dr D.J. HONEY: This is obviously a key clause of the bill, because it is trying to define that this will only be enacted given the imminence of death. My concern is around the impreciseness of that. I bothered to look at the scientific literature on this and some review papers. Having read those papers, I understand why it uses the phrase “balance of probability”, because if doctors are estimating the period that someone is likely to live, that is the estimate that is most often accurate. If a doctor is asked how long someone will live, typically those estimates are quite inaccurate. But if a doctor is asked about the probability of a person living for six months, 12 months or two years, those estimates are much more accurate. However, as the Premier is well aware, our job in this place is to look at where this could go wrong. What really concerns me is that we heard from a relatively small group of people about a number of loved ones whose life estimates were not just a little bit inaccurate—they were wildly inaccurate. The member for Midland told us the harrowing story of Batong Pham, who was given a life estimate of days or hours, but, in fact, he completely recovered and has gone on to live a long and fulfilling life. He was unconscious so he would not have been able to access voluntary assisted dying, but his friends, relatives and loved ones were told that he was completely brain dead. I am recounting the member for Midland’s story because I am not personally aware of it. However, after the suggestion of an ex-member of Parliament, whom many members here know very well, there was a change to his medication and he regained consciousness quite rapidly. Nevertheless, his relatives were told that he should be taken off life support and be allowed to die. He recovered and is living a long, happy and productive life.

Extracted from finalised Hansard
The member for Carine gave us a similar example in which someone was told that they had only months to live but they went on to live for another 17 years. The member for Scarborough gave an extremely moving contribution about the circumstances of her husband, Hal. I will not go through that. My concern is that although we are talking about the balance of probabilities, it is imprecise. I appreciate that this bill will go through this place. What guidance will be given to this provision? What efforts will be made to improve it? These are hard lines in the sand, if you like. The bill refers to the balance of probabilities. The example given by the member for Riverton was of someone being given a balance of six or 12 months and the Premier answered appropriately that in the bill, it is six months and 12 months. My great concern is that someone will terminate their life based on that life estimate even though the estimate could be fundamentally wrong. People may want to end their life because the imminence of death is so disturbing and distressing. I would appreciate understanding how this will be improved. What guidance will be given to practitioners to make sure that we are not simply relying on their native talent?

**Mr M. McGOWAN:** Just to be clear, if a practitioner is unsure, clauses 25 and 36 provide that they must refer the patient for further advice. That is a safeguard. With the example of a person on a life support machine, so that members are aware, an individual on life support would not be able to access voluntary assisted dying. However, as we all know, life support machines are turned off every day by family members in conjunction with medical professionals. It is probably happening in our hospitals right now as we speak. Individuals in those circumstances will not be able to access voluntary assisted dying. The member referred to a miraculous recovery. That person would not have been eligible for voluntary assisted dying.

In relation to the balance of probabilities, a medical practitioner will be required to make a clinical judgement that a disease, illness or medical condition will cause death within six months or 12 months if the condition is neurodegenerative. Only medically qualified professionals will be able to make that determination. The probabilities test will be used as agreed to by the Ministerial Expert Panel on Voluntary Assisted Dying in discussions with the department. The test is easily understood and has case law to support it. When considering whether a disease, illness or medical condition is expected to cause death within six months or 12 months if the condition is neurodegenerative, the medical practitioner will have regard for the treatment decisions made by the patient. This includes a situation in which the patient chooses not to undergo or continue treatment that may prolong their life. For example, if a person has advanced and progressive cancer that will cause their death but they refuse life-prolonging or other measures, the result of that decision is reduced life expectancy. Their time of death may be six months instead of 18 months with treatment. This person will still be able to access voluntary assisted dying as long as they meet the eligibility criteria. In any event, their disease, illness or medical condition is still terminal and they should not be restricted because they choose not to partake in treatment options that they find unacceptable. Patients should not be forced into treatment options to buy time. The bill sets out a robust assessment process that ensures that an accurate assessment will be made of a person’s disease, illness or medical condition. Only qualified and suitably experienced medical practitioners may assess a patient’s eligibility. Independent assessments must be conducted by two medical practitioners, who must each be separately satisfied that the patient meets all the eligibility criteria. Both medical practitioners will be able to refer any part of the assessment to a suitably qualified professional with specialised skills or training if they are unsure.

People refuse medication every day. In fact, I am familiar with someone who is presently in the position of not wanting medication. That is their choice. Some people think medication will make their situation worse. Some people have seen family members go through chemotherapy and decide that they do not want to go through it themselves and choose to live for a few months without chemotherapy than live a few extra months because of chemotherapy. That is a valid choice that people make every day.

**Dr D.J. HONEY:** Thanks, Premier. I am aware that a person whose situation is similar to that of the person in the first example will not be able to access voluntary assisted dying. I referred to it more as an example of the ability of doctors to estimate life expectancy, not as an example of a person in that situation having access to voluntary assisted dying. I appreciate the Premier’s comments.

I come back to the accuracy of the estimate and coordinating and assessing practitioners. My understanding is that there is no requirement in this bill for either of the two practitioners to have any expertise whatsoever in the terminal condition from which the patient is suffering. I have heard this concern expressed by medical practitioners. A general practitioner may have a high level of confidence that they know—this is not uncommon with some general practitioners—but specialists in the area will have a far greater understanding of the illness and the probability of when that person may succumb to their illness. Is it correct that neither of the two medical practitioners will be required to have any specialist knowledge of the disease that will kill a person?

**Mr M. McGOWAN:** There is a requirement that the practitioners have at least 10 years’ experience in the profession, and if the practitioner has any doubt, they are required under the act to refer to a further practitioner for that patient. In practice, the patient will have an illness, disease or medical condition that is advanced, progressive, and will cause their death, and in the vast majority of cases will have had consultation with a specialist and have been informed about treatment options. In all cases, an assessing medical practitioner will need to be satisfied that the
Diagnosis meets the eligibility criteria. Where available, the assessing medical practitioners would utilise results and reports from the relevant specialist in making that determination. If there is uncertainty regarding any of the eligibility criteria, then the practitioner is required to refer for further assessment, thereby linking the patient with a specialist in their disease who would inform the patient about treatment options. In addition, the bill would require assessing medical practitioners to provide the patient with a suite of information, including treatment and palliative care options. It should be noted that an adult patient of sound mind may refuse medical treatment, even if that refusal would lead to their death. The bill does not require the patient to undergo treatment that will prolong their life or might cure them, because to do so would cut across the fundamental principle of patient autonomy. Obviously, if we include a requirement that there needs to be a certain specialist involved, then in Western Australia—the largest state in the world—there are large areas in which people will not be able to access the provisions of this legislation.

Dr D.J. Honey: I think the Premier gets the gist of my concern here. My understanding is that, in fact, the prognosis for the probability of death can be given by two medical practitioners who have no expertise at all in the disease that is going to kill the person. We have “may” and “can”, but there is no requirement for them to seek any specialist advice. I have great respect for medical practitioners. I have a daughter and a brother who are doctors; I have two pending son-in-laws who are doctors. I have a few doctors in my own family, and I regard all of those people very highly. However, we should never look at legislation through the lens of the best possible outcome. That is great, if everything works out well. If everything worked out in the best possible way, I suspect your senior adviser would have had a much less illustrious legal career. Obviously, things do not go right. People do not do things in the best possible way. The member for Dawesville raised the concern about, for example, the setting up of practices that specialise in this area. It may be that two doctors consider themselves experts in everything. It would give me much greater confidence in this bill if there were a requirement that at least one of either the coordinating or the assessing practitioner did have some specialist knowledge. I appreciate the difficulties that may cause in some circumstances; equally, I think it is very important that we do not have a situation of misdiagnosis that adds to the distress of an individual. In fact, that could be the distress that causes a patient to take their life much earlier than would have been the case if they had not had been so diagnosed. Certainly, we were given examples of patients who may have missed out on years of their life if they had been able to access voluntary assisted dying. I am not sure what answer the Premier can give me on this, but I express this view strongly: I believe that at least one of the practitioners should have some expertise in the particular disease. We should not rely on the fact that a general practitioner is an expert in everything.

Mr M. McGowan: As the member knows, the requirement is that there are two practitioners—the coordinating and consulting practitioner—both of whom are required to have at least 10 years’ practical experience. The requirement by law is that if either of them is of the view that they are unable to make an assessment of eligibility—that is, the six months rule—then they are required to refer. That is mandatory. If there is any lack of clarity, or if they are unsure, they are required to refer. I have a lot of faith in doctors. I think that two doctors with 10 years’ experience each who would in all likelihood have a range of medical reports before them would be able to make that assessment quite clearly, but if there were any doubt, then they would be required to refer.

Mr J.E. McGrath: I need to make a comment about this. I could not imagine in any circumstance that if I went to my local general practitioner or any GP and said, “I have been given six months to live, I’ve got cancer”, the GP would say, “Okay, you’ve got six months, fair enough”, and then just write it down. He or she will want some evidence about who the patient has been going to, whether they have been on chemotherapy, and what is their specialist’s name. We have My Health Record information now. They are not going to just tick it off without making some investigation into the patient’s medical background and the treatment that they have been under. I understand the member for Cottesloe’s concern about this, but I have a lot of faith in GPs and the medical system. I would not think that any self-respecting GP would just tick off on something like that. If I went to my GP with something like a skin complaint, in the old days, he would just burn it off or put something on it. Now, he would send me to a specialist. They do not take any chances, because they are worried about litigation. I think this process will be well run, and I think the GPs will make sure that a person cannot just knock on the door and say, “The specialist guy down the road has given me six months to live, I want to end it all.” It is going to be a bigger process than that, and that is why I am supporting it.

Ms M.M. Quirk: Clause 15 is titled, “Eligibility criteria”. I note that clause 15(1)(a) states that the person must have reached 18 years of age. The question of language and how it is used has been an issue throughout this debate. I note that, for example, in clause 15(1)(a), “the person has reached 18 years of age” comes under the heading of “Eligibility criteria”; however, it is also described under the 102 listed safeguards. I would like some clarification: is it an eligibility criteria or is it a safeguard?

Mr M. McGowan: I would say it is both. It is a criteria—obviously, the person must be at least 18 years of age—and it is a safeguard that we do not have people under that age accessing voluntary assisted dying.

Ms M.M. Quirk: The second issue that I want to raise is something that I foreshadowed when we were debating the last clause. I refer to clause 15(1)(c)(iii), which states that the medical condition “is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.” We have heard that that is a subjective test; it is a person-centred test. We look at the individual making the request to make the assessment. This is an

Extracted from finalised Hansard
issue that I raised at the consultation forum at Fiona Stanley Hospital. The circumstances of the individual making the request will be looked at. If someone is indigent, does not have many family members or other social networks, has a history of drug or alcohol addiction, or possibly has a disability, it could be said that they do not have much to live for. The response we got at that forum from Dr Towler was that a person in those circumstances would more likely be assessed as being an appropriate person than someone who had family supports or the personal resilience to persist. In those cases, it seems to me that a subjective test may well be creating a situation in which the vulnerable are vulnerable.

Mr M. McGOWAN: As I said earlier about suffering, it is a subjective test of what the individual involved can tolerate. That is contained within the clause. It will be up to the individual to determine what amount of suffering they can withstand. I think individual circumstances will be different depending upon the individual involved, but that is just one of the many eligibility criteria.

Dr D.J. HONEY: I want to explore two other subclauses, but I will do them sequentially. I refer to clause 15(1)(d), which states —

the person has decision-making capacity in relation to voluntary assisted dying;

Does the Premier have any details of how that decision-making capacity will be confirmed? I hear that there will be a process. My understanding is that the Victorian legislation requires a psychiatric report to make sure that it is in fact an informed decision that is not impacted by any psychiatric or mental condition and the person has the capacity to make an informed decision. There are two parts to it: How will this process ensure that the decision-making capacity is assessed properly? Why is there not a requirement to have a separate psychiatric assessment to test this? This goes to the heart of whether the person has the capacity to make an informed decision.

Mr M. McGOWAN: I think clause 6, which deals with decision-making capacity, may have been dealt with at length earlier. It may have been dealt with last night or the night before. The minister outlined all the criteria for a patient having decision-making capacity. That is where the definition of a decision-making capacity used in this clause is contained.

Dr D.J. HONEY: I appreciate that, Premier. I have not had any understanding of why we do not require a separate psychiatric assessment. I do not believe that was clearly answered before.

Mr M. McGOWAN: The advice I have is that a psychiatric report is not mandatory in Victoria. It is required only when there is doubt about the person’s capacity to make a decision. The conditions about the requirement for a psychiatric referral is contained in clause 25.

Dr D.J. HONEY: I have a question on clause 15(1)(e). We covered this a little bit before. I am not going to go into a detailed description of the issue of coercion. My question is more about the nature of the training in coercion. What can we expect to see in that? Any of the lawyers who are in the chamber who have been involved in this area of law would know that that is an extraordinarily complex and subtle matter. I appreciate that the regulations and the details have to be worked out, but can the Premier give any outline of the sort of training that medical practitioners will have to enable coercion to be detected, particularly as there is no requirement whatsoever for the medical practitioner to know the patient at all?

Mr M. McGOWAN: There is already training for doctors about coercion because people make healthcare decisions all the time. Indeed, someone might make a decision not to have food or water in their last stages. That is exactly the same situation. General practitioners already refer people for further assessment if there is any concern about coercion. Just to be clear, when the consulting practitioner cannot determine whether the patient is acting voluntarily and without coercion, they must refer the patient to a person with the appropriate skills and training to make that determination. This may include experienced registered health practitioners; healthcare workers, including social workers; or police officers with skills and training to determine whether a person is acting voluntarily and without coercion. They may also refer the matter to existing authorities, such as the Western Australia Police Force, if they believe a person is being coerced to undergo voluntary assisted dying. The bill makes it a crime to unduly influence a patient in such a manner. As I said, people currently refuse food and water or treatment and, ultimately, it has the same outcome. It is just much slower and far more painful. Doctors have to deal with those situations as well.

Mr Z.R.F. KIRKUP: I have not gone through any of the eligibility criteria questions that I have. I am conscious that some members may have had similar questions. If I can, I will cover off a few clarifications very quickly. The minimum age of 18 years is stated in the legislation. Is there a minimum age for people to initiate access to voluntary assisted dying? I realise that they cannot make a final decision or access it until age 18, but is there a minimum age for the first request?

Mr M. McGOWAN: People cannot make the first request until they are 18 years old. I imagine that individuals of that age will be rare, but they would probably have gone through considerable suffering up to that point.

Mr Z.R.F. KIRKUP: Obviously, that means that a parent or guardian cannot act on their behalf to do that before that time.

Mr M. McGowan: No.

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: Under clause 15(1)(b), the person must be an Australian citizen or permanent resident. Is that the normal definition of permanent residency status as conferred by the commonwealth?

Mr M. McGOWAN: Yes, it is the definition of permanent resident under the commonwealth Migration Act and the definition of citizen under the Australian Citizenship Act.

Mr Z.R.F. KIRKUP: Is there a way that a practitioner might try to establish the ordinary resident time—so, the time for which a resident has been an ordinary resident of Western Australia? They would obviously try to backdate that by 12 months in some way, shape or form. Does the Premier’s advice indicate how that might be achieved in a practical manner?

Mr M. McGOWAN: The applicant, or patient, would need to provide evidence—any of the normal things such as a lease document or driver’s licence—to show that they have been a permanent resident in the state for a certain period.

Mr Z.R.F. KIRKUP: I am conscious that perhaps in a remote or regional Aboriginal community, those types of arrangements might not be in place, which is possible in some communities that might not have access to driver’s licensing, for example, or a trust might pay their bills for them. Is a statutory declaration or anything like that suitable in that case?

Mr M. McGOWAN: That might be one aspect of evidence to allow for that. I would expect that in those circumstances, the individuals would most probably have lived in the state for their entire life.

Ms M.M. QUIRK: I return to the assessment process and the eligibility criteria under clause 15(1)(c)(iii), which states—

is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

We are all in fierce agreement that the test that is applied there is subjective and relates to the individual. However, I am not sure I got a comprehensive response to my concern about how we protect those who have few supports, maybe a history of mental health or depression and little or no family from being considered a more suitable candidate than someone who has the capacity to have a greater level of resilience. The reason for asking this is that those kinds of people might be either subjected to coercion or simply assessed as having a greater degree of existential suffering.

Mr M. McGOWAN: We are trying to make sure that the legislation is available to all people who meet the criteria in Western Australia, whether they are rich or poor or from a regional area or the city. If someone meets the criteria, the legislation allows them to make an application in those circumstances. A range of protections will be in place to ensure that the person is acting voluntarily and is not of unsound mind.

Ms M.M. QUIRK: I suppose this is analogous to substantive quality in the sense that everyone is considered equal but the outcomes are unequal, and so it is with this clause. Because it is person-centred and because it is subjective, we look at the individual circumstances of the person making the request. Those who have less going for them, if I can use the vernacular, are more likely to be assessed as suitable. How do we ensure that the outcomes are suitable in all the circumstances?

Mr M. McGOWAN: If the practitioner is uncertain that the person is acting voluntarily or if there is concern that the person does not have decision-making capacity, there is a requirement to refer them for further assessment if they apply to access it. As I said, we want to make sure that it is available broadly to people across Western Australia who are in their last six months of life and who are undergoing intolerable suffering. We want to make sure that it is available not just to people of means, but to other Western Australians as well.

Ms M.M. QUIRK: Before I ask the Premier another question, I am grateful that the Minister for Community Services has pointed out that I might have said something I did not mean to say. I might have used the vernacular when describing vernacular, so for the purposes of Hansard, please expunge the vernacular immediately. Luckily there were no children in the public gallery at the time.

Clause 15(1)(c)(i) states that the disease, illness or medical condition needs to be “advanced, progressive and will cause death”. The equivalent Victorian legislation also contains the requirement that it be incurable. What consideration was undertaken of the wording for this clause and why is “incurable” not included?

Mr M. McGOWAN: The Victorian act requires that in addition to the other diagnosis criteria, the patient must be diagnosed with a disease, illness or medical condition that is incurable. That criteria has not been included in the Western Australian bill for two reasons. Firstly, the Western Australian bill already requires that the person have a disease, illness or medical condition that is advanced and progressive and will cause death within a time frame of six months or 12 months in neurodegenerative conditions. Secondly, it is not appropriate to require a person to exhaust all treatment options which may result in the disease, illness or medical condition being completely cured and through which the person’s quality of life would be significantly compromised or lost. Every person should be able to determine which treatment options they wish to adopt. An adult patient of sound mind may refuse medical treatment even if that refusal may lead to their death. The bill does not require a patient to undergo
Mr Z.R.F. KIRKUP: I refer to the previous conversation we had about a statutory declaration for somebody who might be from an Aboriginal community. I am conscious of the government’s efforts to try, and the minister’s comments in the past about trying, to stop people who might be coming to Western Australia to access this, regardless of their length of stay or residency status. Is any mechanism in place that would stop somebody from travelling from another state or territory and signing a stat dec and going through the process within nine days? Obviously, they would have to be eligible, but a key component of their eligibility is their residency status. I am conscious that we should try to restrict any ability for this to be accessed by somebody simply for tourism, if we want to call it that, or someone who is interloping. A statutory declaration obviously can be flouted. Given that the person might not be bound by the law if they successfully access voluntary assisted dying within the nine days, are there any mechanisms to stop that? Can the Premier point to anything that ensures that there are strict requirements for residency for 12 months, outside of showing a stat dec?

Mr M. McGOWAN: This provision is identical to the Victorian provision. Obviously, if a person falsifies a statutory declaration, that is an offence under law, but if they are in agony and have six months to live, that is probably not their highest concern. The requirement is for a person to show that they are a resident of Western Australia. A number of doctors and medical professionals would examine the individual and they would need to be satisfied of that.

Dr M.D. NAHAN: I want to explore the issue the member for Girrawheen raised. It quite surprised me and I want to get this clear. For example, a person meets all the criteria under the bill except their diagnosis is for a disease that will kill them in six months if they do not do anything, but the expectation that they will live is high if they do something. Let us say, it is a tumour. If the tumour is cut out, the person could live beyond six months. If it is left in, they will die in six months. I accept that. I believe the bill will leave that decision to the patient. The patient would not have to take the action if they did not wish to, even if the action would sustain life, whether or not the action would be debilitating—that is, some actions could destroy the body. I can understand that. Some actions would not be debilitating, such as the excision of a tumour in certain circumstances. I am concerned that this legislation could allow someone to access suicide under these restrictive conditions. I do not think it would be very common. I will not argue that it is; I think people fight for life. If people are given a pathway to live, they will take it. But, sometimes, one or two will be excessive. I think that is why the Victorian legislation has a definition of “incurable”. Could the Premier discuss this?

Mr M. McGOWAN: As I said earlier, it is a principle of patient autonomy for people over the age of 18 that we do not force them to have treatment if they do not wish to, provided that that person is competent. I think we probably all know people who have decided either not to go through with treatment because the treatment might extend their life for a short period but their quality of life would diminish, or to start treatment but find they do not want to keep going with it and stop. The alternative is that we force people and tell them they must go through that treatment or else they cannot access voluntary assisted dying when they have six months or less to live. I do not want us to go down that road. How could we say that to someone? I do not know what I would do in the circumstances, but I suspect I would want to enjoy the time I have left and go and see some of the places around the world that I have not seen but would like to see.

Dr M.D. NAHAN: I think this example will be at best a rarity, but our task is to look at concerns about second-order effects. Let us map out something. A conscious person with decision-making capacity has been given a diagnosis that they have a disease that is likely to kill them within six months. However, there is a chance of a cure if an action is taken that would not have second-order debilitating effects, such as chemotherapy and other treatments, and that would take the person’s life way beyond six months. In other words, the disease is not incurable. There is a pathway in this legislation for someone without a great deal of physical pain—no doubt the pain would be mental—to avoid a cure and access VAD. I do not think many people would take that pathway but we are looking for oddities here. I would say that someone who is confronted by that situation and takes that pathway would have a psychological problem—humanity fights for life—but we do not have the ability to force someone to see a psychiatrist in these extreme positions. Would the Premier agree that there is a pathway for a person who has been given a terminal diagnosis and expects to die within six months, but the disease has a non-debilitating treatment, to choose to not take the treatment and to access VAD?

Mr M. McGOWAN: As the member said, people fight for life.

Dr M.D. Naham: Some do.

Mr M. McGOWAN: An individual in that situation can go out to the back shed and take matters into their own hands if they do not want to live. All I would to say to the member is that people fight for life. This legislation is about ensuring that people who want to can choose not to go through further suffering or painful treatment. As the member said, the treatment might not be chemo or whatever, but it may involve amputation, which the person does
not want to go through, or some sort of surgery that would mean that they could no longer operate their limbs and
do not want to go through that surgery. It is a matter of individual choice for the person in those circumstances.
I think it would be impossible to try to construct a bill that would require people to undertake treatment.

The ACTING SPEAKER: Member for Riverton, is it the same question?
Dr M.D. NAHAN: I want to explore something very quickly.

The ACTING SPEAKER: That would be great.

Dr M.D. NAHAN: I think it is a very important issue, by the way. My point is on access to mental health screening.
We have heard of many instances in which a person gets a death penalty by a diagnosis and they go into shock. It
is very common to get existential trauma. I fully understand that. It often leads to death, by definition. There is
a pathway in the legislation for someone who is traumatised mentally and who has just given up to use VAD. They
perhaps have a curable disease, but if it is not acted upon, it will kill them in six months. They could have mental
impacts and are no doubt suffering—mental disease can cause some of the most terrible pain. I am concerned we
do not have a pathway in this bill to filter out those people because there is no necessity for psychiatric treatment—
or maybe we do.

The ACTING SPEAKER: Shall I take that as a comment, Premier?
Mr M. McGOWAN: Doctors, in conjunction with patients, make decisions every day about these sorts of issues—
whether a patient is going to continue to have treatment and their options. Doctors are trained, as part of their
medical degree, in psychology, mental capacity, psychiatric matters and assessing competence. They currently do
that with patients every day. If there is any doubt about a person’s mental capacity or competency, they are required
to refer them for further assessment.

Ms M.M. QUIRK: I intend to move an amendment on this clause but I have another amendment first. Since we
are on this topic —

The ACTING SPEAKER: Member for Girrawheen, I note that we have had about six questions on the definition
of “incurable”.

Ms M.M. QUIRK: We have had none from me, Madam Acting Speaker.

The ACTING SPEAKER: Two from you.

Ms M.M. QUIRK: I did not get the answer I wanted so let me try again.

As the Premier has pointed out, the word “incurable” is in the Victorian legislation; it is not in the Western Australian
legislation. The reason advanced by the Premier was that it was redundant because we have in our legislation the
phrase, “is advanced, progressive and will cause death”. That phrase also occurs in the Victorian legislation, which
leads me to ask: What sort of discussion or consideration was there on omitting the word “incurable”? Did it come
up in community consultations? I am trying to work out the process by which this word was omitted.

Mr M. McGOWAN: I outlined before why the word “incurable” is not included, which I think is a very reasonable
part of it. As I understand it, there was a range of discussions within government with members of the panel and
the chair of the panel on whether the term “incurable” would continue. The term “incurable”, to some degree, is
very subjective. People might say that there is some treatment available in Korea, Russia or Dubai that might cure
them. It could very well make the entire process very difficult for people who want to access voluntary assisted
dying. As I also said, it could be interpreted as making it a requirement that a person undergo some form of
treatment that they do not wish to undergo. I am familiar with people who have suffered from brain tumours who
did not want to go through an operation that might turn them into a paraplegic. That is their choice. I suspect that
if I were in that situation, I would not want to go through that operation either.

Ms M.M. QUIRK: Given your advice, Madam Acting Speaker, I will wind this up very quickly. Maybe the Premier
could get some advice from his advisers. I wonder whether the term “incurable” is directed towards scenarios such
as those in the Northern Territory in which people were judged to be incurable but it was really a paucity of decent
specialists in the Northern Territory. In fact, there is one fairly infamous case in which the disease that was
diagnosed as incurable was readily curable with no long-term effects. I think that needs to be considered. That is
why it is not really a redundant term. It covers that aspect to make sure that the level of diagnosis is rigorous.

Mr M. McGOWAN: The advice I have is that it has nothing to do with the Northern Territory legislation.

Mrs L.M. HARVEY: Subclause (1)(c)(i) provides that a person has to have a condition that is advanced and
progressive and will cause death. I want to examine the nexus between that provision and subparagraph (iii), which
refers to a medical condition that is causing suffering to the person that cannot be relieved in a manner that the
person considers tolerable. Obviously, people suffering from some diseases could have a prognosis of six months
but not necessarily be symptomatic. A person might have some medical intervention that relieves the symptoms.
They might have a prognosis of six months but they may be suffering emotionally. They might be suffering through
a grieving process. They might be suffering from trying to manage the knowledge of their impending demise with
their family members and friends. Indeed, there may be workplace and other pressures on a person when they are

Extracted from finalised Hansard
diagnosed with a terminal illness: “How do I sell my business before I die? How do I finalise my affairs? What will happen with my mortgage?” All these issues cause intense suffering for an individual when they have a prognosis of a terminal disease. What I am trying to understand, and I think it is important that this place gets on the record, is whether a patient will need to be symptomatic. If a person has a terminal disease but is otherwise well, but a whole bunch of other pressures are feeding into intense emotional suffering, I would not like them to access VAD inappropriately. I completely accept that there are a lot of diseases the suffering from which is not linked to pain and other things. It is more just a matter of understanding that for a person to access voluntary assisted dying, they would need to be symptomatic and not check out too early.

Mr M. McGOWAN: The requirement under the legislation before us is that the suffering must be related to the disease that is going to kill them. That is the requirement and that is what the medical practitioners will need to assess. That is the nexus, if you like. As numerous members have said, people generally want to stay alive. I think it is a matter of common understanding that people would make this decision at such a point that their suffering became intolerable. The advice I have is that it is highly unlikely that people would have less than six months to live and have no symptoms.

Mrs L.M. HARVEY: I disagree with the Premier’s last comment, because people can have less than six months to live and be comfortable and not be symptomatic, but I am very heartened and would like to get on the record that tying the suffering to the disease that has been diagnosed is a very good thing. I am pleased that that intention has been recorded in Hansard.

Dr M.D. NAHAN: I have a brief point on that. Following up on what the Leader of the Opposition said, and to be clear, we have discussed what suffering means and it has many aspects. In the case that the Leader of the Opposition mentioned, once a person gets a diagnosis, they go into psychological trauma. It is not related precisely to the disease; it is just the fact that they have the diagnosis. Is that suffering of the terminal nature? It is not physical pain; it does not emanate physiologically from the disease, but from the fact that they have been given the diagnosis. Is that sufficient suffering to warrant accessing VAD?

Mr M. McGOWAN: Clause 15(1)(c) says —

the person is diagnosed with at least 1 disease, illness or medical condition that — …

(iii) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

There is a direct nexus between the disease and the suffering. As we said before, the suffering can be of different types, but it has to be linked.

Ms M.M. QUIRK: The member for Dawesville referred to the eligibility criterion in relation to residency that is set out in clause 15(1)(b). This bill refers to a person being an Australian citizen or permanent resident, which is crystal clear. Subparagraph (ii) says —

at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;

We could have a situation in which someone who is resident in another state gets a diagnosis and moves to Western Australia. The way to overcome this is to have the wording in the Victorian legislation—“is ordinarily resident in Victoria and was ordinarily resident in Victoria for at least 12 months at the time of making a first request”. Sorry; I thought the Premier was listening.

Mr M. McGowan: I am listening.

Ms M.M. QUIRK: What I am saying, and what the member for Dawesville has said, is: surely this is an opening to people travelling to Western Australia so that they can access the provisions of this legislation. As I said, if we had the wording that is in the Victorian legislation, that would certainly avert that occurring.

Mr M. McGOWAN: What was contained in the Victorian clause was not supported by the Department of Health and the drafters because it did not materially add to the clause, as the clause already contains a requirement for an eligible person to have been ordinarily resident in Western Australia for 12 months. It is also not consistent with the legislative drafting conventions in Western Australia and the common law definitions of “ordinarily resident”.

Ms M.M. QUIRK: I am not going to argue the point. There is quite a clear distinction; the member for Dawesville pointed it out. However, I move —

Page 12, after line 3 — To insert —

(ia) is ordinarily resident in Western Australia; and

That will cover the criteria of those who live in Western Australia who might go away somewhere then come back and after 12 months can make an application. It shuts the loophole.

Debate interrupted, pursuant to standing orders.

Extracted from finalised Hansard
Resumed from an earlier stage of the sitting.

Clause 15: Eligibility criteria —

Debate was interrupted after the amendment moved by Ms M.M. Quirk had been partly considered.

Ms M.M. QUIRK: I will quickly repeat what I said before the break when the minister was not here. I have moved an amendment at page 12, after line 3, to insert —

(a) is ordinarily resident in Western Australia; and

The reason for this amendment is to prevent, if you like, assisted dying tourism. Section 9(1)(b) of the Victorian Voluntary Assisted Dying Act states, in part, that the person must —

(ii) be ordinarily resident in Victoria; and

(iii) at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months;

It is a twofold test. First, the person must be ordinarily resident in Victoria; and, second, prior to making the first request, the person must have been ordinarily resident in Victoria for at least 12 months. Clause 15 of the bill before us today does not contain a similar provision—that is, “is ordinarily resident in Western Australia.” This amendment is directed towards clarifying that position, to prevent residents from states such as New South Wales and South Australia, in which similar legislation has not been passed, from travelling to Western Australia as soon as they get a diagnosis, with a view to accessing assisted dying in this state.

Mr R.H. COOK: I thank the member for her amendment. The words we have chosen are consistent with drafting conventions in Western Australia. I also want to provide the member with another scenario. As the member knows, we have a highly mobile workforce. We can anticipate someone moving to Western Australia for work, particularly in the mining industry, as many people have done. The health of that person’s elderly parent might be deteriorating and they might decide that they want to move to Western Australia to be closer to their family who have moved to Western Australia.

Mrs M.H. Roberts: They move closer to the family for a short while.

Mr R.H. COOK: They may move there to be closer to their family for a period of time, and it may not be much longer than 12 months before they find themselves facing the end of life. From that point of view, I think the wording we have struck upon is appropriate, not only for Western Australian drafting conventions, but also to meet the needs of the community. If someone has been living in Western Australia for 12 months and they would in every other sense be eligible for voluntary assisted dying, I do not see that there is a reason that they would not be eligible for this. I think the member’s intent with this amendment is correct in that we do not want people coming to Western Australia to access these laws. We do not want that to be the dominant motive. I thank the member for her amendment and her concern, but I think we will decline the offer to support it.

Ms M.M. QUIRK: Just before desisting on the path of this amendment, I make the point that two or three times I have had a response either from the minister or the Premier that something has been excluded from the Western Australian bill that is in the Victorian legislation because of drafting style or a drafting requirement. In all three examples there has been a substantial change in the meaning when the omissions are made. It is not a purely technical matter of having a particular drafting regime or style; it literally changes the meaning quite significantly.

Mr R.H. COOK: I do not agree with the member that there is a substantial difference. At the risk of sounding a little bit parochial, I think our Western Australian legislators do a good job of drafting, just because the Victorians have something in their legislation does not necessarily mean we should adopt it.

Mr P.A. KATSAMBANIS: I would like to speak on the amendment. The fact that a similar provision exists in Victoria makes it even more important, and I would argue critically important, that this provision is included in our legislation, because without, the risk that a person would shop around for a jurisdiction and move to it falls all to Western Australia. I will try to explain. A person needs to be ordinarily resident in Victoria and have been for at least 12 months before making the first request, so it is a twin hurdle. Here in Western Australia all the person has to do is come here for 12 months, so they do not have to have been ordinarily resident in Western Australia; they do not have to prove that they established their residency for the purposes of living here rather than simply coming here to access this legislation and waiting 12 months. It would be a more liberal regime. For that reason I think this is a worthwhile addition to the legislation. It makes sure that moving to Western Australia solely to access the rights under this legislation is not a more attractive proposition than moving to Victoria, and that it is curtailed to those people who are, as the amendment says, ordinarily resident in Western Australia and not people who established their residency solely or primarily to access this sort of regime.

Mr R.H. COOK: Was there a specific question? Sorry, member I was reading my notes.

Mr P.A. Katsambanis: The answer is no, which is my point.

Amendment put and negatived.
Ms M.M. QUIRK: I move —

Page 12, line 9 — To delete “progressive” and substitute —

progressive and incurable

The word “incurable” that is in the Victorian legislation is not in the Western Australian legislation. I think the Premier interpreted this as saying that if people could be cured but chose not to avail themselves of that option, they would be restricted if the term was limited to “incurable” as it is in the Victorian legislation. I proffered the explanation that it may need to be in the Victorian legislation because of a situation such as the infamous one in the Northern Territory under the Rights of the Terminally Ill Act. I briefly want to illustrate this case to show why that term needs to be in the bill. I refer to an article in The Lancet, volume 352, 1988, by David Kissane, Annette Street and Philip Nitschke—so it is co-authored by three people on both sides of the argument, if you like. They referred to a case in which a patient developed an indolent rash, mycosis fungoides, 12 years before the request for euthanasia. The article goes through the various treatments that the patient received, and I will not go into that for the squeamish. The article states that the patient’s oncologist advised her that the median survival with this mycosis fungoides in the systemic phase was nine months, and he said that he had no further active management to offer. The pain was well controlled. There were some other side effects that could be managed. The patient did not live in Darwin, but travelled to Darwin and looked for a specialist who would give a second medical opinion. Two surgeons agreed to see her and then withdrew. One physician assessed her and declined to satisfy that she was terminally ill. This was a politically controversial time and the patient therefore made a public appeal for help that was broadcast on national television. After this program, an orthopaedic surgeon—remember she had a skin condition—agreed to see her and certify that the Rights of the Terminally Ill Act had been complied with. Having obtained the necessary signatures, the patient went home to spend Christmas with her family, before returning to Darwin, accompanied by her husband and one child. She underwent euthanasia on 2 January, 1997. I do not want to go into too much medical detail but I refer to a journal article in Derm101 of March 1997 with the headline “Mycosis fungoides is common, rarely fatal, and diagnosable when lesions are flat”. The article states —

For almost 175 years, since the seminal publications … about mycosis fungoides … it has been an article of faith among dermatologists, general pathologists, and dermatopathologists that the disease is rare … nearly invariably fatal … and not diagnosable, clinically or histopathologically, when lesions are “early,” … We view the matter differently, to wit, mycosis fungoides is common, rarely fatal —

Dr M.D. NAHAN: I would like to hear more from the member for Girrawheen.

Ms M.M. QUIRK: Thank you very much. It continues —

and diagnosable with specificity … These polar perceptions of mycosis fungoides have profound implications, not only for physicians who are called on to diagnose and manage patients with the disease, but for patients who have flat lesions of it only. Should those patients be led to think that their destiny is sealed because of the inevitability of development of plaques and tumors, or should they be made to understand how unlikely it is that they ever will develop raised lesions or die of mycosis fungoides?

That is one of the seven cases in the Northern Territory. I have spoken to a dermatologist about this who advises me that it is basically known that the disease is not fatal. He was surprised that an orthopaedic surgeon was the second certifier in that case. That is illustrative of my first unsuccessful amendment to insert the words “ordinarily resident”. That was a case in which the woman travelled to Darwin to avail herself of the legislation there. The second amendment states that the disease or condition needs to be “incurable”. I use that word to ensure that mistakes like this do not happen, and that is why I am moving this amendment. That is the wording in the Victorian legislation; there is a reason to have it in there. It may not eliminate but it will certainly diminish the chance of a false diagnosis being made and putting the patient in a position where they think they have no other choice.

Ms A. SANDERSON: I want to add a few things to the record about the case raised by the member for Girrawheen. She referred to Mrs Janet Mills who suffered from mycosis fungoides for a number of years, a disease which, as the member Girrawheen said, is often but not always terminal. A person can live with this disease but it also can be terminal. There is no reason to believe that in the case of Mrs Mills it was not terminal. In fact, three doctors certified that it was. Her treating oncologist and a second qualified signatory affirmed that her condition was unbearable, untreated and terminal with a prognosis of around nine months—that was her treating oncologist and a second qualified signatory. The orthopaedic surgeon was a third signatory in the process—not the second, but the third. Everyone agrees that that was less than ideal. Part of the issue was that the number of doctors willing to participate in the process in the Northern Territory, given the politics of the time, was very small, and her condition was very rare. Being able to find a doctor who could adequately assess her was difficult. It is almost certainly due to the extreme rarity of her disease that that was the case. Mrs Mill’s death in the Northern Territory was legal, it was well-considered and it was undertaken with her full consent and the support of her husband and treating oncologist. The physician with the most experience of this rare disease and the personal experience of
treatment Mrs Mills affirmed that her condition was terminal and untreatable; it was in no way a wrongful death. It is also important to acknowledge that for 12 years she had suffered from a rare form of cancer that caused very severe, distressing and remedial dermatological symptoms, specifically skin tumours that caused awful suffering and scratching. My notes say that Mrs Mills said that it was bad news because she used to scratch day and night. Her hands and feet would blister. She wanted to go and she knew that the time was right. She could not take it anymore. She felt her situation was hopeless and she wanted to get some help but she could not.

We have to look at these cases in their entirety, not at just snippets, and make sure that we draw on all the facts and the evidence available in these instances. I want to add that to the record so that members have a number of views around this particular case.

Mr R.H. COOK: I would like to thank both members for their contributions. This scenario took place in 1995 in the Northern Territory. By description alone, members would appreciate that a significant period of time has passed since that legislation was struck over 20 years ago. The Northern Territory was the first jurisdiction to legislate and we can now benefit from not only the Victorian legislation, but also the Oregon act and legislation in other jurisdictions around the world. In that respect, the member is right to raise the issue as one of potentiality in the event that we had not learnt the lessons since that time. From that perspective, I offer that to allay members’ concerns.

I understand that prior to the lunchbreak a significant time was spent on the definitions and the policy positions around “incurable”, so I will not go into that further. However, I assure members that significant changes have taken place since 1995.

Dr D.J. HONEY: I rise to support this amendment. One of the concerns expressed throughout this debate both before we started debating in this chamber and during this debate, is the issue of creep. This goes back to the stories that people have provided. The overwhelming majority of stories we heard were about people in dreadful pain with an utterly incurable disease that was not treatable in any way whatsoever. They were not just in distress from a particular condition, but their life was an utter misery. I will not go into that in more detail. I know that it must be personally painful for the members who told those stories.

I am not a medical practitioner and I do not profess to have expertise in the area, but there are a range of absolutely treatable medical conditions that if left untreated, will result in death. My father had a very serious heart condition from having suffered rheumatic fever when he was a little boy. It damaged a valve in his heart and led to his heart essentially being destroyed. He took a range of medication and he lived for 12 very productive and happy years. If he had not taken that medication, then he would have been near death. Taking the medication allowed him to live for 12 productive years. If patients suffering from serious diabetes do not take their medication, they will die. As people age, they are subject to more medical conditions. As I say, I am not a medical expert, but I am certain that people can suffer from a vast range of medical conditions whereby if they do not take their medication, they will die. The problem here is that it is almost an encouragement for someone who thinks for other reasons, “Well, I want to end my life. I will simply stop making taking my medication even though this is perfectly treatable and then I will qualify for the voluntary assisted dying process.” It is not the situation that people have been talking about. In the public debate, we have heard very emotive stories. I do not discount the sincerity of the stories of people suffering terrible, incurable and painful disease and who just want to end it all. I do not think any of us would be human if we were not moved by those stories. However, because of this clause in the bill, someone who has a perfectly curable disease who can live an otherwise perfectly good life, for other reasons may decide to end their life and simply by not taking their medication, they then qualify for the voluntary assisted dying process.

I have heard it only anecdotally, but I understand that the Victorian legislation included this.

It seems to me that if we adopted this suggested amendment to the bill, we would automatically avoid this concern about creep; that is, suddenly this covers a much broader scope than has been used as the justification for this bill. A number of members have referred to the large number of people who support voluntary euthanasia. We also know from more recent polls that when people are asked more subtle questions, support for voluntary euthanasia as a priority drops away very dramatically. I have never heard a public debate that said we would broaden the scope of this legislation to include people who have perfectly curable diseases and who are taking medications that mean they can lead perfectly pain-free and productive lives, so that if they stop taking that medication, they will qualify for this process. It can be only an assertion, but I assert that if we asked people that question and we put it in that way, they would say that that is not how they see this bill should operate. It worries me that in a number of areas we have seen creep. We have seen creep of this bill from the Victorian bill.

We do not even know how the Victorian bill is going to operate. We have no idea. One person has been through it and it is used as a model. Even though we have not seen how the model operates and any pitfalls, we have gone even further—I am using the royal we—in this bill, to allow further loosening. I think it is an entirely sensible amendment and it is about finding a balance, but my great concern here is that it expands the scope of this bill far too widely.

Mrs A.K. HAYDEN: I want to add a small contribution to support this amendment moved by the member for Girrawheen. The terminology the member for Cottesloe just used was “to avoid the small creep”. That is the main

Extracted from finalised Hansard
message that I have been trying to get across throughout the debate and my questioning on this legislation. I was going to share this story during my second reading contribution, but I ran out of time so I chose not to insert it. I thought it would be quite advantageous to share it with members today because it fits with this amendment perfectly. I was not aware that the member was going to move this amendment when I got this message. This person wants to remain anonymous, but I have a lot of detail on their personal story. It is about adding the word “incurable” into this clause and why it is very important, as the member for Cottesloe said, to avoid that small and slow creep that may happen. The story reads —

A family friend was diagnosed with a rare and aggressive form of cancer called High Grade Small Cell Neuroendocrine carcinoma in November 2018. Commenced palliative chemo right away, advised that without chemo, survival was maximum 6 months.

With chemo, average life span is 12–18 months for this type of cancer.

He completed 3 x 21-day cycles of chemo. Following this, on 16 January 2019, scan results of his abdomen, chest and head showed the chemo did nothing and that the cancer had grown.

The family looked for other options in other states and countries without success—someone with less fight in them would have probably given up at this stage.

They were filled with hope when they met with Dr Kynan Feeney, Associate Professor Oncologist at St John of God Murdoch. Dr Feeney and his team have been doing various immunotherapy trials, but not for this type of cancer.

They agreed to continue with a new round of palliative care, but give him an immunotherapy drug to help his body fight the cancer.

They were given no guarantees, but the alternative was just continuing with the palliative chemo until it stopped working.

2–3 months ago when he completed the treatment, following scans he was given the all clear by the doctors. This individual was told that he had maximum six to 18 months to live with palliative chemo treatment. Under this legislation, that is progressive and he would be able to access voluntary assisted dying. Through research and trying and testing different things unknown to the medical field at the time, this person has now been found to be all clear by the doctors. If I add it all up, we are talking about nearly two and a bit years later, this person is now not having to undergo chemotherapy and has been given the all clear. Adding the word “incurable” would help reinforce and ensure that we do not allow the small opportunities that may occur, because as I have said in this place—I believe every member in this place believes this—it takes only one life to be taken that did not need to be taken to make this legislation not worthwhile. I am pleading with the minister to consider any safeguards that can be added to help this legislation protect those who may be vulnerable and to support this amendment.

Ms M.M. QUIRK: I just need an explanation of why it is not in the bill. I accept that the prognosis has to be six months or 12 months for neurodegenerative diseases, so it may be considered advanced and progressive and that time frame is sufficient. But I really just need to understand what the rationale is for not putting that in, just as a matter of circumspection. I will not take up much more time. I wanted to correct or add to a couple of things that the member for Morley said. The article that I quoted from was co-authored by Phillip Nitschke and there were three doctors, but two of the doctors refused. In the end, there was a first oncologist, somewhere other than Darwin, and then there was a third doctor. Two of them refused. As I said, I read from a professional journal that said the disease is not rare and is relatively common. The journal is with Hansard so I cannot quote the citation again, but it is not at all true that it is a rare disease. To confirm that, I consulted with a practising dermatologist. If the minister could briefly explain the rationale for not including that word, I do not think we need to be pursuing this much further.

Mr R.H. COOK: I think this issue was canvassed extensively prior to the lunchbreak, but I am very happy to elaborate further to reiterate that it is not appropriate to require a person to exhaust all treatment options that may result in the disease, illness or medical condition being completely cured, but for which the person significantly compromises or loses their quality of life. Every person should be able to determine which treatment options they wish to adopt. An adult patient of sound mind may refuse medical treatment even if that refusal may lead to death. The bill does not require a patient to undergo treatment that will prolong their life or that might cure them, because to do so would cut across the fundamental principle of patient autonomy. I take on board the comments made by the member for Darling Range in her anecdote, but that patient was given between six and 18 months to live so would not satisfy the conditions of this legislation at any rate. Ultimately, one person’s incurability is another person’s medical miracle waiting to happen. From that point of view, I think we need to put the patient, the person, back into the centre of this debate. That is why the framework that we will put in place with this bill will provide all the necessary safeguards and protections and afford appropriate rights.

Extracted from finalised Hansard
Ms M.M. QUIRK: Just in terms of one last example that the Premier gave, I need clarification on whether this would fall within it. The Premier said that someone might have gangrene—he did not say gangrene, but let us say a person had gangrene—and be told that if he did not have his leg amputated, he would die from the infection. Obviously, if he underwent the amputation, he would survive. The minister would say that that would be a case of patient autonomy and that it is within the rights of the patient to say that, no, he did not want his leg amputated, and as a result he would certainly die within six months. Is that the correct kind of example to bring up in this context? I was a bit puzzled by it, that is all.

Mr R.H. COOK: I have been doing my best in this debate to not provide responses to scenarios because we could be here all night; at this rate, I think we probably will be here all night testing out different scenarios as it is!

Ms M.M. Quirk: That was just one that the Premier provided.

Mr R.H. COOK: That is right.

Ms M.M. Quirk: I’m giving you the opportunity to comment.

Mr R.H. COOK: And I appreciate that.

Without necessarily trying to paraphrase or verbal the Premier, I think what he was trying to say was that in some respects, the treatment might, to that patient, be worse than the prescribed cure. I am thinking in particular of someone who might have a tumour of some form that might be technically operable, but that operation would be highly compromising to that person’s quality of life and could potentially leave them in a very debilitating, if managed, state of affairs. From that point of view, I guess the Premier was trying to underscore the principles of what we have here; that is, if a person has a terminal disease that, on the balance of probabilities, will take their life within six months, and that person is adjudged to have the capacity to make a decision about the future of their end-of-life choices and an understanding of the implications of that, they should be able to access voluntary assisted dying. It will end suffering and, in that sense, it provides a rational and humane outcome. It is unlikely that someone will choose death in situations in which they could have a higher quality of life. There is a bit of creeping language around this that people are somehow trying to slip through the net to advance a form of self-emasculating, for want of a better description. This is not that; this is about providing agency to someone whose life will end within six months, who is suffering intolerable pain, and who, within the safeguards that we have crafted in this legislation, should be able to have better outcomes in respect of their end-of-life choices.

Dr M.D. NAHAN: We went through this when the minister was out of the chamber and the Premier was here in his place. I just want to understand something from perhaps a slightly different angle. My concern is that people will access this who are suicidal and who need help to stop their suicidal tendencies, rather than to have access to VAD. This will be a rare event, but we are dealing with potential premature death, so it is important that we deal with the rare ones. This will be someone who qualifies and accepts that the disease is potentially curable without a debilitating treatment. One could debate that; that is up to the person. For some people, to lose a leg would be pretty debilitating, but it would not be to everyone. We could come up with scenarios, but I do not want to go into that. Is there a mechanism by which the consulting physician, doctor or medical practitioner can look at this and say, “I’m worried about your rationality here. I’m worried that you are perhaps asking about or discussing VAD when you actually need to address your psychological treatment”? Is there something in the vetting process to weed out those cases? I will give an example; this really shocked me. I had a constituent come to me who wanted me to advocate for euthanasia and I discussed his situation with him. He wanted this to apply to himself and I discussed his situation with him. He wanted this to apply to himself and I asked him what his ailments were. He essentially agreed that they were old age ailments relating to hearing, eyesight and creaky bones—whatever. I said, “I can’t help you on that. Whatever we think about euthanasia, you will not be helped on that.” He died two months later of a heart attack, completely unrelated. But if he had had an ailment that he could use as an excuse, he would have used it. Can the minister show me some processes for stopping people misusing the VAD process for what we would all identify as suicide?

Mr R.H. COOK: As I mentioned in both my second reading speech and in my reply to the second reading debate, it is a requirement that the medical practitioner be satisfied that the person has decision-making capacity; that is, they are making the decision in the full knowledge of the impact of that decision, their options with respect to their end-of-life choices and, indeed, their options around other aspects of their medical condition. If the medical practitioner is not satisfied, there is an obligation on them to refer and to better inform themselves of that person’s decision-making capacity. This is something on which the Royal Australian and New Zealand College of Psychiatrists provided quality feedback to the Ministerial Expert Panel on Voluntary Assisted Dying. It said in relation to the decision-making process that a mandatory mental health assessment was not necessary, but that there are protocols and tools that can be provided to the medical practitioner to make sure they can make that assessment. It also said that it was happy to provide a framework under which a patient could be referred, to better inform the decision-making process. So, yes, the member is right. It is not sufficient that someone is sad or has in some respect had enough. In the case of the member’s constituent, God rest his soul, he was simply feeling bad; he was not, on the balance of probabilities, going to die within the next six months and, as the member observed to him, he would not have been eligible for this legislation.

Extracted from finalised Hansard
Dr M.D. NAHAN: The constituent I just mentioned was a very sane man; he had just had enough. He had also been an advocate for euthanasia and he wanted to apply it to himself, unfortunately. I will not go into the whole story. But I think he would have passed any rational test; he knew what he was doing or wanted to do, but my problem is that he might have used the excuse of a terminal but curable disease to achieve his aim of ending his life, which is not the real purpose of this legislation. It was his rational choice. He was old and he did not want to go on, but that is not what we are here for, and that is not being discussed with the community. If he had a disease that was terminal but curable he would have used that. Do we have some process by which we catch it up, or are we just going to say that it is up to them, if they get a curable disease, and they want to use it to assist dying, then that is it?

Mr R.H. COOK: I empathise, member, and from that perspective I think of half a dozen reasons why that — [Interruption.]

The ACTING SPEAKER (Mr I.C. Blayney): Minister, you woke me up.

Mr R.H. COOK: Mr Acting Speaker, I think Mr Speaker made a call earlier, when the member for Collie–Preston’s phone went off again.

The ACTING SPEAKER: I will have to consult with the Speaker when he comes back. That is, the Speaker, not the electronic speaker.

Mr R.H. COOK: I think the member’s original observation is correct. That person would not be eligible. This is why we have medical practitioners in this role—highly trained, highly experienced, and additionally trained clinicians who are in a position to sit down with that patient and understand what is troubling them. Indeed, we do this every day. Our medical workforce is an extraordinary group of people; they do an amazing job. I think we should be careful about thinking that they would have the wool pulled over their eyes. We rely upon them to make these calls day in and day out. This bill, in fact, provides extra safeguards to assist them in that process.

Amendment put and negatived.

Mr Z.R.F. KIRKUP: Under clause 15(1)(e), a medical practitioner must be satisfied that a patient is acting voluntarily and without coercion. I am assuming that practitioners will be informed about how to best judge that capability, or that level of coercion, and the nature of their voluntary action through levels of training. Is that right; and, if so, can we have some understanding of that what that would look like in a training package?

Mr R.H. COOK: The medical practitioner would have already had significant experience and training in patient management—understanding what is troubling the patient, and what is going on in their life—and be able to cross-examine, because obviously, in order to treat a patient, they would have to understand everything that is impacting on them. As the member observed, there will be extra training for that. As I mentioned in my response to the second reading debate, that will in part be informed by the Victorian training, but, in addition to that, we have had significant input already from the Royal Australian and New Zealand College of Psychiatrists, and it has offered to continue to provide that feedback, particularly in the psychosocial issues. To provide further detail, it is likely that the training will be provided in an online modular format, similar to the structure used in Victoria, but reflecting particular observations and nuances of the WA bill, and the WA community. There will be an assessment component, under which the practitioner will be required to demonstrate competency. The training package in WA will be developed in consultation with the Department of Health, the Royal Australian College of General Practitioners, key medical nursing and allied health stakeholders and experts, clinical education, regulatory, palliative care and end-of-life stakeholders and experts, cultural stakeholders and advisers, and consumer community representatives.

Mr Z.R.F. KIRKUP: Just so that I understand correctly, was the suggestion that there is already a baseline level of practitioners’ understanding of coercion, and the will of their patients? Is that how I understood the minister, and the training will be an enhancement of those existing skills? Is that my best understanding of what he said?

Mr R.H. COOK: Yes, member. These are people who have been to university for six years. I was at university for over six years, and all I came out with was a bachelor of arts. In addition to that, there will be postgraduate training, on site, of general practitioners. As specialists in general practice, they obviously have further training in relation to that. The Royal Australian College of General Practitioners has offered to accredit the course, so that it is a recognised component of its qualifications, and therefore it has to be satisfied that it provides enhanced skills.

Mr Z.R.F. KIRKUP: Thank you, minister. I appreciate that answer. Obviously, coercion is a critical concern for everyone who is supportive, or not supportive of the bill.

[Interruption.]

Mr R.H. Cook: That is not true!

Mr Z.R.F. KIRKUP: Is that the sixth time today?

Ms A. Sanderson: He is trying very hard to get kicked out.
Mr R.H. COOK: My understanding is that it would be a recognised form of CPD, and it would be continuous, but that is self-evident. Essentially, those qualifications or skills would continue to be upgraded, and so on. I do not want to create the impression that this is a “go online, tick a few boxes” course. This program will be fully assessed for competency. GPs already have screening and clinical assessment tools to use as part of their clinical practice, but obviously in this instance, that medical practitioner would need to be further convinced. If they have a sense that coercion may be involved, they may refer the assessment to a practitioner skilled in this area. If they are of the opinion that they cannot make an accurate assessment for themselves, they may also refer the matter to existing authorities, such as the WA Police Force, if they believe that a patient is being coerced into undergoing voluntary assisted dying. As the member would be aware, the bill makes it a crime to unduly influence a patient in such a manner.

Ms M.M. QUIRK: In relation to coercion, a number of studies over the years about elder abuse recommend that people such as GPs get training, because a lot of it is going through to the keeper, and they are missing it. I am pleased that the minister is confident that GPs have the capacity to assess it, but the evidence and the research suggests that quite the opposite is happening. I was going to talk about the training course at clause 35. Does the minister want to leave it until then?

Mr R.H. Cook: Yes, member.

Mrs A.K. HAYDEN: I want to ask about clause 15(1)(c)(ii), which reads, in part —

will, on the balance of probabilities, cause death within a period of 6 months or, in the case of a disease, illness or medical condition …

Can the minister explain what sort of tests there are for the balance of probabilities?

Mr R.H. COOK: I am advised that the probabilities test is used, as agreed by the ministerial expert panel. This test is easily understood and has case law to support it. When considering whether a disease, illness or medical condition is expected to cause death within six months, or within 12 months in the case of a neurodegenerative condition or disease, the medical practitioner will have regard to the treatment conditions made by the patient. This includes situations in which the patient chooses not to undergo or continue treatment that may prolong life. To answer the member’s question, the probabilities test is understood in case law and I understand people are familiar with it in a clinical context.

Mrs A.K. HAYDEN: Thank you; I appreciate that. In closing, the minister said people with medical expertise will understand that language. Obviously, that is neither myself nor quite a few others in this chamber. The minister said the board will form that view. Has it been formed yet or will it be formed after the passing of this legislation?

Mr R.H. COOK: It was the ministerial expert panel. Sorry, my apologies; I was having a 54-year-old moment!

Mrs A.K. HAYDEN: I have them, too!

To clarify: has that been set or will that be set after the passing of this legislation?

Mr R.H. COOK: Sorry, member, I think we are at odds and that is why we are getting confused. What I was referring to that the ministerial expert panel recommended is that we choose the criteria “balance of probabilities”. There are a range of opinions in the conversation we are having today around what is the appropriate test and how that is described. We have received advice from the ministerial expert panel who considered the legal implications and also what in some respects understood within the medical fraternity as being a useful tool to help them make those decisions. It was decided that “balance of probabilities” provided the greatest clarity.

Mrs A.K. HAYDEN: I appreciate the minister explaining that for me; it is a difficult thing to understand. Is the minister able to give an example? Has this been used in any other clinical assessment? Is it currently being undertaken anywhere else within WA?

Mr R.H. COOK: I am advised that “balance of probabilities” is a commonly used criteria in the medical fraternity.

Mrs A.K. HAYDEN: I do not mean to be pushy, this is just simply for me to try to understand: can the minister provide an example of where else this may be used, if that is possible? If not, that is fine.

Mr R.H. COOK: We do not have a great example at the moment for the member. We can provide that.

Mrs A.K. HAYDEN: I would appreciate that. I just want to highlight that I do not believe this was adopted in the Victorian legislation. The Victorian legislation states that it is expected to cause death within weeks or months but not exceeding six months. The Victorian legislation seems to have a lot tighter time frame. Can the minister explain the difference between the path he has gone down and what Victoria went down and why?
Mr R.H. COOK: The ministerial expert panel looked at a number of ways to prescribe this concept. To clarify what I said before, we did finally settle on “balance of probabilities”. Victoria originally came up with the idea of “reasonably foreseeable”. In terms of discussions with other parts of government, most notably our friends from the legal area, they thought that “reasonably foreseeable” was not tight enough. In ongoing discussions with the expert panel and the Department of Justice, it was decided that “balance of probabilities” provided the greatest clarity and the most utility in terms of defining this period.

Mrs A.K. HAYDEN: I have a final question, I hope, on this clause, depending on the answer I receive. If I understand clause 15(1)(c)(ii) correctly, it is within a period of 12 months on the balance of probabilities. The last line has “within a period of 12 months”. The Victorian legislation has “not to exceed six months”. Are we enabling an additional six months?

Mr R.H. COOK: No. This essentially reflects the same approach that the Victorians took, which was six months, or 12 months for a neurodegenerative condition. The subparagraph states —

(ii) will ... cause death within a period of 6 months or, in the case of a disease, illness or medical condition that is neurodegenerative, within a period of 12 months;

Does that clarify it?

Mrs A.K. Hayden: I think so. I will rely on Hansard.

Mr R.H. COOK: I understand that is in section 9(4) of the Victorian legislation. I am quite happy to read that out for the member.

Mrs A.K. Hayden: That would be great.

Mr R.H. COOK: It states —

… if the person is diagnosed with a disease, illness or medical condition that is neurodegenerative, that disease, illness or medical condition must be expected to cause death within weeks or months, not exceeding 12 months.

Mrs A.K. Hayden: Twelve or six?

Mr R.H. COOK: Twelve months for a neurodegenerative condition.

Mr Z.R.F. KIRKUP: In clause 15, “Eligibility criteria”, it is stated at paragraph (f) that the person’s request for access to voluntary assisted dying is enduring. I will put a hypothetical situation to the minister: an individual seeking to access voluntary assisted dying no longer chooses to proceed with it and then returns saying they wish to proceed—does that indicate their will is enduring?

Mr R.H. COOK: No. The enduring request provides that the patient’s request for access to voluntary assisted dying must be enduring. This provision reflects the enduring nature of voluntary assisted dying and that in order for the process to continue, the patient’s choice to participate is paramount. The patient is not obliged at any stage of the process, even after the completion of the request and assessment process, to take any further action to access voluntary assisted dying. To provide an outline of what that looks like, they must be able to make a first request, a written declaration, a final request, a final review, final dispensing and time of administration. They must be able to clear all those hurdles.

Mr Z.R.F. KIRKUP: I appreciate that, minister. I have got the process tattooed on my brain at this point! So, a person makes a first request and goes through an assessment. They have a second assessment with a consulting practitioner and then they make a final declaration and final request. They wait some time before making an administration decision. There is no onus on them in the legislation, as far as I am aware, to make any decisions within a certain time frame. There is only an absolute minimum between the first and final request times. How is it established that they have an enduring will? A person goes through all those processes and is at the point they want to make an administration decision. They have gone through all the other processes. They have been deemed eligible and they wait three months, for example, before making their administration decision. Does that indicate their will is enduring? At what point would it be assessed that they do not have enduring will? How much longer would they have to wait before it is suggested that they do not have an enduring will, or do they have to explicitly say “I no longer wish to proceed”, in which case what mechanism is facilitated? As far as I am aware, there is no way, after their final request, they can return to their coordinating practitioner to inform them of that.

Mr R.H. COOK: That would be considered an enduring request. In that respect, the person would not need to demonstrate enduring beyond six months, for obvious reasons, but they would not have to go step by step in terms of the time lines. As the member would know, particularly from the Oregon experience, many patients simply want to know that they have that option, and do not need to access the assisted dying substance. I refer the member to clause 56, which states —

The patient may at any time —

(a) revoke a self-administration decision by informing the coordinating practitioner for the patient that the patient has decided not to self-administer a voluntary assisted dying substance; or

(b) revoke a practitioner administration decision by informing the administering practitioner for the patient that the patient has decided not to proceed with the administration of a voluntary assisted dying substance.
Mr Z.R.F. KIRKUP: I appreciate that clarification, minister; thank you. In a hypothetical situation, the person has reached the point at which they can make an administration decision. As the minister rightly pointed out in his contribution a moment ago, in all likelihood, on the balance of probabilities, the person has only six months, or less, in which to live, having had the diagnosis that they are unfortunately likely to die within that period of time. What would happen if that did not occur within six months? What would happen if they reached seven months? They have gone through the entirety of the process. That might have taken only nine days. They have made the administration decision. However, as per the Oregon experience, they have decided to wait. They want to have this substance just in case, as an insurance policy. Seven months might have elapsed since the person made the administration decision. Would the person have to revert to the first request stage all over again; and, if not, why not?

Mr R.H. COOK: No. The person would have cleared each stage of the process, and their decision would be considered enduring, even though there might be a gap between the dispensing and the administration decision.

Mr Z.R.F. KIRKUP: I appreciate that, minister. It is good for me to understand the process. If the person had reached the point of seven months and had not yet passed away, would that mean they would no longer be considered eligible, because they would have breached the eligibility requirements?

Mr R.H. COOK: No. They would still be considered to be dying within six months, even though it might have gone to seven months from the original observation. However, we would think that by the point, the person would be very frail.

Mr Z.R.F. KIRKUP: I appreciate that. I am talking about an extreme case. I am trying to understand for how long a person can continue to access the substance. A person might want to access assisted dying and have that substance as an insurance policy, and they might still be with us a year later. My concern is about whether the person would need to revisit eligibility. The person has gone through those processes. We know that there are issues with diagnosis and prognosis. I think we all understand that people are human, and that it is not an exact science, as it were. The person has made all the assessments, all the requests and all the declarations and is at the point of the administration decision, but nine months, or a year, has passed, and the person is still alive. Could that person still access the administration decision if they choose to go ahead with it, even though nine or 10 months had passed, or would they need to go through the entire process again because such a significant time had elapsed, which I think is a possibility under this process?

Mr R.H. COOK: There is no time limit, but obviously, in the opinion of the medical practitioners, the prognosis would still need to be the same. From that point of view, if the medical practitioner said to the person, “For some reason, you have confounded medical science; we think you are going to survive for another 12 months”, the person would obviously no longer meet the requirements for voluntary assisted dying and would need to go back to square one at some other point in time.

Dr D.J. HONEY: I am intrigued by this point. From my reading of the bill, nothing would trigger that. I had not thought of this point, but I am grateful to the member for Dawesville.

Dr M.D. Nahan: He has a lot of value.

Dr D.J. HONEY: He has a lot of value—immense value—in our party.

The member for Dawesville is clearly highlighting this incrementally. The prognosis might have been demonstrably wrong. We might say it was wrong by a margin. However, even if it was wrong by one year or two years, I do not see anything in this bill that would trigger any review. If the prognosis was clearly completely wrong, nothing in this bill would trigger any review. I am happy to be corrected on this. I think this is what the member for Dawesville was trying to get to. I do not see anything in this bill that would trigger any reconsideration going out two years, three years or four years. The person would continue to be qualified to access voluntary assisted dying, and would continue to have access to the voluntary assisted dying substance, when clearly the prognosis was demonstrably wrong. In that situation, what is the safeguard in this bill that would trigger any sort of review, retrieval of the poison, or the like?

Mr R.H. COOK: Thank you, member; I appreciate that. I find it an odd line of questioning. The member for Cottesloe probably has more medical practitioners in his electorate than anyone else in this chamber, yet he seems to be attacking medical practitioners and their judgement more than anyone else here.

Dr D.J. Honey: I am not attacking anyone.

Mr R.H. COOK: From that perspective, I do not understand the member’s concerns around the medical fraternity. However, it should provide comfort to the member that, at all stages, the patient’s decision must be enduring, and, at all stages, the patient must have received the same prognosis. It might be that that prognosis would be reviewed. That happens from time to time. At each stage, the medical practitioner would need to be satisfied that, on the balance of probabilities, death would occur within six months. The patient would go through that process, as they work with their medical practitioner, and would continue to meet the requirement. However, if at some point the medical practitioner said, “For some reason, you have confounded medical science. I do not believe you are going to leave us in six months”, the patient would no longer be eligible for voluntary assisted dying. I know that the

Extracted from finalised Hansard
under the constant guidance of a medical practitioner. Once they take the substance home, what steps are required? Is there a daily or weekly check, or is there none? That is really simply the question.

Dr D.J. HONEY: Thank you, minister. I think the minister was verballing me in saying that I am attacking the medical fraternity, particularly in relation to this question. I am not attacking them at all. I assure the minister that there was nothing in my statement to suggest that. I do not know why the minister did that.

I have recognised that in every profession, including that of members of Parliament, there is a range of abilities and skills. Some of those are very, very good, and some are not. In relation to this matter, the minister said that that would be under constant review. Let us look at a situation in which this poison will be self-administered. It is in the person’s house, the doctor is not there, they are going to administer the material themselves and there is no administering practitioner. What triggers the review? They are not going back to their doctor and they are not going back to the doctor who did the assessment; they have simply got this material. What triggers the review? This is not a criticism of medical practitioners. I am not quite sure how that was inferred from what I had asked; that is not relevant to what I asked. This is a person who has the material. They are not going back for assessments and they have got that material there for self-administration, which I understand is what is going to be done in the majority of cases. Whether it is because they are defying the best science or whether the science was not so good in the first place is immaterial. What triggers the review to say that this case should be reassessed? I appreciate that this is not about sheep stations, but I think the member for Dawesville has raised a really excellent point.

Mr R.H. COOK: I think there is this emerging view of a patient somehow sitting in a bedroom or a room somewhere staring at the clock by themselves waiting for death to overtake them. They would obviously be in an ongoing relationship with their coordinating practitioner. Let me put the opposite scenario to the member. They have the voluntary assisted dying bill substance and the doctor tells them, “You have got two weeks, and I am going to review you.” What message does that send to the patient? In that sense the patient says to themselves that this is their one chance to relieve their suffering and they might need it, but the doctor says they will come and review the patient in a particular period of time. Is that the coercion that the member is concerned about? Is that a situation in which the doctor is implicitly part of the coercion process? I want the member to understand that this patient would be deeply involved in medical care and would have an ongoing relationship with the coordinating practitioner. In that sense, I would say that their situation would be constantly under review. I would say they should be constantly reviewed in relation to all these matters. From that point of view, I think we should allow the patient to enjoy extra days in life and say good luck to them, but if they feel that they gain comfort from having the voluntary assisted dying substance and they continue to face inevitable and imminent death, they should be able to have that voluntary assisted dying substance to provide comfort.

Dr D.J. HONEY: It looks like there will not be any satisfaction in getting any answer to this question. There is no necessity, and in fact I would argue that in many cases it is likely that the coordinating practitioner may well not be the patient’s general practitioner. There is no reason whatsoever to suppose that the coordinating practitioner is in any way involved in the ongoing treatment of the patient, in which case there is no reason necessarily that the coordinating practitioner has any relationship whatsoever with the patient’s regular doctor; we know that. The assertion that there is going to be this ongoing review because the patient has ongoing contact with the coordinating practitioner is not necessarily so. My reading of the bill indicates that that is not necessarily so. The time could go out to an extended period. I know the member for Dawesville mentioned some small increments, but it could be much longer than that, and in that case it would be provable that the diagnosis was completely wrong, but that is the basis upon which the substance was administered. In that case, I would have expected that it would have been appropriate to have a review. I am not discussing or presupposing that the coordinating practitioner would be hovering around the door waiting to leap in there the moment the patient goes one day past the time period. Maybe this question is not answerable here and it needs to be looked at, but I think there should be a point —

[Interruption.]

Dr D.J. HONEY: Is the minister sending in reinforcements?

Mr R.H. COOK: I thought it might have been the member for Collie–Preston’s phone again!

Dr D.J. HONEY: I do think there has to be a point at which ipso facto the prognosis was wrong and the process should be nullified, but I am not sure I am going to get an answer.

The DEPUTY SPEAKER: I remind members that we have been on this clause for over an hour now, so if members have something new to add, go for it.

Mrs A.K. HAYDEN: I get told that I am a bit direct, and I apologise if this question is direct, but it might be easy for the minister to answer and get rid of the confusion I have. My understanding is that the patient gets access to the substance and can take it home and self-administer it. I have been listening, and the minister said the patient is under the constant guidance of a medical practitioner. Once they take the substance home, what steps are required? Is there a daily or weekly check, or is there none? That is really simply the question.

Extracted from finalised Hansard
Mr R.H. COOK: When the coordinating medical practitioner or consulting practitioner becomes aware that the person has died, they have to notify the board. Is that what the member is asking?

Mrs A.K. HAYDEN: When they take the drug home, what happens between the drug being taken home and the drug being administered?

Mr R.H. COOK: Under the Medicines and Poisons Act, a person has responsibility for the safekeeping of the substance. We will come to that in detail in later clauses, but there is a designated person responsible for it.

The DEPUTY SPEAKER: The member for Dawesville wants another question—something fresh I hope!

Mr Z.R.F. KIRKUP: I am always fresh, Deputy Speaker!

The DEPUTY SPEAKER: You had better stop now or I will have to sit you down for misleading the house!

Mr Z.R.F. KIRKUP: I refer to the issue of eligibility in subclause (2) and the implications under the Mental Health Act. I am keen to understand whether the coordinating practitioner determines that if a patient is fine, they are coping and there are no mental health issues, but the consulting practitioner believes that there is a concern under the Mental Health Act, it stops the clock, as it were—stops the process. Is there a possibility for a patient to seek a third opinion from another consulting practitioner?

Mr R.H. COOK: Yes, in that situation it would be said that the consulting practitioner is doing their job, which is verifying the original decision from the coordinating practitioner. The way it would work is that the coordinating practitioner would make their assessment and then refer it to the consulting practitioner. The consulting practitioner would indicate that they have red flags and they would have to refer back to the coordinating practitioner. It does stop the clock.

Mr Z.R.F. KIRKUP: If we proceed with that scenario, is there a capability for the patient to go to a different consulting practitioner to seek a second opinion?

Mr R.H. COOK: I will answer this and then I ask that we get back to the clause. It is the coordinating practitioner who would then make the decision to make another referral to another consulting practitioner. But that is not what subclause (2) refers to. We can get on to those details on the appropriate clause.

Mr Z.R.F. KIRKUP: I apologise. I was not trying to be vexatious, minister; I was trying to understand whether a patient having a mental health concern that is identified will impact on their eligibility and whether that needs to be satisfied by both a coordinating practitioner and a consulting practitioner if a consulting practitioner disagrees with that and believes there are concerns under the Mental Health Act. I am not trying to make this more complex. I thought that was where we were. There are very clear guidelines under the Mental Health Act about what would be considered to be a disability or the like, and I assume that that would be front of mind for any practitioner when they assess the patient. Would that be provided as part of the information to a practitioner and possibly during training as well?

Mr R.H. COOK: Yes.

Mr D.T. REDMAN: I will take the minister’s guidance if he would prefer to answer this on a later clause, but I think it is relevant in that this clause is about eligibility criteria. I want to confirm whether it is a coordinating practitioner or a consulting practitioner. Is it right that there are in fact three decisions that they can come to? Either they can say that the patient is eligible and competent, they can say that the patient is not eligible or is incapable of making that decision or they can be undecided and cannot determine that that is the outcome. So there are three possible decisions from one of those practitioners.

Mr R.H. COOK: Yes, that is correct. If they cannot decide, they can refer to get further advice to inform a decision one way or the other.

Clause put and passed.

Part 3, Division 1 — Heading —

Ms M.M. QUIRK: Before we get to clause 16, I need to move an amendment to the title of this division. I move —

Page 13, line 3 — To insert after “practitioners” —

and relevant expertise and experience

Mr R.H. COOK: I think the reason the member wants to make this amendment is to give effect to a subsequent amendment, so maybe we could invite the member to speak in an informal sense to the subsequent amendment so that we understand better what she is trying to achieve by changing the title of division 1.
Mr P.A. KATSAMBANIS: a medical practitioner, particularly a GP, would gain when they have had a patient for a long time. As that is not a practitioner and the consulting practitioner for a patient may not have any relevant and ongoing knowledge and with ending a person’s life. We are dealing with circumstances in which it is possible that both the coordinating illness or medical condition expected to cause the patient’s death. I think it is pretty fundamental. We are dealing experience of the patient’s full history—not just their pure medical history, but the more holistic knowledge that practitioner or the consulting practitioner for a patient to have relevant expertise and experience in the disease, be made in the substantive amendment to insert new clause 16A, which would require either the coordinating another very sensible set of amendments. Obviously, the change to the heading is simply to reflect the change to Ms M.M. QUIRK: I believe that the issue around independence was canvassed widely this morning. In addition, the clauses that give effect to the process I am referring to are clauses 25 and 31.

Mr R.H. COOK: I thank the member for her suggestion. We will not support her amendment. Our bill does not require that one practitioner be a specialist in the person’s illness, but it has a requirement for further independent assessment if there is doubt about the eligible illness, disease or medical condition. This difference in requirement from that in the Victorian act reflects the practicalities of responding to the geographic remoteness of many places in WA and distance from medical care. The requirement to refer to further assessment serves to ensure specialist expertise when required. This position is consistent with the view of the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying. In short, to reflect upon the example that the member gave, we would require the orthoped to refer to a specialist in order to have all the necessary information in front of them to make sure that they were in a position to assist in the voluntary assisted dying process. In practice, the patient will have an illness, disease or medical condition that is advanced and progressive and will cause their death and, in the vast majority of cases, will have had consultations from an ample number of specialists, all of whom will have brought their expertise to bear on that patient’s medical record.

Ms M.M. QUIRK: I am not quite sure which clauses the minister is referring to when he talks about the need to refer to another practitioner. Also, where is there reference to an independent practitioner?

Mr R.H. COOK: I believe that the issue around independence was canvassed widely this morning. In addition, the clauses that give effect to the process I am referring to are clauses 25 and 31.

Ms M.M. QUIRK: I do not know whether someone else has a comment while I look at those clauses.

Mr P.A. KATSAMBANIS: Are we speaking about both amendments—the amendment to the heading and new clause 16A?

Mr R.H. Cook: Yes. I assume that we will vote on the change that the member has recommended to the title and then we would have a subsequent vote, or the member may choose not to move the new clause if that vote is not successful.

Mr P.A. KATSAMBANIS: I can speak only for myself, obviously. This is a conscience vote. I think this is another very sensible set of amendments. Obviously, the change to the heading is simply to reflect the change to be made in the substantive amendment to insert new clause 16A, which would require either the coordinating practitioner or the consulting practitioner for a patient to have relevant expertise and experience in the disease, illness or medical condition expected to cause the patient’s death. I think it is pretty fundamental. We are dealing with ending a person’s life. We are dealing with circumstances in which it is possible that both the coordinating practitioner and the consulting practitioner for a patient may not have any relevant and ongoing knowledge and experience of the patient’s full history—not just their pure medical history, but the more holistic knowledge that a medical practitioner, particularly a GP, would gain when they have had a patient for a long time. As that is not provided for in this bill, and so there is no need for any particular long-term understanding or experience of the medical issues or the overall history of a patient, including ideas about whether there are any family pressures, coercion, duress and the like, there should be a requirement that in signing off that a patient has a disease, illness or medical condition that is expected to cause the patient’s death, at least one of the practitioners has some relevant expertise and experience in that disease. If we used the often misused idea of a pub test or a cafe test—we could use a cafe in Maylands or in Hillarys, wherever people want to use the test—and pulled over the average person on the street and walked them through this sort of procedure, they would nod their head and agree that if we are signing off that someone has a disease, an illness or a medical condition that is expected to cause the patient’s death, for the purposes of permitting them to end their life, one of those medical practitioners signing off should know a bit more about that disease, illness or medical condition than the average man on the street. I will leave it at that. From the experience we have had over the past three days, it seems as though the bill that we have been presented with is a fait accompli. Suggestions might be accepted in principle but not in practice. I would imagine that these suggestions will meet with the same result as other suggestions, whether formal amendments or simply suggestions of improvement. This would improve the bill and add a significant safeguard. It would assuage the doubt of many people in the community. I hope that my previous experience over the last three days is not repeated and that the sense and logic of this amendment is accepted by the government and introduced into the bill.
Dr M.D. NAHAN: Earlier we discussed this issue of whether one of the medical practitioners involved in the process had specific expertise in this area. I cannot imagine a situation in which that would not happen. If a person goes to a general practitioner with an ailment, on almost every occasion the GP will send them to a specialist to identify the disease and make the percentage diagnosis. If a GP is involved in the care of a patient considering voluntary assisted dying, I cannot imagine that a GP would not send their patient to a specialist—one would be struggling not to see a specialist. If a person had something fundamentally wrong with them, I do not think a GP would not do it because they might be sued. The public that supports a move down this path would expect this to happen, so why not put it into the bill? It is a logical step that everyone would expect to happen. In 99 per cent of cases, the GP coordinates the patient’s care irrespective of what is in the bill, but for that other one per cent, a person with relevant expertise might need to coordinate the care of a patient, particularly in rural areas where there might not be specialists.

Mr R.H. COOK: The medical practitioner involved has to make not only a decision on the prognosis for the person’s survival, but also a range of decisions, which we have discussed at length here today, about the person’s capacity to make a decision and the enduring nature of that capacity, whether that person has been coerced and whether that person is impacted by other issues. In fact, a general practitioner is better placed to make this call than a specialist. A specialist can tell us about the tumour, its impact and the technological aspects of it, but this is about the whole patient, and in particular whether their suffering has got to the point where it is unbearable. From that point of view, this is absolutely the right way to go.

We sought advice from the Ministerial Expert Panel on Voluntary Assisted Dying and it backed this position. As I said, this position was endorsed by the Joint Select Committee on End of Life Choices in its report, and the WA branch of the Medical Board of Australia also provided advice to the ministerial expert panel that this was the appropriate way to go. It does not mean that a specialist cannot be involved in the process. It may be that a specialist is one of these people, but we do not need to unnecessarily place restrictions on this provision. As the member for Riverton so eloquently outlined in his comments just then, a general practitioner is armed to the back teeth with reports from specialists. Those reports will inform the general practitioner in this case about the issues related to the prognosis. But it would not inform the general practitioner about how that patient is feeling about their situation, about their level of distress or suffering, or about their decision-making capacity. The consulting practitioner needs to make a range of other decisions and assessments in this regard. The member for Hillarys said that this is a simple, quite straightforward and reasonable safeguard. I think it is actually quite damaging and I do not believe it is necessary. If we are serious about people in more isolated communities having access to the same rights as everyone else in the community, this amendment is counter to that objective.

Ms M.M. QUIRK: I have had the opportunity to look at clause 25, which we will probably talk about at some length shortly. It requires a referral to a specialist only if the coordinating practitioner is “unable to determine”. In the worst-case scenario, the coordinating practitioner might, with overconfidence, not regard themselves as incapable of making a determination. Not only is a level of competence not required, but there will be cases when people overstep their level of competence and, on top of that—I am beginning to sound like a broken record—there is no requirement expressly stated in the act about independence.

Division

Amendment put and a division taken, the Deputy Speaker (Ms L.L. Baker) casting her vote with the noes, with the following result —

Ayes (8)
Dr D.J. Honey
Mr A. Krsticevic
Mr R.S. Love
Ms M.M. Quirk
Mr P.A. Katsambanis
Mr S.K. L’Estrange
Dr M.D. Nahan
Mrs A.K. Hayden (Teller)

Noes (38)
Ms L.L. Baker
Mr M. Hughes
Mr Y. Mubarakai
Mrs J.M.C. Stojkovski
Dr A.D. Buti
Mr D.J. Kelly
Mr K. O’Donnell
Mr C.J. Tallentire
Mr J.N. Carey
Mr Z.R.F. Kirkup
Mrs L.M. O’Malley
Mr D.A. Templeman
Mrs R.M.J. Clarke
Mr W.R. Marmon
Mr P. Papalia
Mr P.C. Tinley
Mr R.H. Cook
Mr M. McGowan
Mr S.J. Price
Mr R.R. Whitby
Ms M.J. Davies
Mr J.E. McGrath
Mr D.T. Punch
Ms S.E. Winton
Mr M.J. Folkard
Ms S.F. McGurk
Mr J.R. Quigley
Ms A. Sanderson (Teller)
Ms J.M. Freeman
Ms L. Mettam
Mr D.T. Redman
Ms B.S. Wyatt
Ms E.L. Hamilton
Mr D.R. Michael
Ms R. Saffioti
Ms J.J. Shaw
Mr T.J. Healy
Mr S.A. Millman
Ms J.J. Shaw

Amendment thus negatived.

Extracted from finalised Hansard
Clause 16: Eligibility to act as coordinating practitioner or consulting practitioner —

Mr Z.R.F. KIRKUP: Clause 16(3) states —

The CEO must publish the requirements approved for the purposes of subsection (2)(a), (b) and (c) on the Department’s website.

Obviously, the eligibility requirements will be published publicly. Why is there a need to continue to publish them on the department’s website if they are already in the bill?

Mr R.H. COOK: I am advised that even though someone might be a medical practitioner, they would need to hold other skills or have other levels of experience to provide them with clinical currency in addition to their basic qualifications. For instance, they might have additional aspects to their licence. It would be those subsequent requirements for a medical practitioner.

Mr D.T. REDMAN: I wanted to canvass a point that has been raised in all the discussions on VAD, and that is the commentary around the independence of the two assessments. I recall the minister at different times stating that there are two independent practitioners and the expert panel’s review refers to at least two independent assessments.

Mr R.H. Cook: Yes.

Mr D.T. REDMAN: There is a notion of two independent practitioners and two independent assessments. Page 65 of the “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report” refers to ensuring the independence of the practitioners and makes the point that if the two practitioners come from the same practice, it would seem a bit close. It refers to one practitioner having authority over another, which might put pressure on the second practitioner having a decision that complies with the first. I would be interested in the minister’s guidance on what provisions the bill makes for two truly independent assessments and, by extension, in the sorts of areas that the Nationals WA represent where there are limited doctors. The scope to get two independent practitioners could be problematic. If there were only two or three in town in one practice and two independent doctors was a formal requirement, it would certainly limit access to voluntary assisted dying in some isolated parts of the state. I am interested in what direction the bill gives to the independence of the assessments and where, if anywhere, the criteria about the independence of the practitioners is expressed.

Mr R.H. COOK: I thank the member. When the Premier was acting in this spot earlier today, he provided some commentary on this issue. The independence comes from their assessment. The member would know, as I am sure we all appreciate, there is not a lot of independence in the medical fraternity of Western Australia anyway. They all went to uni together and know each other. It is one of the great strengths and in some respects an inherent weakness of our health system. The independence is with regard to the assessment that they make of the patient. Do not forget that they must then, on the authorised form, make a declaration about their assessment. They are held responsible for that assessment. They cannot sign off the assessment with, “Well, the other person thought it was a good idea. Therefore, I do too.” They have to make that assessment themselves.

Mr Z.R.F. KIRKUP: Clause 16(3) states —

Is that factor a consideration in determining an independent assessment?

Mr R.H. COOK: In relation to that issue around independence that we discussed, obviously, if someone is to be a coordinating or consulting practitioner, they have to be registered as such and receive the training and be in a position to serve in that role. The board will have oversight of the practitioners who can serve in that role and, through the implementation period, will be able to get a better understanding of the overall distribution of medical practitioners who are participating to make sure that there is no suggestion that somehow they are forming a posse. What we will see, in the context of the implementation period and the oversight of the board, is an understanding of what best practice is in relation to the process to make sure that we have true independent oversight and that those assessments are undertaken as part of an independent assessment.

Mr A. KRSTICEVIC: The minister referred to an independent assessment between two practitioners, and I ask the minister to clarify something. To me, that would be a process in which they are both given access to the raw information without anyone having made any interpretation of it. In analysing that raw information, they may then come to the same conclusion. I want to make sure that we are talking about that, but also, if a practitioner knows that they are the second practitioner that the patient is coming to see, from my perspective that practitioner will already have a preconceived idea that the first practitioner has already given a sign-off and a tick. The second practitioner is starting from a position of saying, “I’m the second practitioner now; therefore, they must have already had one that gave them the green light, otherwise they would not be coming to see me”, so they are already starting with a preconceived notion in their head of what the diagnosis should be before they have even looked at the information. I am wondering if there is a way of making sure that they do not know that they are the second practitioner. They are just one practitioner and it just happens that at the end of the process there are two; could that be perceived as bearing some influence on such a case?
Mr R.H. COOK: I think the member once again mischaracterises the role of medical practitioners in our community. They have many years’ training and have sworn a range of oaths and have obligations under the law to undertake their practice in a particular way and without interference. Yes, they will have the same raw information as the member described it. I should just say that the raw information will include detailed interviews that they will undertake with the patient. They will not have the initial assessment, but it stands as self-evident that they would know, if they are the consulting practitioner, that the coordinating practitioner has already formed their assessment.

Dr M.D. NAHAN: Just to follow up, I would like to explore this a bit. As the member for Warren–Blackwood mentioned, in rural areas there are a lot of towns that have just one medical practice with a limited number of partners. In that situation, can both medical practitioners who carry out the assessment be employed by the same firm, be in partnership in the same practice, or use the same database? If a patient comes and sees the coordinating practitioner, the practitioner will put all the data on the database of the practice. If the second practitioner also works at the same practice, they will then look at that data. That is what they do when they go into practice. I go to a bulk-billing clinic and I rotate doctors; I do not necessarily see the same doctor each time, and they all use the same database. Is there some process in train to allow the same medical practice to do that, but to have some sort of independence so that there are two completely independent assessments?

Mr R.H. COOK: It is technically possible that they could be in the same practice. They would both be informed by the same medical records, as would any two doctors undertaking that process. Again, they would have to each sign and make declarations consistent with the assessment process on the authorised forms that they have come to a decision about that assessment.

Mr W.J. JOHNSTON: I have a couple of questions. Under subclause (3), does the chief executive officer already have draft requirements? I apologise if this question has already been asked, because I have not been here for the whole debate. If the CEO has draft requirements, can that be tabled or provided to members?

The DEPUTY SPEAKER: Is this relevant to this clause?

Mr W.J. JOHNSTON: Yes, it is under clause 16(3).

Mr R.H. COOK: There is no working document on what those requirements would be, but to provide the member with a characterisation of how that might look, it might go to something to the effect of each coordinating or consulting practitioner satisfying particular requirements approved by the CEO. The CEO-approved requirements for specialist and general registration will include that the medical practitioner must have recent clinical experience—for instance, not working solely in management or research roles—and will have regard to the level of licence under which the practitioner currently practices. The member will know that in some instances—typically in the case of overseas-trained doctors—there are some things they can do, but other things that they must do under the supervision of another practitioner. The CEO will be responsible for saying that in addition to their technical qualifications, they may have to have a certain amount of clinical experience or, if they are a provisional or overseas-trained doctor, they may be limited in terms of how they can practise in the community. There will be limitations around those sorts of features.

Dr D.J. HONEY: I have a concern about clause 16(2)(c). One of the issues for the coordinating practitioner is in determining whether the person has capacity or is suffering from any particular mental health condition or, as a number of us have discussed a number of times, whether the person is subject to any undue influence. One issue that could have a dramatic effect on the assessment of a patient—this was certainly a contributor to the case I mentioned yesterday—is cultural differences. Someone who comes from a vastly different culture might not be familiar with our community, and I recognise that we have a diverse community. I am wondering if that might be a confounder here—that an assessment might be affected by those cultural differences. We see again and again at a societal level that we are very empathetic about people within our society and community. If someone is killed in Cottesloe, it is a dramatic thing and affects everybody in that community and in Perth more generally; but if someone is shot in Beirut, or 100 people are shot in Beirut, they are not part of our community and not part of our society, and I know that some people may care, but in large part, people ignore it. We see that time and again. I wonder whether that could end up being an issue if we have people involved in this process who have not spent a lot of time in our community. Cultural differences may lead to inaccurate assessments.

Mr R.H. COOK: Whoa!

Ms A. Sanderson: interjected.

The DEPUTY SPEAKER: I was looking for relevance, but I think we will pay it. Go ahead, minister.

Mr R.H. COOK: Once again, the member is reflecting upon our medical workforce. He continues to do this and, quite frankly, I do not understand why. They are an extraordinary group of people, regardless of where they come from. The CEO-approved requirements for limited or provisional registration necessarily limit the types of medical practitioners, so that only an overseas trained specialist who meets all of the following criteria may apply to be a consulting or coordinating practitioner: their registration allows them to work in a gazetted area of need, or as a sponsored provider within a health service in WA; they have undergone a formal assessment by the relevant
Australian college; the relevant Australian college has approved their specialist pathway and supervision program; they have at least five years of experience as a consultant; and they have completed at least 12 months working in a supervised position within Western Australia. Essentially, these are people with extraordinary skills who are recognised as specialists within our jurisdiction and many others, and they would have all the skills necessary to carry out their duties.

Dr D.J. Honey: I hope the minister is being genuine, because that sounds like a disingenuous comment at the start. It is not a criticism of a person’s professional skills, or other medical practitioner per se. This comment would apply to anyone.

Ms A. Sanderson: That is exactly what it is.

Dr D.J. Honey: No, it is not. It is that when people come from quite different cultural backgrounds, they can misinterpret it. We are talking here about a very subtle matters. In particular —

Mr M. Hughes: It’s drivel.

The Deputy Speaker: Members, can we get on with this please.

Dr D.J. Honey: We were told that this would be a respectful debate, and that comment is an extremely disrespectful comment.

Several members interjected.

The Deputy Speaker: Members! I do agree with the member. This needs to be a respectful debate. We are here for a long haul with this, so please keep your cross-chamber comments to yourselves. Member for Cottesloe, would you please get to your point?

Dr D.J. Honey: I am. Thank you, Madam Deputy Speaker.

It is not a criticism of the medical practitioner. This comment on this query could apply to any person, whether an engineer or someone else. It is just that some of the matters that are trying to be assessed here are very subtle; in particular determining whether there has been coercion or not. I understand from what the minister has said about the period of 12 months, maybe it is an unfounded concern, but I have a concern that if someone comes from a very different cultural background, regardless of their medical expertise, it may not be possible for them to make those subtle assessments that go to whether this person has been influenced to make this decision.

The Deputy Speaker: Thank you, member. I am not sure about the relevance of this, and I think the minister has already answered it. Go ahead, minister, if you want to.

Mr R.H. Cook: Obviously part of one’s medical training would be cultural competency, and understanding the dimensions of that is an important area for carrying out their duties.

Mrs A.K. Hayden: I want to follow on briefly on the question raised by the Minister for Mines and Petroleum about clause 16(3). If I understand correctly, the minister said that no list is currently available, so where it states that the CEO must publish the requirements approved for the purposes of subsection (2)(a), (b) and (c) on the department’s website, when would that list be made, and when would it be put up on the website?

Mr R.H. Cook: If the Parliament passes this bill, it will be done during the implementation phase.

Ms M.M. Quirk: I am also going to clause 16(3), which reads —

The CEO must publish the requirements approved for the purposes of subsection (2)(a), (b) and (c) on the Department’s website.

I really do not want to be a pedant—I know my colleagues probably think that I am—but we had a query earlier in relation to clause 7, “Voluntary assisted dying substance”, in which it says that the CEO may in writing approve a schedule for poisons. I think we were advised at that stage that that was a drafting style rather than a direction, whereas in clause 16(3) it says that the CEO must publish the requirements. Can the minister explain why there is that difference? Apparently the drafting style has been abandoned when it comes to this subclause. I am just not sure.

Mr R.H. Cook: This is not a drafting style. This states that the CEO has a responsibility to publish and make public the requirements with regard to each of those subsections.

Ms M.M. Quirk: Surely under clause 7, the CEO has a responsibility —

The Deputy Speaker: Member, we have dealt with clause 7.

Ms M.M. Quirk: It is to do with the drafting style, and I was specifically given that answer. Yes, I am aware of that, Madam Deputy Speaker. In relation to clause 16(3), the minister has just answered that the CEO has a responsibility to publish those requirements but, according to that, the CEO does not have a similar responsibility to approve the use of poisons in writing.

Mr R.H. Cook: That is right, member. Under clause 7, the CEO has an authority, and under this clause he or she has an obligation.

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: Can the minister confirm that the website that this information would have to be published on would be the Department of Health website, presently health.wa.gov.au, just for the purposes of all this?

Mr R.H. COOK: Yes.

Clause put and passed.

New clause 16A —

Ms M.M. QUIRK: I live in hope. I wonder whether members have had time to reflect on the prudence of including such a provision. I move —

Page 14, after line 5 — to insert —

16A. Relevant expertise and experience

Either the coordinating practitioner or consulting practitioner for a patient must have relevant expertise and experience in the disease, illness or medical condition expected to cause the patient’s death.

We have had some discussion about the fact that there is no requirement for referral to a specialist. That only occurs where the initial doctor is unable to determine. As I said, he might have an overweening confidence or ego, and think that he can well diagnose a disease or condition, so the requirement for a specialist is only activated when the diagnosing doctor is unsure or uncertain. For that reason, I have moved this provision.

Mr R.H. COOK: We dealt with this particular argument during debate on the last clause. The member moved the amendment related to the title of the division and we decided that we would discuss both issues because one was material to the other. However, it was really a requirement of the member to have moved the second amendment. I assumed, given she did not move the second amendment, that she had decided not to progress with it because the argument had already been had around the title of the division. The Deputy Speaker may need to take advice, but in the spirit of this debate I am happy to go to a vote on the amendment. I do not know how we do that consistent with the standing orders, so I seek the Deputy Speaker’s guidance.

The DEPUTY SPEAKER: Members, I moved quite quickly to clause 17. I am prepared to give the member for Girrawheen the opportunity to speak on new clause 16A, if she wants to, as we have started to discuss it. Member, did you want to move straight to putting it?

Ms M.M. QUIRK: I am happy for it to go to a vote.

New clause put and negatived.

Clause 17: Person may make first request to medical practitioner —

The DEPUTY SPEAKER: The member for Dawesville was on his feet. I do apologise for that.

Mr Z.R.F. KIRKUP: Clause 17 relates to the first request. Subclause (2) states that the request must be clear and unambiguous. The minister has provided us with some clarity over the last couple of days about what that looks like. I am trying to think of alternative situations. Someone might have a speech impediment or they cannot speak, or they speak a language other than English in a remote Aboriginal community. Language is obviously a barrier when it comes to people in authority, so there might be some concerns. Can the minister provide us with some insight as to what that might look like for people, say, from a disadvantaged circumstance?

Mr R.H. COOK: Clause 17 provides —

(1) A person may make a request to a medical practitioner for access to voluntary assisted dying.

The first request must be clear and unambiguous and made by the person either in person or by means of audiovisual technology. This provision takes into consideration the geographical spread of Western Australia and that some people may need remote access to medical services. The request may be verbal or by gestures by other means of communication available to that patient. This is to prevent discrimination against people on the basis that they cannot speak. As long as their request is clear and unambiguous, this will suffice.

This clause reflects the position that a request for access to voluntary assisted dying must be distinguished from a request for information about voluntary assisted dying. That is why this provision requires the request to be clear and unambiguous. The patient is also able to communicate via an independent accredited interpreter, which is covered under clause 160. The medical practitioner who receives the request will ascertain whether the request is clear and unambiguous. “Unambiguous” is an ordinary, commonly understood term. It would be evident to the medical practitioner what the patient’s intent is.

Mr Z.R.F. KIRKUP: Hello, Acting Speaker.

The ACTING SPEAKER (Ms J.M. Freeman): Hello.

Mr Z.R.F. KIRKUP: It seems I am following the member for Kalgoorlie at this point in time, with the greetings!

The ACTING SPEAKER: Greetings!

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: If a request were to be made via a gesture, could I have some indication what that might be? I believe a first request would be a very poignant conversation and a very appropriate one to have. To me, the gesture element is a difficult part because I think it is a relevant empowerment for a patient to make. We need to be satisfied that there are expectations on practitioners about what they should be expected to interpret or understand. This is a relatively complex and difficult conversation for people to have at the best of times; that is, if they are making a first request to their practitioner. In a gesture sense, do we know what that might look like or does the minister have other examples from other jurisdictions as to what it might look like?

Mr R.H. COOK: The member will recall that I provided some extensive information about this earlier to the member for Scarborough. A person who is in this situation will have already established protocols and arrangements about how they communicate with their treating physician. Obviously, it would not be a simple wave in the air; it would be something which is considered, as I said, clear and unambiguous. The role of the medical practitioner in this case would be to satisfy themselves very clearly, consistent with those protocols. I would imagine, particularly in a technology-driven world, that an iPad would play a clear role in this for someone who could not speak, for instance. We are trying to create a balance between making it available to people who do not have that immediate capacity but just make sure that there is an obligation on the medical practitioner to be satisfied that it is both clear and unambiguous.

Mr Z.R.F. KIRKUP: I appreciate that response. I understand the need to make sure that it is as unambiguous as possible. When I interpreted “gestures”, I assumed it was to gesticulate; not to rely on another device to do it on the patient’s behalf. I think it makes much more sense if there were the capability for an iPad or some other computer to intercede in the conversation or to be used on behalf of an individual who might not be able to communicate. In the minister’s mind, will language gestures be satisfactory in terms of catching the requirements for another device to be used? Do we not need to define that a device might be used? Is the minister okay with the word “gesture”? I realise we have to make sure it is clear and unambiguous. I assume a device would be used to communicate a clear and unambiguous message; is that right?

Mr R.H. COOK: Yes. Context is everything of course. In this sense, the patient may use sign language. They may have a physical gesture but one which is about communicating detailed information to their treating clinician. Do not forget that communication is a two-way street. They would have to be able to conduct a conversation through alternative means, albeit in a way that provides clarity and is unambiguous.

Mr D.T. REDMAN: My question goes to the broader issue of communication in isolated areas of the state. There is reference in clause 156(2)(a) to a person who is not able to make a request in person being able to access audiovisual communication. I want to confirm whether the opportunity to use an audiovisual device as a strategy of communication simply refers to the component of the process in and around the first request, the final request or the administration decision. Is it correct that there are only those three circumstances in which audiovisual communication can be used as a matter of communication as distinct from in person?

Mr R.H. COOK: Just to clarify, is the member talking about a person who is remote from the practitioner?

Mr D.T. Redman: Yes.

Mr R.H. COOK: Okay.

I take the opportunity, while I am on my feet, to refer the member for Dawesville to clause 156.

We anticipate that there will be remote patients in Western Australia who want to engage with a coordinating or consulting practitioner. We have not prescribed which parts of the process would involve the capacity to utilise teleconference or telephone communication because, essentially, that is part of an ongoing conversation that the patient would have with their medical practitioners. They may not need just one communication to form the assessment. They might want to have a number of conversations with the patient before they come to their conclusions on the assessment. Some of those might be face to face. However, the member would understand that, in another instance, they might say, “I’m going to get back to the person and clarify that particular issue”, or, “I’m worried about that comment they made”, and that might be done through an alternative means. Therefore, from that perspective, we anticipate that in Western Australia there would be utilisation of some of that communication capacity.

Mr D.T. REDMAN: Further to that, I promote and support alternative methods of communication.

Mr R.H. Cook: Indeed.

Mr D.T. REDMAN: I also promote moving to a process in Western Australia in which general practitioner services could be provided by audiovisual or other means. We now have emergency telehealth, which is very successful. Those things certainly provide opportunities. This clause makes reference to clause 156(2) of the bill. I am jumping ahead a bit, but that states, in part —

If it is not practicable for a patient to make a first request, final request or administration decision in person —

(a) the patient may make the request or decision using audiovisual communication; and

Extracted from finalised Hansard
That seems to limit the audiovisual communication to those three components of the process—the first request, the final request and the administration decision—as distinct from the practitioner’s assessment. Therefore, I guess by extension, would it be possible for the full consulting or coordinating practitioner’s assessment of that first stage to be done through the use of audiovisual tools, as distinct from in person?

Mr R.H. COOK: It is jumping ahead. We will come to that when we get to clause 156. I appreciate that clause 17 makes reference to clause 156, but that is simply to facilitate —

Mr D.T. Redman: That clause is just with respect to the first request.

Mr R.H. COOK: Indeed. Essentially, clause 156 facilitates the capacity for the first request to be made using audio telecommunications equipment.

Dr D.J. HONEY: I want to get this clear, because this is inextricably tied to clause 156(2), and perhaps it will save some debate later to discuss it more broadly. Does this mean that a person could go through this process without seeing a medical practitioner in person? Could a person go all the way through to having the administered substance delivered to them without ever having face-to-face contact with a practitioner? I do not want to hear the general “It would not happen” or “We would not expect it to happen.” I want to know whether that could happen under this bill.

Mr R.H. COOK: That is not relevant to clause 17.

Dr D.J. HONEY: I think it is, minister, because this is obviously the first part of initiating the process.

The ACTING SPEAKER: Member, under standing order 94, “Relevance”, it has to be relevant to the debate.

Dr D.J. HONEY: I believe it is relevant, thank you very much, Madam Acting Speaker. Clause 17(3) states —

Would a person who had a disability and could not speak clearly be able to access that remote method of communication?

Mr R.H. COOK: No, the person could not, if the person with the disability, or whatever the member referred to, did not have the capacity to make a clear and unambiguous statement or request. Essentially, this is about two things—first, providing an opportunity for a person to make a first request by other than verbal means; and, second, making sure that that request is clear and unambiguous.

Mrs A.K. HAYDEN: I want to follow on from the member for Warren–Blackwood about communications. Can the minister explain how a non-verbal communication could be made clearly and unambiguously by means of an audiovisual communication? Could the minister explain that to us so that it will be clear for anyone who may read this debate? How can we make sure that the telecommunication will be unambiguous if the person has a problem communicating?

Mr R.H. COOK: This is very similar to the question from the member for Cottesloe. The person would need to have telecommunications capacity. They could use sign language, a communication board or some form of digital device. If the person could not do that, such as if they were on the telephone and the medical practitioner was not able to see the person’s hand gesture, or something of that nature, that would not constitute a clear and unambiguous request.

Dr D.J. HONEY: For the purposes of section 19, if a person in a remote community wanted to access this and they found a medical practitioner’s number in the telephone book and called that person, would that trigger the obligations under those other clauses. It is not a smart alec question; it is an important question.

Mr R.H. COOK: No, it would not.

Mr W.J. JOHNSTON: I have one simple question about clause 17(2)(b). I understand that we will get to clause 156(2)(a) in the future, but of course it is relevant here, because the minister has referred to it. Will the request need to be made contemporaneously? In other words, could the person record their request and send it, or would it need to be made live to the practitioner?

Mr R.H. COOK: It has to be contemporaneous.

Dr M.D. NAHAN: Similar protocols and processes must already exist for doctors who have to make decisions about palliative care for patients who perhaps are in a similar situation. Is this building on similar processes that already exist in the medical profession?

Mr R.H. COOK: Yes.
Mrs A.K. HAYDEN: I am not across all of this, and I know our member for Hillarys would be far more educated on this area than me, but was there any federal legislation flagged in regard to this bill and the commonwealth Criminal Code related to disseminating material online to do with suicide? Was that ever looked into? Does the bill conflict; and have any safeguards been put into it to make sure it does not?

Mr R.H. COOK: Yes, it was considered.

Mrs A.K. HAYDEN: Does the bill conflict with any commonwealth legislation; and, if so, has anything been done in this legislation to make sure that does not happen? The last thing we would want is for a doctor to get caught up in unintended consequences of committing a criminal act under federal law.

Mr R.H. COOK: We covered this extensively this morning. I tabled information that was provided to me by —

Dr D.J. Honey: She was not here.

Mr R.H. COOK: Is that right? My apologies. This was canvassed extensively this morning and those issues were thoroughly ventilated.

Mr K.M. O’DONNELL: Greetings, Madam Acting Speaker.

The ACTING SPEAKER: Greetings, member for Kalgoorlie.

Mr K.M. O’DONNELL: I stepped out of the chamber, so I hope my question has not been answered. I refer to the request being clear and unambiguous. In my electorate we have a good service provider in Goldfields Individual and Family Support Association for disabled people. I cross paths with quite a few of them at market days, movie nights and things like that. When I say hello to some of them, I get an “uhhhhhhh” sound. I do not know how Hansard is going to record that!

Dr M.D. Nahan: How do you spell it?

Mr K.M. O’DONNELL: I apologise, Hansard!

I am not trying to find a crack in this clause, but disabled people have the same feelings and pain threshold. If that person struggles with speech, the carer probably understands what they are going through, but how can they convey that? Does that minister understand where I am getting to?

Mr R.H. COOK: We have covered this extensively. It essentially comes down to the ongoing protocols that they have to communicate with their carers and physicians, and those protocols may be a range of things. The conversation would certainly go beyond the sort of dialogue that the member might expect at the local market day. When they are discussing their medical needs with their doctors and other carers, they would obviously have more robust and accurate ways of describing things and communicating. As I said, communication is a two-way street, so clearly there would be ways that they could undertake that process. Please, members, understand: at all stages the request must be clear and unambiguous.

Mr Z.R.F. KIRKUP: Just to clarify one aspect, the practitioner who receives the first request has to note it on a form or prescribed documentation to the board. Let us use gestures as an example: How would they describe them? Is there capacity for them to provide that information to the board? I am trying to understand the situation, by extension, that the member for Kalgoorlie described to us. If a carer acted on behalf of the person making the request, would they have to record that the carer acted on their behalf? If the person used gestures, would the practitioner have to explain those gestures? Will there be capacity in the information that has to be provided to the board to record and reflect that?

Mr R.H. COOK: Obviously, how practitioners interact and record those interactions with their patients would be part of their clinical training. They would have all kinds of patients before them with differing ways of communicating. How they would report the first request to the board is covered in clause 21 and what the member is asking is covered in clause 21(2)(d).

Ms M.M. QUIRK: I just have a couple of queries on this clause. Clause 17(2)(b) applies that a request can be made by way of audiovisual communication. When Attorney General Quigley wrote to Hon Christian Porter, the federal Attorney-General, was it contemplated whether this clause breached commonwealth law?

Mr R.H. COOK: The whole bill was crafted in contemplation of the commonwealth legislation that it has to be in concert with. As the member will recall, we had a lengthy discussion this morning about that relationship. These are the sorts of issues that the Attorney General and the commonwealth Attorney-General will no doubt discuss.

Ms M.M. QUIRK: I will ask the other question I had. This is not me being glib, but we need to get this on Hansard. I have looked up the definition of “gesture” and one common definition is that it is movement of a part of the body, especially the hand or the head, to express an idea or meaning. That is good. A second common definition is that a gesture is an action performed to convey a feeling or intention. That is good; it is also in the spirit of the clause. The third common definition, though, is an action performed for show in the knowledge that it will have no effect. For the purposes of Hansard, the minister will need to say that the first two meanings of “gesture” are relevant to the intent of the legislation, but that the third is not.

Extracted from finalised Hansard
**Mr R.H. COOK**: I draw the member’s attention to subclause (2)(a), which states that the communication must be clear and unambiguous. Therefore, the request must be able to be communicated effectively.

**Mr P.A. KATSAMBANIS**: I do not want to go over ground that has already been covered, but I think it is really important to deal with interaction between clause 17 and clause 156(2)(a). Was the correspondence that the Attorney General sent to the federal Attorney-General, Mr Porter, on 28 August, which I believe is the day we started debating this bill in this place, done on the minister’s request or in consultation with him or was it done by the Attorney General in his own right?

**Mr R.H. COOK**: I think we have now passed the threshold of repetition and relevance. We covered these issues at length this morning and I really think we have dispensed with them.

**Mr P.A. KATSAMBANIS**: I take issue with that. If the minister does not want to answer that question, that is fine. He can put on the record that he does not want to answer that question.

**Ms A. Sanderson**: Do not verbal!

**Mr P.A. KATSAMBANIS**: There are people on your side who are experts at verbalising—absolute experts at verbalising!

**Mr R.R. Whitby**: Tone it down; keep it respectful.

Several members interjected.

**The ACTING SPEAKER (Ms J.M. Freeman)**: Member for Hillarys —

**Mr P.A. KATSAMBANIS**: I want to continue.

**The ACTING SPEAKER**: I am just going to let you settle down, member of Hillarys.

**Mr P.A. KATSAMBANIS**: I am very settled.

**The ACTING SPEAKER**: Are you all right? Are you okay?

Several members interjected.

**The ACTING SPEAKER**: The question is —

**Mr P.A. KATSAMBANIS**: I have not finished! I am pausing. I have noticed that there seems to be a lot of haste in shutting people down when they are halfway through their questions. It is not good enough.

**The ACTING SPEAKER**: And your question is?

**Mr P.A. KATSAMBANIS**: The issue here is that the constitutional validity of similar provisions in Victoria and their interrelationship with the commonwealth Criminal Code were first raised by the Victorian health minister on 26 June —after this bill had been drafted but well before it came to this place for debate. I want to know, firstly, why it took from 26 June until 28 August for our Attorney General to contact the federal Attorney-General. Secondly, did the state Attorney General do this off his own bat or did he do it in consultation with the health minister, who is the minister responsible for the bill that is at question here in the correspondence between the two Attorneys General? Thirdly, I would like to know what legal advice was received by the state of Western Australia between 26 June and 28 August, either by the Attorney General off his own bat or in consultation with the minister, that gave rise to the concerns that led to that letter being sent to the federal Attorney-General. I think the people of Western Australia have the right to know, and particularly the practitioners and patients who might want to utilise this clause and who might be forced to utilise it in many cases because of the absence of medical practitioners in some parts of Western Australia. I think those people deserve and have the right to know. I ask it, as I have asked all questions around the operation of this bill, in good faith. I want to be assured that the legislation the government has presented here is actually going to work. I also want to know what the process was in the lead-up to it. I ask the minister to answer those questions. I think they are pretty simple. They are fair questions. The warning was raised in Victoria on 26 June. It took more than two months before the Western Australian government took some action. What happened within that time and who is leading this conversation with the federal Attorney-General—is it just our Attorney General on his own or is it in consultation with the minister?

*Extracted from finalised Hansard*
Mr R.H. COOK: I appreciate that the member is very concerned about this. Therefore, he should perhaps have been here for the debate this morning when we canvassed these issues with the member for North West Central.

Mr P.A. Katsambanis: I was, but this is the point to ask it!

Mr R.H. COOK: And in the context of that debate, I said to the member for North West Central, “Look, I appreciate that these issues have been raised and we can discuss it now to save us time later.” Everyone nodded furiously.

Mr P.A. Katsambanis: That was his issue, not mine.

The ACTING SPEAKER: Member for Hillarys!

Mr R.H. COOK: Is the member confirming that he wants to have the debate again?

Mr P.A. Katsambanis: No, this is the right place.

Mr R.H. COOK: Is the member saying that he would like to have the debate again—is that right?

Mr P.A. Katsambanis: In summary, I have asked you three direct questions.

Mr R.H. COOK: In summary, we became aware of it on the same day that the Victorians did, because the issue was raised in public. The Department of Health has had extensive consultations with the Department of Justice and the commonwealth Attorney-General’s Department and his office. Those conversations are ongoing. The Western Australian Attorney General wrote to his federal counterpart, Hon Christian Porter. What was going on between 26 June and that time? Obviously, there were extensive discussions with the Solicitor-General, the State Solicitor’s Office, the Department of Justice and the Director of Public Prosecutions. This process was widely dissected this morning. I suspect that when we get to clause 156, the member may want to raise these issues again.

Mr P.A. Katsambanis: Not if you answer them here.

Mr R.H. COOK: That was the commitment that was given to me this morning.

Mr P.A. Katsambanis: By whom?

Mr R.H. COOK: By the member for North West Central. Everyone was sitting around and nodding furiously. We have well and truly ventilated these issues. From that perspective, I think we should move forward so that we can consider other aspects of clause 17.

Ms M.M. QUIRK: I was really trying to assist in the last question, minister. It really would have taken only a yes or no answer, but I will now need to repeat it. In clause 17(3), the word “gestures” is used. If there is any ambiguity in the legislation when it goes to a court, the first place the court will look is the debates and what the minister said. I want confirmation that a movement of a part of the body—an action performed to convey a feeling or intention—is the gesture that the minister is referring to in this legislation. Does the minister just want to say yes and we can get on with it?

Mr R.H. COOK: By way of interjection, yes, but it would have to be clear and unambiguous.

Ms M.M. QUIRK: Yes. The third meaning of gesture is that it is an action performed for show in the knowledge that it will have no effect. For example, a shrugging of the shoulders would be ambiguous because it might mean that the person wants to end it all or it could mean that they do not care. All I am trying to do is to say that it is a clear and unambiguous action that is not an action to show that it will have no effect.

Mr R.H. COOK: From where did the member get the definition she gave?

Ms M.M. Quirk: I think it is from Webster’s dictionary.

Mr R.H. COOK: Obviously, there are a range of definitions that someone might use or refer to. Can I provide the member with the very clear advice that the gesture may be physical but the intent must be clear and unambiguous.

Ms M.M. Quirk: Thank you.

Mr P.A. KATSAMBANIS: I will return to the interaction between clause 17(2) and clause 156(2)(a). We want to know how the second part of clause 17(2)(b) is going to work—the “if that is not practicable” part. We are in a situation in which our Attorney General has written to the federal Attorney-General for clarity. I appreciate that the minister has made that letter of our state Attorney General of 28 August 2019 available through the tabling of it. I now request that the minister be prepared to give an undertaking that when a response is received from the federal Attorney-General, Mr Porter, he provide that response in some way that it becomes publicly available.

Mr R.H. COOK: As the member would be very aware, that is for the Attorney General to decide. I cannot make that commitment on his behalf.

Mr P.A. KATSAMBANIS: Could the minister at least undertake to request it of the Attorney General? This is a live issue. It is acknowledged by the correspondence itself that it is a live, unanswered issue. I think it would be extraordinarily helpful for those people who want to utilise these provisions to be aware of the federal Attorney-General’s answer. I think that would be the starting point.

Extracted from finalised Hansard
Mr R.H. COOK: I will certainly discuss it with the Attorney General. The commonwealth Attorney-General may not want his privilege waived in the context of making that letter public. I am happy to discuss it with him. As I said to the member for North West Central, this will not stop the legislation; it simply means that the Department of Health will have to adapt the way in which it operates. This is the commitment I gave to the member for North West Central this morning.

Mr P.A. KATSAMBANIS: I just want to clarify a point. The minister mentioned that the federal Attorney-General may not want to waive his privilege. I cannot see how any privilege, particularly legal professional privilege, would attach to correspondence between the state Attorney General and the federal Attorney-General. There might be other issues that the federal Attorney-General might want to raise, but I cannot possibly see how the federal Attorney-General could claim legal professional privilege in a letter that he would write to the state Attorney General in response to a request made by the state Attorney General, particularly given that that request has now been tabled in this Parliament. I will just give the minister the opportunity to respond. I understand that the federal Attorney-General may, if he wants to, request that the response be kept confidential. I do not know why he would do that but it is his right if he wants to do that. But just for clarity, I cannot see how any privilege, particularly legal professional privilege, would attach to that sort of correspondence.

The ACTING SPEAKER (Ms J.M. Freeman): I will take that as a statement.

Clause put and passed.

Clause 18: No obligation to continue after making first request —

Mr Z.R.F. KIRKUP: We spoke earlier about the enduring will. Clause 18(3) states —

If the request and assessment process ends under subsection (2), the person may begin a new request and assessment process by making a new first request.

Are there any time requirements that sit between the first and subsequent request? Can it happen almost immediately?

Mr R.H. COOK: There is no time requirement.

Mr Z.R.F. KIRKUP: If a person makes a request to their practitioner and is unsure about their requirements or what they want to do, I am conscious of the time taken between the request and the assessment stage. Was this not covered off when we talked about the enduring will? I thought that if a person were to get through the process, it would not have to be revisited, or is this provision specific to the first request and assessment stage of the process?

Mr R.H. COOK: Yes, that is correct. It is under this particular division.

Mr P.A. KATSAMBANIS: I would like some clarification on how this clause is going to operate. Clause 18(2) states —

The request and assessment process ends if the person decides not to continue the process.

There is no requirement that that person make the decision not to continue the process or communicate that decision to anyone else. In the absence of any communication of that decision, is it possible that the board may end up receiving multiple first requests on behalf of the same person if that person then decides to start the process all over again with a different practitioner at some point in the future?

Mr R.H. COOK: If the patient does not wish to continue to participate but does not make that request, one of two things may happen. A form would have been sent to the Voluntary Assisted Dying Board and it will sit on its books. The board might contact the consulting practitioner to find out what is going on. The medical practitioner might say, “This person has clearly had a different view of things. I haven’t had a formal discussion with them but it is clear that that’s their intention because I’ve called them a couple of times and they have not returned my calls.” But there is no formal way of withdrawing from the process. The patient may simply state that they do not wish to proceed.

Mr P.A. KATSAMBANIS: This process often deals with people in some distress, either through pain or more general stress. If a request is made but not followed up, and then sometime later through another practitioner, a second or a subsequent request is received by the board, in isolation and without knowing the individual, a question mark could arise around the issue of capacity. This person may have simply forgotten that they made a first request. In those sorts of circumstances, is there any obligation on the board to investigate further into that person’s state of mind, because there really cannot be an obligation on the next practitioner down the line because they simply do not know what has occurred? The state of mind might not necessarily lead to a lack of capacity, but just a question mark around it. What obligation is placed on the board under those circumstances?

Mr R.H. COOK: The board does not investigate matters itself but provides oversight of the process. If it saw any irregularities, it would refer the matter to the chief executive officer and say, “We have seen some irregularities here that we think you need to investigate.”

Mr P.A. KATSAMBANIS: It is really helpful to place that on the record. I think the minister understands where I am coming from on this. As I said earlier, we are dealing with people in immense pain and distress. We would not
want a circumstance in which a question mark arises in the system and the system does not respond. With a minister putting that on the record, I hope that the people dealing with these matters at the board and the CEO level take heed of that commentary and at least actively peruse the documentation that they receive.  

**Mr R.H. COOK:** Yes, that is the function of the board.  

**Ms M.M. QUIRK:** I want to raise two issues. Firstly, in what form does the request to discontinue need to be? Is it a similar form to that in clause 17; and, if so, why does the clause not say so?  

**Mr R.H. COOK:** There is no formal process to withdraw from the process. The patient may simply state that they do not wish to proceed.  

**Ms M.M. QUIRK:** I am acting as the devil’s advocate because we are very keen for there to be no issues around voluntariness or coercion. I would have thought that there probably need to be some protections in here because family members or whoever are forcing their loved ones not to proceed. If we are going to be consistent throughout the legislation, then perhaps there needs to be some formal assessment or judgement if there is a withdrawal.  

**Mr R.H. COOK:** Yes, member. As we have often said, the experience overseas is that the elements of coercion involve in the majority people trying to talk people out of the process, not into it.  

**Ms M.M. QUIRK:** That is what I am talking about.  

**Mr R.H. COOK:** That is why the medical practitioner would need to be alive or awake to those issues as well.  

**Ms M.M. QUIRK:** There is no requirement for that, as I understand it, minister.  

**Mr Z.R.F. KIRKUP:** We are talking about clause 18 and asking a number of questions about the enduring nature of what we are trying to achieve here. I think it is important that this clause is thoroughly scrutinised as part of the legislation. I am keen to flesh out the important role of the Voluntary Assisted Dying Board in tracking information when a patient chooses to no longer proceed with a first request. I am conscious that if someone is travelling around, makes a number of first requests and then stops, that might indicate a lack of enduring will or decision-making capacity. Will there be an option for the board to actively engage with a practitioner and say, “This person has actually done this a number of times. They’ve not proceeded with a first assessment as per this clause. This has happened a number of times, and you should just be aware of it”? I think the minister referred to a two-way street in terms of communication. Does the board have the capacity to go back to a practitioner and provide that feedback?  

**Mr R.H. COOK:** They would not go back to the practitioner; they would go to the chief executive officer.  

**Clause put and passed.**  

**Clause 19: Medical practitioner to accept or refuse first request —**  

**Mr P.A. KATSAMBANIS:** I have a query on the clause that is headed “Medical practitioner to accept or refuse first request”. A number of issues arise, but I refer in particular to clause 19(4), which states —  

Unless subsection (5) applies, the medical practitioner must, within 2 business days after the first request is made —  

(a) inform the patient that the practitioner accepts or refuses the request; and  

(b) give the patient the information approved by the CEO for the purposes of this section.  

My question is: why is that information to be in a form approved by the CEO and not, as is ordinarily provided in legislation, particularly for really important documentation, in a form approved by regulation—a prescribed form, made by regulation? Why was the decision made to exclude this sort of form from the appropriate scrutiny that regulations would be subject to in a democratic state like ours?  

**Mr R.H. COOK:** Is that the document referred to in clause 19(4)(b)?  

**Mr P.A. Katsambanis:** I was referring specifically to the document in clause 19(4)(b), but for the purposes of the question, so we are not repeating ourselves, all the documents required in this clause. The question applies, and I imagine the minister’s answer equally applies, to all the documentation required under this clause.  

**Mr R.H. COOK:** Some documentation, particularly forms lodged with the board, have an official and meaningful role in the process. In this case it is about the information that the patient must have so that the system is satisfied that the patient has the information in front of them. We want to make sure that the patient’s decision is well informed, and this principle is fundamental to the proposed model for voluntary assisted dying. That is why it is important that the chief executive officer has oversight. I do not think it is necessary for it to be a form that is tabled in Parliament; this is simply to make sure that the patient has the information that they need.  

**Dr D.J. HONEY:** This is a clause that a number of practitioners and certainly I have considerable concerns about. This is when we cross the line at which a doctor could potentially be compelled to participate in the VAD process against their wishes. Some doctors may wish to participate, but I suspect a large number of doctors will not wish to participate at all. Some doctors have a vehement personal objection to voluntary euthanasia. They find it abhorrent.
and in complete opposition to the Hippocratic oath to sustain life. To be frank, it makes them feel sick that they could be compelled to be involved in this process. We do not know what the information is, but I take it that, in the case of a refusal, it is information that tells the person how to access voluntary euthanasia somewhere else. We do not know that, but I take that to be the case, and I am happy to be informed about that. If that is the case, we will inevitably be compelling some practitioners who are vehemently opposed to any involvement in this process and think it is abhorrent to give the patient information to allow them to access the process. I understand that we have this libertarian view that a person should be able to do whatever they like, and that is fine. That argument can be progressed to varying degrees. But in this case, we are forcing doctors to do this. Referring to other clauses in the bill, if they do not do so, they will actually be potentially subject to an accusation of professional misconduct—we do not know how that will be determined—and a $10 000 fine. This is a really heavy hammer for medical practitioners who are utterly opposed to voluntary assisted dying, and should be allowed to be. But even if they are utterly opposed to it, they still have to participate in a process that they find absolutely abhorrent, and if they do not, they are subject to a fine.

A lot of the answers I have heard during debate on this bill are, “Oh, well, that wouldn’t happen. It probably won’t happen; no-one would do that.” The trouble is that we all know that if it is possible for something to happen, it probably will happen. If the board is composed of strident advocates of voluntary euthanasia, it could be that they will take a very heavy-handed approach; we do not know whether that will be the case or not. Can the Attorney General tell me whether I am correct or whether my concerns are misplaced? Perhaps we will start there.

Mr J.R. Quigley: Sure. When a patient consults with a doctor, be it in a hospital or a practice, it is a professional requirement for the doctor to keep notes on what the patient is approaching him or her about. If we go to clause 20, regardless of whether clause 20 exists or does not exist, the doctor would have to make a record in their notes. Let us forget this bill; the doctor would have to record in their notes that a patient had been talking about hastening their own death. That would be a professional requirement, as it is for a solicitor—as the member for Hillarys would know—to keep an accurate record of conversations with their client. Failure to do so would constitute professional misconduct.

I now go to clause 20(b), under which the practitioner must also record their decision to accept or refuse the first request. Sans this bill, the doctor would have to record that in his notes anyway: “A patient has approached me seeking to hasten their own death, and I said, ‘Don’t talk to me about that’”, or, “I don’t know anything about that”, or whatever. Paragraphs (a) and (b) of clause 20 place no additional professional requirement that the doctor is not already duty bound to record in his or her attendance notes. We now go to clause 20(c). If the practitioner’s decision is to refuse the first request, the reason for the refusal—

Mr P.A. Katsambanis: It’s the same answer as paragraphs (a) and (b).

Mr J.R. Quigley: Pretty well, the same answer as paragraphs (a) and (b): “I’m not going along with this, because I don’t believe in voluntary assisted dying.”

Mr P.A. Katsambanis: Or not—it could be for other reasons, too.

Mr J.R. Quigley: I was going to say that the member said it was the same as paragraphs (a) and (b), so I agreed with him in part, and then I said, “Member for Hillarys”, because I was going to go on, that there might be another reason, and the other reason might be that the doctor does not believe, on the balance of probabilities, that the patient is going to die within six months.

Mr P.A. Katsambanis: Possibly that, too.

Mr J.R. Quigley: Perhaps the doctor does not believe that the patient has a terminal illness. They would have to record that in the notes anyway. The only additional requirement on the medical practitioner under clause 20 is whether the practitioner has given the patient information referred to in the clause that has already been passed—that is, clause 19(4)(b), which requires the doctor to “give the patient information approved by the CEO for the purposes of this section.” That would be standardised information about voluntary assisted dying—for example, eligibility criteria showing that the patient is not eligible because the doctor does not believe the patient is going to die in six months. I am looking at the manager of opposition business, and I say that I do not believe he is going to die within six months, so he is not eligible.

Mr D.C. Nalder interjected.

Mr J.R. Quigley: At three o’clock in the morning, I might review that. But the member is not eligible. There might be a number of reasons. This is the only additional requirement.

The Speaker: Excuse me, your time is up. Sit down—that is a good boy!

Point of Order

Mrs A.K. Hayden: Before I go any further, I want to note the time. We have actually been advised that the government plans on sitting right through until possibly six o’clock tomorrow morning. Normally, when the government does that, it allows for a dinner break and a comfort break for members, the staff, Hansard and the advisers. I am just pointing out to the house that right now we should normally be going on a dinner break, and

Extracted from finalised Hansard
I will be seeking the support of the Speaker and of the minister in the chair, who I note has been swapped out, because he obviously needs a break. I am advised that the advisers will be swapped out because they need a break, but so do the members, the clerks, the ushers and Hansard. I am saying that we need to have a comfort break for work health and safety reasons, for the wellbeing of members and staff. This is something that I think should be considered.

The SPEAKER: Okay; I will treat this as a point of order. Does anyone else want to speak on it? Leader of the House?

Mr D.A. Templeman: Not at this point.

Ms M.J. Davies: I rise to support the point of order that the member has made. Given that we have been advised that we may well be here until 6.00 am tomorrow, and I truly hope that is not the case, I do not think it is unreasonable, and it is certainly not without precedent, for us to have a dinner break factored into the proceedings of the day. It is actually, from my perspective, mismanagement of the house that we do not get an opportunity to have a break away from a very significant and considerable bill, and it is putting an enormous amount of pressure on everybody in this place. We are taking our duty seriously. Some members have been in here all day, and I think it is not unreasonable for us, and also the staff, to be given the time to step out of the chamber and make sure that we have had a break before we come back and potentially sit here for another 12 hours. I ask that the government give some consideration to the point of order raised by the member for Darling Range.

Mr D.A. Templeman: Mr Speaker, I will have a conversation with you perhaps behind the Chair in the next few minutes, and we can then respond to the request.

The SPEAKER: The main thing is that it has to be the consensus of the house if a dinnertime is changed, so what we have to do is get together. I have already spoken to the minister and he does not want to have a break.

Ms J.M. Freeman: Where is the minister now?

Mr S.K. L’Estrange: He is having a break.

The SPEAKER: Excuse me, this is a point of order.

Mr S.K. L’Estrange: Further to the point of order —

The SPEAKER: We just want to get a consensus. Have your point of order, then.

Ms J.M. Freeman: If you would like to swap the Chair, Mr Speaker, I will speak with you behind the Chair.

The SPEAKER: Mr Healy can come in here and take my place. Member for Warren–Blackwood, did you want to say something? You look like you are getting ready.

Mr D.T. Redman: I was going to say something but —

The SPEAKER: As I said before, it has to be the consensus of the house. I do not have the power to say you have to take a break.

Mr D.T. Redman: I do not want to be here for every single clause. I have clauses that I want to look at and make some comment on. The last thing I want to do is be out of the house having a break or a meal and miss a clause, because the house is moving either very fast or very slow. I cannot possibly anticipate that, so I think, in the interests of proper debate on a very significant bill, it would be significant for me to have a bit of a break as well.

Debate Resumed

The ACTING SPEAKER (Mr T.J. Healy): Thank you, members. We will continue debate on the clauses. I think the Speaker will probably step back in in a moment. I know he has just stepped out of the chamber. The dining room is open. I am not sure whether someone had the call. Member for Cottesloe.

Dr D.J. Honey: I appreciate the information that the minister has provided, but I do not believe it corresponds with the normal situation in a doctor’s surgery. If I go into a doctor’s surgery and say that I want to talk to the doctor about this, and the doctor says no, I do not believe there is any requirement whatsoever on the part of that doctor to record anything. But let us go further here. This does not relate in any sense to a normal situation for a doctor. I want to go back to the nature of the request, and we had an answer from the minister before that I cannot understand in the context of the bill, and that is about how the contact is made. But let us dwell on this point. Let us imagine a hypothetical. A doctor is working on the emergency ward at Sir Charles Gairdner Hospital, and a patient comes in. That patient is a person who is living on the streets, is extremely ill with a terminal illness, and is depressed and demoralised. They come in and say, “Doctor, this is hopeless. I’ve fallen over again. I’m sick and I want to end my life.” My understanding is that that doctor on the emergency ward has no choice in this matter. That doctor then has to say whether or not they will act as the coordinating practitioner for that person. They have to make that decision. If they say no, they have to provide information to that person—which we have not seen—and it may be that they do not wish to provide that. If they do not submit a form to the CEO within 48 hours.
outlining that they have had contact with this person and the details about why they do not want to do it, and if they do not also hand that person information that the CEO requires them to provide, the bill specifies they are potentially subject to a finding of professional misconduct and a $10,000 fine. I know the Attorney General is acting for the Minister for Health at the moment, but I take it that he has had a fair degree of involvement in this. The Attorney General’s explanation did not correspond in any way with the situation involving someone coming into a doctor’s surgery and saying, “I want you to treat me” or “I want you to assess me.” I do not believe that there is any requirement—the doctor simply says no and that is the end of the process. In this bill, it is not.

I know that many doctors will not care about that. Even if they do not want to participate in voluntary assisted dying, they will be fine with providing the information. My concern relates to people who are vehemently opposed to this bill. There are members in this house who are vehement supporters of this bill—in fact they think this bill is weak—and they think we should get this bill through this place as quickly as we possibly can. They believe that any questions on it are a waste of time. They want this important legislation to pass. Equally, there are good people who, for legitimate reasons, are vehemently opposed to this bill. There are good doctors who are good people who are vehemently opposed to any concept of voluntary euthanasia. As I see it, this bill compels them, under threat of professional discipline and a $10,000 fine, to participate in the process. I do not think that the Attorney General’s explanation was sufficient.

Mrs A.K. Hayden: I would like to hear more from the member.

Dr D.J. Honey: I will not be long. I am not trying to stretch this out.

In the situation that I have explained, that person may be subject to professional discipline and a $10,000 fine when handing that information to them is anathema. I do not know of any other professional who is compelled under threat of professional misconduct and a $10,000 fine when all that has happened is someone has come into their workplace and asked them to do something. That is all it is: someone has come into their workplace and asked them to do something. I would like the Attorney General to either reassure me that that person is not potentially subject to a finding of professional misconduct and a $10,000 fine—I know that it is not guaranteed—otherwise they are. I appreciate there may be a break and I am quite happy to continue after any break.

The Speaker: Thank you, member. We have an agreement with the chamber that we might as well take a half-hour break or a couple of minutes more. We will return at 6.45 pm. Later on in the night, if the chamber agrees, we will have a short comfort break. Everyone agrees with that, so I will leave the chair until the ringing of the bells.

Sitting suspended from 6.13 to 6.45 pm

Dr D.J. Honey: The minister would have heard the question that I asked before the break, and I am waiting for the minister to respond to that. Perhaps the minister will remember. My question was around the extent to which a medical practitioner must be involved in this process, up to giving information, and that there are potentially very serious consequences if a practitioner does not comply with that. I just want to remind the minister. I will not go over it all again.

Mr J.R. Quigley: I did not realise before I came to the chair that the member has jumped forward to clause 20, and the question was framed around clause 20. If the member could reframe his question around clause 19, I would be pleased to answer it.

Dr D.J. Honey: No, minister. I was very much framing it around clause 19(4)(b), which states—

The Acting Speaker: Member, I think you are reading clause 20.

Dr D.J. Honey: No, I am not.

The Acting Speaker: There is no clause 19—my apologies.

Dr D.J. Honey: It is clause 19(4)(b).

The Acting Speaker: I withdraw. I apologise.

Dr D.J. Honey: Can I say I think we should all give each other considerable latitude and consider this in the goodwill that it has been done. I mean it. This is an extraordinary way of conducting this—

The Acting Speaker: Member, if you could ask your question.

Dr D.J. Honey: I will. Thank you, Mr Acting Speaker. But I think we can all be forgiven for some small transgressions and I hope you will do that for me.

There are two parts to my question. I do not care whether we deal with it in clause 20, but the second part is the part that I think a significant number of practitioners—I know the great majority might not—would find highly offensive to them personally. They simply want no part of this. They want no part of informing the patient about

Extracted from finalised Hansard
voluntary assisted dying and do not wish to participate in it. I appreciate that this is not participation to the extent of assessing the patient and so on. But nevertheless, they do not want to be involved even to the extent that they are required to give patients information about where they can go to do it. They find it repugnant. As I pointed out before, I do not believe there is anything equivalent that a doctor has to do—I am happy to be disabused of that view—whereby there is the potential of the most serious consequences. They could be found guilty of professional misconduct and fined $10,000 if they do not do it. I am more than happy to talk about the first section later if the minister does not wish to answer it now.

Mr J.R. Quigley: Of course, there are other situations in which doctors are under a legislative threat to do things. One of those is to report child sexual abuse. It is a mandatory reporting condition. As far as the information being required, it will be a pamphlet provided to the medical profession. Doctors who do not wish to participate can just hand the pamphlet to the patient, or the practice can do it. The patient can go outside and see the receptionist before they leave the practice. It does not matter. They will leave with a little pamphlet. That is all. It is not a problem. However, with child sexual abuse, they have to go further. They have to contact the police and make a statement. If they do not do all those things, we will prosecute them.

Dr D.J. Honey: The minister has given the example of child sexual abuse. I cannot comprehend that there would be a doctor alive who would have a moral objection to reporting that and following the process that the minister has outlined. That is something that everyone in society finds highly egregious.

Mr J.R. Quigley: What about infectious diseases?

Dr D.J. Honey: Equally, I do not know. As I said, I am happy—

The Acting Speaker: Minister, I might ask him to finish and then we can—

Dr D.J. Honey: I am happy for the minister to inform me of other areas, but infectious diseases is about protecting the whole community, not an individual making a choice.

The Acting Speaker: Member, infectious diseases—which part of the clause is it?

Dr D.J. Honey: No. There was a comment made by the minister representing the Minister for Health.

The Acting Speaker: Just for my clarification, is it clause 19(2)(b) or clause 19(5)(b)?

Dr D.J. Honey: No. We are going through clause 19(4)(b), Mr Acting Speaker. I think you will appreciate that in the context of the discussion it is an important point to elucidate. This is something someone may find highly morally repugnant and not wish to participate in. In this case they may be subject to the most egregious penalties. I do not believe the example the minister gave about reporting the sexual assault of children is at all comparable to this. I will ask the minister in another way. Does the minister believe that someone who finds this completely morally or otherwise repugnant to them should be compelled to give information to someone about something they fundamentally oppose because it makes them feel sick and goes against the whole tenet of their training and their profession up to that point? Does the minister believe that someone should be compelled to do that under threat of professional misconduct and a $10,000 fine? Is that appropriate?

Mr J.R. Quigley: It does not matter what I believe.

Dr D.J. Honey: I would put it to the Attorney General that it does matter, because he is representing the minister responsible for this legislation. At the end of the day, this comes down to values and judgement. There is obviously a strong focus on the rights of the patient, the individual, who wishes to access this process and their right to choose. I have different views about different parts of this legislation, but I think I can fully understand why some people strongly support it. I do not agree with all of that, but I think I can understand why they support it. But in this case we are also looking at the rights of the medical practitioner and their being compelled to do something that they may find utterly repugnant under threat of being charged with professional misconduct and a $10,000 fine. I do not know whether it is true, but I have been told that in Victoria some medical practitioners are reconsidering their jobs because of the extent to which they may be required to be involved in this process. I understand that members who are strong proponents of this bill may think that is just fine, but they should put themselves in the locus of that medical practitioner. The Attorney General can guess by my question that I do not believe that. The Attorney General is here representing the Minister for Health. Does he believe that it is appropriate for someone to do something that they find morally repugnant under threat of being charged with medical misconduct, professional misconduct and a $10,000 fine?

Mr J.R. Quigley: As I said, it does not matter what I believe. I said in my second reading contribution that having been raised in the family of Catholicism, it does not matter what I believe. I cannot impose my beliefs on other people—full stop. As to moral repugnancy, a lot happens in the medical profession that is at the edges, and that mainly happens in palliative care when doctors are faced with a terrible moral dilemma: do they give the patient morphine, which they know suppresses the respiratory system, but which they also know breaks the law? It does not matter what I believe. If this bill gets through the upper house, this will be the law, and it does not matter what I believe.

Extracted from finalised Hansard
Dr M.D. NAHAN: Let us say the doctor is not necessarily in all cases a conscientious objector.

Mr J.R. Quigley: I am sorry, he is not a conscientious objector?

Dr M.D. NAHAN: No, he is not, so he meets the criteria. In this case a patient whom the doctor has known for a long time comes to see him. The doctor does not have the belief that it is solely up to the patient to decide to take his own life to avoid pain. The doctor is of the view that he should try harder and should do something else. Can he back off and say that he does not support this? I do not have a doctor now, but my family doctors in the past would have done this. It was part of their business to advise us on the pathway to deal with health issues. They would have said, “Listen, I know you very well.” If I were towards the end of life in deep pain and palliative care would not work, they would agree. However, if the patient is not in pain yet, or it is perhaps curable, can the doctor in this case say, “No, with this patient, I do not want to. I don’t think he’s trying hard enough, so I’m going to back off.” Can they refuse to treat or address the patient if that is the case?

Mr J.R. QUIGLEY: Firstly, the patient would not be eligible to apply.

Dr M.D. NAHAN: Yes, they would.

Mr J.R. QUIGLEY: Because they would not be suffering.

Dr M.D. NAHAN: Yes.

The ACTING SPEAKER: Member, let the minister finish. There are plenty of questions to ask.

Mr J.R. QUIGLEY: Clause 15(1)(c)(iii) refers to the eligibility criteria — is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable; I am not trying to slip away from the example cited.

Dr M.D. NAHAN: We have had a discussion on that. The suffering can take many dimensions. It is not just physical. We have gone through that. It is not only physical pain, but also psychological pain or the feeling of distress, and the perception of suffering is determined by the individual. Suffering is not necessarily physical pain. Under this bill, it is up to the patient to decide what suffering is, and to decide whether it is tolerable or not. In this case, I am saying that the coordinating medical practitioner will make an assessment on an individual basis. They want to address the suffering some other way than through assisted dying. We also had a debate, unlike Victoria, where it is a requirement that for the ailment to be eligible, it is terminal. It is terminal—it is not fixable. Under this bill, a patient can have an illness that can be addressed, fixed, and made non-terminal, if they do certain things. What I really want to know is, under this act, does a medical practitioner have the right to select whether he addresses a patient or whether he does not? Does he have the right to choose? What I am really asking is does the choice of the patient trump all the decisions of the doctor?

Mr J.R. QUIGLEY: Absolutely.

Ms M.M. QUIRK: Just to follow on what the member for Riverton said, clause 19(2)(b) states one of the reasons for which the medical practitioner can refuse as — the practitioner is unable to perform the duties of a coordinating practitioner because of unavailability or some other reason;

Can the minister give us some examples of other reasons that may well fall into the area that the member for Riverton is talking about?

Mr J.R. QUIGLEY: Sure. An example could be that the medical practitioner has not done the training.

Mr Z.R.F. KIRKUP: Some of the reasons for which a medical practitioner can refuse a first request are outlined in clause 19(2). I am keen to understand that if a practitioner is unable to perform some of the duties because they do not believe that the patient has capacity, is that a reason that they can refuse to participate in the first request stage?

Mr J.R. QUIGLEY: The person is not eligible.

Mr Z.R.F. KIRKUP: I appreciate that the person is not eligible, Attorney General. What I am asking is whether a practitioner can refuse on those grounds. I appreciate that the person is not eligible, but, obviously, the medical practitioner has to make a decision about eligibility. That is the basis on which they make that decision. If they make a decision because they believe the patient does not have mental capacity, is that something they can do; and, if so, what are the steps that would be taken thereafter?

Mr J.R. QUIGLEY: It could be on any ground—the doctor is unwilling to participate, the doctor is sick, or the doctor unbelievably forgot to get his flu vaccination and he caught the flu and cannot go into a ward.

Mr Z.R.F. KIRKUP: I appreciate what I believe was not an answer to my question. I will try to move through that. Clause 19(1) states —

If a first request is made to a medical practitioner, the practitioner must accept or refuse the request.

Extracted from finalised Hansard
My understanding of the bill is that a decision must be reached and the patient must be informed within two business days, and we will get to that point later. As part of the decision to accept or refuse the request, is there a requirement for how that must be communicated to the patient? A patient might come from a diverse background and cannot speak English or they might be deaf. Is there a requirement set out later in the bill about how that decision must be communicated to the patient?

Mr J.R. QUIGLEY: No.

Mr Z.R.F. KIRKUP: If I understand the Attorney General in his acting capacity, he is suggesting that there is no prescription on the practitioner for how they must inform the patient that they have accepted or refused the request.

Mr J.R. QUIGLEY: Correct.

Mr Z.R.F. KIRKUP: Is it not somewhat unusual that there is no stipulation or requirement for how the practitioner must inform the patient? Surely there has to be some obligation on the practitioner for how they need to inform the patient.

Mr J.R. QUIGLEY: They can choose a number of ways—verbally, in writing, by text.

Mr Z.R.F. Kirkup: They can text the patient?

Mr J.R. QUIGLEY: Why not?

Mr Z.R.F. Kirkup: I don’t know.

Mr J.R. QUIGLEY: They just have to inform the patient. There is no prescribed method, just as long as the doctor communicates his or her response.

Ms M.M. QUIRK: If, of course, the practitioner fails to give the message and there is some professional conduct hearing or whatever, how the doctor has communicated may well be relevant for the purposes of misconduct proceedings. Does the Attorney General think it might not be advisable to have some sort of prescribed form? I think he mentioned a pamphlet earlier. Maybe he can expand on that.

Mr J.R. QUIGLEY: Certainly. They are two different things. First, the pamphlet is simply a method of handing over information about voluntary assisted dying, so he is not doing anything other than handing out a government pamphlet. Second, the doctor always manages risk. They all do. If they are complying with the legislation, they will make sure that they have covered their risk and they can show that they have informed the patient.

Mr Z.R.F. KIRKUP: Subclause (4)(a) provides that within two business days after the first request is made, the medical practitioner must inform the patient whether they accept or refuse the request. As the Attorney General has just said, the pamphlet concept—

Mr J.R. Quigley: No.

Mr Z.R.F. KIRKUP: Hold on—if I can finish before everyone jumps in. They also must give the patient information that is approved by the CEO for the purposes of this subclause, which I imagine is a pamphlet or something like that, as has been suggested. We are all okay with that so far. What format must be used to inform that patient? The Attorney General has suggested that it could be a text message. It could be done in any way in that case. Conceivably, given how broad subclause (4)(a) is, there is a significant bandwidth of ways that somebody could choose to inform the patient. It could be by text message, verbally or in writing. Is there no requirement for the practitioner to call in the patient again to have a face-to-face meeting to inform them of their decision?

Mr J.R. QUIGLEY: No.

Mr Z.R.F. KIRKUP: Under the principles of this bill, there is a requirement for a practitioner and patient to have had an ongoing and enduring relationship as part of their overall health care. Why did the government not include a prescription on how a patient should be informed about whether a practitioner choses to accept or reject the first request?

Mr J.R. QUIGLEY: The member’s question contains an assumption. In any event, the doctor must make a record of it under clause 20. They could go into a room and whisper, “No”, and the doctor would have complied with the act. They would be safer to go in with a nurse and whisper, “No”, because if they were ever charged for professional misconduct, they would have a witness. It might be safer to text the patient and say, “I inform by text.” All they have to do is inform; the doctor can just whisper, “No”. The patient might then buzz the nurse to come in and ask to get a better doctor.

Mr J.E. McGrath: From my limited experience of going to my GP, I expect that if a GP wanted to convey that message and if the applicant did not have any problem getting to the surgery, the doctor would either get their secretary or someone to contact their patient to say that the doctor would like to see them. That is what normally happens. They would then turn up and the doctor would tell the patient to sit down, and the doctor would say, “This is what we are going to do. This is where we are.” I think that would be the normal thing to do. I do not think...
that needs to be prescribed because I suspect doctors would need to do that anyway. I doubt a doctor would send a text. But I would think that the normal procedure would be to tell the patient to come back into the surgery because they want to talk to the patient about something when they get that scan or X-ray back.

**Mr J.R. Quigley:** Were you listening to my phone call?

**Mr J.E. McGrath:** No! I am just describing how I think it will work. I think it will work that way. That is the normal way GPs work. They send the patient off to get a scan, X-ray, blood test or whatever. If the patient does not get a call, they know the results are pretty good. But if they get a call saying that the doc wants to see them, they know the news might be not that good. I think that is how it normally works. I cannot imagine that many doctors would send a text. If a patient is in hospital, I think that the doctor would find a way to go to the hospital or find some other way to relay the message. I think that medical professionals are so professional and because there is that patient–doctor relationship, it would be done person to person. But I am not a medico.

**Mr J.R. Quigley:** I will respond to that. The member is correct. I was only talking about the text as a ramp-up of proof. We cannot prosecute someone if they say, “There’s the text. You were right.” I had something that the local GP said was ringworm. It would not cure. I rubbed this cream on this ringworm and I went to see a mate of mine who is a dermo, Phil Swarbrick. He said, “They’re putting the wrong cream on; let me have a nick.” He then rang me back here, two days later. He said, “Can you come in and see me straightaway.” I thought that it was a bit more than ringworm. The description the member gives is right. I only gave an example of risk management. The doctor could walk in and whisper, “No.” But how will the doctor prove he said no? If the doctor goes in with a nurse, they could prove better. The doctor could write to them, just so long as the patient knows so he or she can make decisions about their life.

**Dr D.J. Honey:** Just in relation to that communication, quite often when people want to make an appointment with a doctor, they ring up. In fact, when I ring the surgery and they ask me what I want to see the doctor about —

**Mr J.E. McGrath** interjected.

**Dr D.J. Honey:** They have for me, member for South Perth. I am happy for the member to share his experience, and I will share my experience as well.

**Mr J.E. McGrath** interjected.

**Dr D.J. Honey:** I thank the member for South Perth.

What if the person says they want to see the doctor about VAD and the receptionist says, “No, our surgery doesn’t do that”? This is not a contrivance; would that comprise a request, or is that really just a nothing—just a communication with the receptionist?

**Mr J.R. Quigley:** A nothing.

**Mrs A.K. Hayden:** I refer to clause 19(1) —

> If a first request is made to a medical practitioner, the practitioner must accept or refuse the request.

The wording in the previous clause we discussed is “must”.

**Mr J.R. Quigley:** Sorry, which part are you are addressing now?

**Mrs A.K. Hayden:** Clause 19(1), but the previous clause we discussed provides that they must always see the first request; they must be able to provide the information on the first request and cannot deny that. We established that in the last clause we discussed. A constituent rang my office today and wanted me to ask a question about the fact that in a country town there might be only one GP. If there is one GP and someone goes in and asks for a first request, they do that. They might not want to, but they have to because they are bound by the legislation. Time passes, the patient decides not to do it, and they come back again. I think a time frame has been established that can be reset and there can be a new request. Is it the intention of this legislation that the same GP must see the same patient every time they come forward after the delay period has kicked in after a first request, and that they must re-enact that same first request approach and provide the information?

**Mr J.R. Quigley:** Does the member mean, start it all again?

**Mrs A.K. Hayden:** Yes.

**Mr J.R. Quigley:** Well, they would have to be a noggin to have a refusal and then say, “I’ll take my wallet out and I’ll go and pay for another refusal. I know what he’s going to say; he’s told me already, but I’ll take my wallet out like a fool and go in and pay for another refusal.” That does not make much sense to me.

**Mrs A.K. Hayden:** I think the Attorney General is misunderstanding what I am saying.

**Mr J.R. Quigley:** I’m sure I am!

*Extracted from finalised Hansard*
Mrs A.K. HAYDEN: This legislation says that if a patient goes in to see their GP, the GP must provide the information because it is the first time they have seen them.

Mr J.R. QUIGLEY: Correct. Sorry; within two days.

Mrs A.K. HAYDEN: Within two days. If they take that information and go away, there is a time frame that has been articulated, and I cannot recall what that time frame is; the advisers might be able to help. It then becomes a first request again when they go in and see the GP. Let us say I go in and see the GP and I want to access VAD and the GP does not want to give me that advice, but under this legislation, they have to. They give it to me, I go away. Six months pass and I come back again and ask for that same advice. Can I actually do that, and does the GP have to give me that advice?

Mr J.R. QUIGLEY: That matter was before the chamber and was voted on a clause ago, in clause 18(2). The request and assessment process ends if the person decides not to continue with the process. That is one part of it. I am now trying to address what I think the member is saying; that is, if the medical practitioner in a country town refuses and the patient goes away, what period must elapse before they can come and make a new request?

Mrs A.K. HAYDEN: Not refuses—he gives it to them. It lapses. They come back to him and he has to give it as a first request.

Mr J.R. QUIGLEY: I do not know how it lapses. The person can discontinue. They can decide not to continue with the process.

Mrs A.K. HAYDEN: They discontinue and then they want to go back and seek more advice again, down the track.

Mr J.R. QUIGLEY: People’s minds fluctuate somewhat, especially in an end-of-life scenario. It is not until we look down the barrel, as I have, that we realise that people’s minds fluctuate. The process becomes a new process only if the person has discontinued. They might make their first request, and then go away and think, “Oh, this is a bit problematic. I don’t know whether I can take the syrup”, so they pause. That might be a good thing. They do a few more rounds of chemo and say, “Oh, I cannot do this anymore.” I was on a trial of 10 and saw people say, “Can’t do this anymore.” I saw eight of them give up the trial of 10. It is only if someone says, “I don’t want to go on with this. I am discontinuing. Forget it.” Then they take them up to the radiation ward again and they say, “Oh, no, not this again. I want to make a request.” In that situation, they would have recommenced the process.

Mrs A.K. HAYDEN: With that in mind, they are re-engaged, so is that again their first request?

Mr J.R. QUIGLEY: After the discontinuance, yes, but not during a long lapse, bearing in mind the lapse cannot be too long —

Mr J.R. QUIGLEY: You will not be around.

Mr J.R. QUIGLEY: Yes, they will not be around. It will be in someone’s will, because they will accede to someone’s first request only if, on the balance of probabilities, the wake is going to be within six months.

Mrs A.K. HAYDEN: I thank the Attorney General so much for articulating it so well. If someone goes back to a country town and sees the same doctor, who does not support voluntary assisted dying, that doctor would be forced to give that information again to that patient as a first request. Will the doctor who is not for this process need to keep repeating that advice to that same individual as a first request?

Mr J.R. QUIGLEY: That is what I said a little while ago, perhaps not clearly enough. If a terminal patient went in and got a refusal and a pamphlet and then discontinued, said they were not going on with it, and then a month later decided, “I’m crook. I’ve changed my mind. I’m out of here”, if he or she wants to spend $75 to go back and get the pamphlet again, they can, but they know what the answer will be. I appreciate the difficulty in the regions where there is only one doctor, and in a lot of towns there is no doctor. That is why most people in these situations who are within six months of death from a terminal illness have been treated by a specialist, and in a tertiary hospital. We have included in later clauses the delivery of voluntary assisted dying material to extend to nurse practitioners—because they are not making a decision—to facilitate VAD for those in the regions who are ailing and have decided to go home and spend their last month with their family and for whom the doctor has prescribed the substance. It would be inhumane to say to that person in a regional town—I was going to name the country town, member, but it might be unfair; it might have a doctor, and I am sure Mukinbudin probably has one—“Stiff; you can’t take the medication at home because there is no doctor in your area.” The nurse practitioner will not take part in the assessment, which the member for Darling Range is referring to. One would have to question the mental capacity of a person who kept on going back and paying $75 for a pamphlet. We would have to question whether this person is with it and go back to the capacity section.

Mr A. KRSTICEVIC: I want to check on the first request. If a doctor does not want to participate in voluntary assisted dying, can they have a sign up in the reception area of their practice that says that it does not participate in this process, but have pamphlets on the counter? Someone can walk in and say to the receptionist that they are there to talk about voluntary assisted dying and the secretary can say, “Sorry, we do not practise that; however,
here is a pamphlet, by all means help yourself”. The person has not seen the doctor, but they have walked into the practice and spoken to the secretary who has moved them on. Will the practice be caught up with any reporting requirements? Are there any obligations there? Can they do that without having to go through this process, without having to speak to anybody because the sign is there already stating, “Don’t even bother coming to talk to me” and that person has not spoken to the doctor? Is that a way doctors can get themselves out of the system, so that they do not have to participate at all?

Mr J.R. QUIGLEY: Correct.

Dr D.J. HONEY: I am not privy to all the details of the case the member for Darling Range referred to, but I think the concern of that particular medical practitioner is that if they are in a small community and someone wishes to make a point that they think this doctor should participate in this process, they might use this as a way of, if you like, badgering the doctor and forcing them to go through that first stage all the time. The Attorney General made some comments around the qualification and whether the person had an illness and so on. But of course this stage will not involve any assessment at all, it is purely if a person has made a request and if a practitioner says, “Yes, I will be involved”, or, “No, I won’t be involved.” I think the context of the member for Darling Range’s question is whether someone used that as a process, if you like, to bully the doctor because they think the doctor should be involved and that all doctors should be involved. I know that that is unusual, and we have made the point a number of times that many of our concerns do not relate to the usual situation, but they relate to the reasonably possible situation. Certainly in my case and the member for Darling Range’s case, we are keen to make sure, even if it is reasonably unlikely, that that could not occur. I am interested in the Attorney General’s response.

Mr J.R. QUIGLEY: Certainly. I was in the Peter MacCallum Cancer Centre that had floors of terminally ill patients and in my close experience I have not come across one terminally ill patient who sought to harass or badger the doctors. I have not found that in my personal experience. Those people who are ill are the last people on earth who will badger. But if this terminally ill patient says, “Blow that doctor, I’m going to keep on badgering him” and goes back, the doctor does not have to see him. The member is raising a hypothetical, so I have to give a hypothetical answer. The doctor does not have to let the person onto the premises. The doctor can leave a message with the receptionist that says, “If that dying person turns up on my doorstep again asking for VAD, tell him to go away. If he won’t go away, get someone to take him away.” He does not have to badger the doctor. The doctor has told him, “No, I don’t do that” or “No, you don’t qualify. Here’s your pamphlet—end of story.” There is no compunction on the doctor to receive that person back into their surgery. Indeed, the doctor may take active steps to legally stop someone coming onto their premises to badger them. If the member does not think that happens, that does happen, especially in the abortion area when protesters have sought to go into doctors’ premises, and been arrested. Under this bill, no-one is going to be allowed to badger the medical profession.

Dr D.J. HONEY: I am not going to labour this point. I only want to say that the patient does not have to have any condition at all to come in and make a request. The assessment phase is determined whether the patient is terminally ill or not.

I am not asking the Attorney General to give me an answer on clause 17; I am asking him to give me an answer on clause 19, but to do that I have to give background to clause 17. When we looked at clause 17 and the way in which that first request is made, we were told that that request may be made by audiovisual means and that that can be audio and visual or, I presume, audio or visual, but in some effective way that would be described as audiovisual. If someone rang a medical practitioner and made that request, I asked the minister whether that would comprise a request to the medical practitioner. In the context of clause 19, would that not comprise a request that the doctor has to accept or reject if they have used an appropriate means of communication that the doctor could understand?

Mr J.R. QUIGLEY: The member referenced clause 17 to give context to his question—is that right, member for Cottesloe?

Dr D.J. Honey: Only to explain how a first request is made.

Mr J.R. QUIGLEY: That is right; by referencing clause 17. If the Chair will permit my indulgence, I will jump forward to clause 156. Clause 156 states, in part —

Communication between patient and practitioner

(1) In this section —

audiovisual communication means a method of electronic communication that is designed to allow people to see and hear each other simultaneously.

In a brief ministerial statement a couple of weeks ago, I announced that the Legal Aid Commission had done this in regional centres such as Esperance, Kununurra et cetera—that is, used existing facilities such as community centres and small business centres in towns that have —

Mrs A.K. Hayden: CRCs.

Extracted from finalised Hansard
Mr J.R. QUIGLEY: Yes, community resource centres or business centres. All the hospitals have those. So long as the doctor can see the patient, the patient can see the doctor and the doctor knows who he or she is dealing with; it does not have to be across the desk. That was clause 156(1).

The ACTING SPEAKER (Ms S.E. Winton): We will get to that later. Is there anything else on clause 19?

Dr D.J. HONEY: Thanks for clarifying that, Attorney General. The reason for my concern was that it was said earlier that a telephone conversation could comprise communication. It may have been a simple slip of the tongue by the minister. The Attorney General has made it very clear that it is audio and visual. I am satisfied with the Attorney General’s answer.

Mr J.R. QUIGLEY: The minister said that people can use a telephone and he was right. It can be a telephone so long as the person hits FaceTime. A person with an Apple phone may ring and say, “I’ve had enough!” The doctor might say, “That’s Quigley. He had enough a long while ago, let’s get him out of here!” The minister was correct. People can use a telephone so long as the doctor can see the person and the person can see the doctor.

Ms M.M. QUIRK: I have regrouped. Clause 19(5) states that when the medical practitioner refuses the first request due to a conscientious objection, the practitioner, firstly, is immediately required to inform the patient; and, secondly, give the patient the information referred to subclause 4(b). That provision is not in the Victorian legislation and I want to know the rationale for needing it. What is the overseas experience of people not being able to access the relevant information? Why is it considered necessary?

Mr J.R. QUIGLEY: It is necessary for the patient—we put patients first. If the patient goes to a doctor—one of those doctors to which the member for Cottesloe referred earlier who is vehemently opposed to the process—why should that person, who has gone beyond endurable suffering, not be told immediately by the doctor, “I don’t do this”? Why should that person be left hanging 48 hours to hear the inevitable—“I don’t do this”? There is a moral obligation to put patients first. When a patient makes a request and the doctor has a conscientious objection, he should there and then exercise in good conscience his decision and tell the patient. The patient, who is suffering intolerable pain, can then press the buzzer and say to the nurse, “Get me a more compassionate doctor”.

Ms M.M. QUIRK: I think we are at cross-purposes. I appreciate that if the practitioner gives the no answer immediately, they must then provide information in the form that is effectively approved by the CEO. Can the Attorney General’s advisers tell me, and he can convey it to me, of jurisdictions, other scheme or similar regimes in which patients have been able to readily access an alternative doctor?

Mr J.R. QUIGLEY: None that I am aware of.

Ms M.M. QUIRK: Attorney General, given that that is the case, why is subsection (5)(b) necessary?

Mr J.R. QUIGLEY: It is necessary for the patient—we put patients first.

Ms M.M. QUIRK: Attorney General, as I said earlier, this provision is not in the Victorian legislation. From the Attorney General’s comments, can I infer that the Victorian legislation is inferior and that Victoria does not put patients first?

Mr J.R. QUIGLEY: Certainly. Our legislation is better than the Victorian legislation in the same way that our football is better. We put this provision in for the patients. I saw Premier Andrews say on television that the Victorian legislation has 58 safeguards. My advisers counted and bracketed the safeguards in this bill and there are 102 safeguards. The game finishes—102 beats 58. We have put so many safeguards in the bill and we say that Victorian legislation has 58 safeguards. My advisers counted and bracketed the safeguards in this bill and there is no patient–doctor relationship—“Get the hell out of the room!”

Ms M.M. QUIRK: In relation to subclause 4(b), what is envisaged to be included in the information that will be provided to patients? Will it be just a list of doctors who will do the deed, or is it contemplated that other information will be provided; and, if so, what?

Mr J.R. QUIGLEY: Certainly. In any case of acceptance or refusal, the medical practitioner is required to provide the patient with information approved by the CEO of the Department of Health for the purposes of this bill. Objectors must still provide general information about assisted dying, such as a phone number for Public Health or Royal Perth Hospital, or the website—any of those things. The patient is dying. The patient is entitled to know what are the available legal alternatives. Hand them a pamphlet; no problem.

Mr Z.R.F. KIRKUP: I am curious. Subclause (4) provides that the practitioner must arrive at a decision and inform the patient within two business days. I appreciate that is the case. However, from my reading of the bill, that is unless subclause (5) applies, which is in relation to a practitioner who has a conscientious objection. Is that correct?

Mr J.R. Quigley: Yes.
Mr Z.R.F. KIRKUP: I am just making sure that I am on the right path so far.

Mr J.R. Quigley: You’re always on the right path!

Mr Z.R.F. KIRKUP: The Attorney is very kind.

It is conceivable that a practitioner might not have made up their mind within two days. They might not have a conscientious objection, but they might not yet have reached a conclusion. Would they still be bound by that two business day rule as per subclause (4)?

Several members interjected.

The ACTING SPEAKER: Thank you, members.

Mr J.R. QUIGLEY: I am sorry, but, with the cross-banter, I do not know that I have got the accuracy of the member’s question.

Mr Z.R.F. KIRKUP: I appreciate that, Attorney General. Before we were interrupted by the Minister for Tourism, I was asking about a practitioner who had not yet arrived at a decision about whether they would accept or refuse. Subclause (4) suggests that once they arrive at that conclusion, they must provide the patient with information about their decision within two days. They might not have a conscientious objection as defined in subclause (5), but they might not yet have accepted or refused because they are still making up their mind and have not arrived at a conclusion.

Mr J.R. Quigley: About conscientious objection or about eligibility?

Mr Z.R.F. KIRKUP: I am talking about their role as a medical practitioner and whether they can accept or refuse. If they have not made up their mind yet, would they still be required to inform the patient within two business days?

Mr J.R. QUIGLEY: The answer is yes. However, it is inconceivable that a doctor who had a conscientious objection would go through the training to be eligible to be a first doctor. I have friends, whom I break bread and drink wine with, who are doctors, and over the table they tell me of their absolute conscientious objection to this. Those friends, who are practitioners, will not get trained. Therefore, they can tell the patient, when the patient first approaches them, “You’ve come to the wrong doctor. I can’t participate, because I’m not trained.”

Mr Z.R.F. KIRKUP: Can I just get some clarification. I am not entirely certain that is the case, Attorney General. In order for a practitioner to simply receive the first request, they do not have to be trained. Can I clarify that that is the case?

Mr J.R. QUIGLEY: I hate to be bested by you, but you are correct.

Mr Z.R.F. KIRKUP: I appreciate that, Attorney.

Dr M.D. Nahan: That’s not a common occurrence!

The ACTING SPEAKER (Ms S.E. Winton): No. Enjoy it, member for Dawesville!

Mr Z.R.F. KIRKUP: I will revel in the moment right now. Thank you very much. We will chalk one up. In that case, let us end tonight and be off here!

The ACTING SPEAKER: It might be a good Facebook post for you.

Mr Z.R.F. KIRKUP: Thank you very much.

Mr J.R. Quigley: We have to do this in good humour, members! It is a grave and a serious business, but we do it with goodwill.

Mr Z.R.F. KIRKUP: Thank you very much. I appreciate your good faith, Attorney General.

I would like to be absolutely certain, given the interplay here. The practitioner does not have to be trained to receive a request. What if they open their practice and receive a request but have yet to arrive at a decision? I know of practitioners in my district who have not yet made up their minds. They might not be conscientious objector, in which case there is no obligation on them to immediately inform the patient, but they may not yet have arrived at a decision to accept or refuse. Clause 19(4) reads to me that once they accept or refuse, that is when they have two business days to inform the patient. From my reading of this legislation, there is no time requirement for them to arrive at a decision; is that correct?

Mr J.R. QUIGLEY: If they have a conscientious objection, they will be under a legal obligation to state that conscientious objection or at least say no immediately. We realise that requirement is not in the other jurisdictions. We think it is fair to the patient and puts the patient first. In any other case, they have two days to mull it over. Whilst they are mulling it over for two days, members should bear in mind that on Ward 9B someone is in pain, thinking that the pain is never going to end. They should not have to wait to hear from a doctor to say no. Conscientious objectors have to tell them immediately. If the practitioner has not made up their mind, they have two days to mull it over.
Division

Clause put and a division taken, the Acting Speaker (Ms S.E. Winton) casting her vote with the ayes, with the following result —

Ayes (40)
Ms L.L. Baker  Mr M. Hughes  Mr S.A. Millman  Ms C.M. Rowe
Mr J.N. Carey  Mr D.J. Kelly  Mr Y. Mubarakai  Ms R. Saffioti
Mrs R.M.J. Clarke  Mr Z.R.F. Kirkup  Mr M.P. Murray  Ms J.J. Shaw
Mr R.H. Cook  Mr F.M. Logan  Mr K. O’Donnell  Mrs J.M.C. Stojoyk
Ms M.J. Davies  Mr W.R. Marmion  Mrs L.M. O’Malley  Mr C.J. Tallentire
Mr M.J. Folkard  Mr M. McGowan  Mr P. Papalia  Mr P.C. Tinley
Ms J.M. Freeman  Mr J.E. McGrath  Mr S.J. Price  Mr R.R. Whitty
Ms E.L. Hamilton  Ms S.F. McGurk  Mr D.T. Punch  Ms S.E. Winton
Mrs L.M. Harvey  Ms L. Mettam  Mr J.R. Quigley  Mr B.S. Wyatt
Mr T.J. Healy  Mr D.R. Michael  Mr D.T. Redman  Ms A. Sanderson (Teller)

Noes (6)
Dr D.J. Honey  Mr A. Krsticevic  Ms M.M. Quirk
Mr P.A. Katsambanis  Mr S.K. L’Estrange  Mrs A.K. Hayden (Teller)

Clause thus passed.

Clause 20: Medical practitioner to record first request and acceptance or refusal —

Dr D.J. HONEY: Just to go through this clause, this will not take long at all, but in this case I take it that the medical practitioner has no choice at all. They absolutely must record this and if they do not, they will potentially be subject to charges of professional malpractice and the $10 000 fine.

Mr J.R. QUIGLEY: Correct. I do not want to waste the chamber’s time. This is what we discussed before the dinner break when the member referred to clause 20 in relation to clause 19. So, tick, yes, the member is right. They are all the things that a medical practitioner is required to do anyway in the course of their professional practice, and the only additional requirement is that they have to give the patient the information if they say no. Otherwise, they are all the things that a professional medical practitioner is required to do. One of the advisers was talking to me about professional malpractice. I think that is a bit strong. That is the only comment I would like to make. Otherwise, we statutorily construct a regime that reflects good medical practice anyway—practitioners take notes about their patients and about what they are telling their patients, and there is the additional requirement to give them a pamphlet telling them the information outlined in clause 19(4).

Ms M.M. QUIRK: I refer to clause 20(d), which indicates that the practitioner has to record whether he has given the patient information referred to in clause 19, which we have just talked about. That information is, as it says in clause 19, “information approved by the CEO for the purposes of this section”. Would the minister describe that provision as a safeguard?

Mr J.R. QUIGLEY: It is one of our 102 safeguards.

Ms M.M. QUIRK: Given that we do not know what is in that information at this stage, how can we describe it as a safeguard?

Mr J.R. QUIGLEY: Because it is a safeguard for the practitioner as much as it is a safeguard for the patient. The practitioner can show that he or she has discharged their obligations. I repeat: it is one of our 102 safeguards built into this bill.

Ms M.M. QUIRK: The minister concedes that we do not know what is going to be in that information yet, Attorney General. To the extent that we do not know, does that not present a problem in referring to it as a safeguard?

Mr J.R. QUIGLEY: We do not accept the assumption contained in the member’s question that we do not know what is going to go in the pamphlet. We do know what is going to go in the pamphlet—it is information to allow the patient to access information about voluntary assisted dying elsewhere. We know what is going in the pamphlet. We reject that proposition.

Ms M.M. QUIRK: Going back to clause 19(4)(b), and “information approved by the CEO for the purposes of this section”, has any work been done at this stage on what the CEO is likely to want in the information?

Mr J.R. QUIGLEY: Of course not! It would be entirely inappropriate to get ahead of the Parliament of Western Australia and for bureaucrats to start drawing up pamphlets without knowing the decision of the Parliament of Western Australia. But once the Parliament has made a decision, information will go in the pamphlets that will enable a person who is dying and is within six months of death to find out information about voluntary assisted dying elsewhere, from websites, telephone numbers et al. We cannot make the pamphlet until this chamber and the other chamber have made their decisions.
Mr Z.R.F. KIRKUP: Clause 20 states —

The medical practitioner must record the following …

There is then a series of events. I assume that it has to be recorded so that the board can be informed and so that in the event of a possible investigation that is initiated by someone like the CEO, there is accurate record keeping in place. If that is the case, is there any prescription as to how that information must be recorded? Could it simply be that the practitioner records it by audio and says, “I saw patient X today; they requested voluntary assisted dying”? Does it have to be in writing? If so, what form does it have to take?

Mr J.R. QUIGLEY: There is a requirement that that, of course, has to be kept in the patient’s medical records, so that there will be a traceable and accountable pathway for the board. If there is not an accountable pathway, the board can even refer the matter to the coroner in the appropriate case, if the pathway is not there, transparent and accountable. If someone has had a sudden death in a hospital and there is not a transparent record of the process, I would expect the board to refer that to the coroner and say, “This is a bit off.” That is one of our 102 safeguards.

Clause put and passed.

Clause 21: Medical practitioner to notify Board of first request —

Mrs A.K. HAYDEN: I have one simple, quick question on clause 21. Earlier, the Attorney General referred to a doctor who does not want to participate in voluntary assisted dying, and the way they can do that is to have a sign near the receptionist saying, “We do not do this, but here is a brochure; help yourself”. With that in mind, clause 21 provides that the medical practitioner is to notify the board of a first request. First, how can this happen if the medical practitioner has not met with the individual and they have just picked up a pamphlet and left?

Mr J.R. QUIGLEY: There has not been a first request.

The ACTING SPEAKER: You said “one” question!

Mrs A.K. HAYDEN: Sorry; I might have to elaborate a little further. Can the Attorney General explain why a medical practitioner who refuses a patient’s first request is required to notify the board of that refusal?

Mr J.R. QUIGLEY: Our intent in this provision is to ensure that the board is notified from the outset of a patient’s request to participate in voluntary assisted dying, to track that the correct process is being followed in each and every case of voluntary assisted dying and to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

Mrs A.K. HAYDEN: What is the board required to do with that notification?

Mr J.R. QUIGLEY: It is required to monitor and oversight the voluntary assisted dying process in the state of Western Australia.

The ACTING SPEAKER: Member for Darling Range—one question!

Mrs A.K. HAYDEN: It would be one question if I could get a complete answer! A medical practitioner who refuses the patient’s first request is required to notify the board of that refusal. The board is required to do what with that notification? The Attorney General said “to monitor”. Is that all it will do—just monitor? Will any action follow with the medical practitioner who refuses? What will happen there?

Mr J.R. QUIGLEY: And it will receive, ultimately, the notification of the person having died during this process of voluntary assisted dying so that the board knows who it is, the contact details of the medical practitioner, the date of the first request—the member can see the list in clause 21(2). They have to notify the board and, ultimately, they have to notify the board of what happened in the end, obviously, if they continue the process. If they say, “I’m not going on with this”, they walk away.

Mr Z.R.F. KIRKUP: I have a number of questions on clause 21. I note that under subclause (1), the board must be given a copy of the first request form. Is there a requirement for how that form must be transmitted? Can it be scanned and sent as a PDF electronically? It is a very sensitive piece of information that contains a lot of specific details, and we would not want that to be manipulated in some way, shape or form. Is there any requirement for how it must be transmitted to the board?

Mr J.R. QUIGLEY: It can be and is likely to be, I assume. The board will have a website, obviously. That is what is intended. The practitioner will fill in the form electronically. As the member for Warren–Blackwood explained earlier, Mukinbudin has a medical practitioner. We would not want that medical practitioner to have to travel to Midland Public Hospital to lodge a form for the board. So a doctor in the regions treating a patient will be able to go online, fill all that in, hit send and they will have notified the board.

Mr Z.R.F. KIRKUP: I think we are going to get to the content in a moment as to what needs to be included in the form, but I want to clarify something first. I do not believe that the website for the board is specified anywhere else in the legislation.

Extracted from finalised Hansard
Mr J.R. Quigley: No.

Mr Z.R.F. Kirkup: I just wanted to make sure. I assume that that will be rolled out as part of the implementation phase. I imagine there will be need to be a quite serious process by which a practitioner will be validated so that they can access the website, and that website will need to be very secure. I want to extrapolate something, but I do not want to hold this up. I am conscious of the rise—I have spoken about this in this place before—in the number of fakes and deepfakes. An audiovisual call can be now be faked. There are examples internationally in which CEOs have had their voices and images entirely manipulated to authorise large transfers of money between companies. Let us assume that a patient accesses this in an audiovisual sense in, say, a FaceTime call. That can be faked. It could be any patient to any practitioner. There is a website opportunity. That, too, could possibly be exploited. I think it is a really good idea to make sure there is very little latency between the two—the practitioner and the patient. But I am concerned that in establishing a website, which is not specified in the legislation, very clear security requirements will need to be built into that website, which I am sure the Attorney General appreciates.

Are there any boards in any other jurisdiction across this country or internationally that are looking at establishing a similar facility to ensure that the type of website that will be created is absolutely secure and its privacy assured?

Mr J.R. Quigley: Thank you for a most interesting question. A person intercepts or hacks the line and uses what we have seen in the United States—a simulated face.

Mr Z.R.F. Kirkup: Yes.

Mr J.R. Quigley: They make the application to the doctor. They then have to make a second application to another doctor. Here we get to the fake bit. Then they go back to the first doctor and they must sign a written request.

Mr Z.R.F. Kirkup: Not in person, though.

Mr J.R. Quigley: They must sign a written question witnessed by two independent people. Who is going to take this? What is the member suggesting? Is he suggesting that the fake person is going to swallow the potion?

Mr Z.R.F. Kirkup: I was not going to continue to labour the point, but this is a very real and emerging threat. However, the Attorney General has asked the question. If a person wants to access medication that will definitely be used to terminate life, I think that will have a high level of value if it falls into the wrong hands. That is where the motivation comes about. I appreciate the need for an audiovisual engagement, because in a regional or remote setting it is very difficult to find a practitioner. My only concern is that that could be exploited. Having a website would open up another avenue for exploitation; that is all.

Mr J.R. Quigley: Thank you, member. But at the end of the day—I do not like to call it medication—the potion—

Mrs L.M. Harvey: The substance.

Mr J.R. Quigley: Thank you, member for Scarborough. The substance has to be given to the patient by either a medical practitioner or a nurse practitioner.

Mr Z.R.F. Kirkup: No. It can be given to an agent—someone in the middle. That’s not true.

Mr J.R. Quigley: They have to receive it and take it to the person.

Mr P.A. Katsambanis: No, only on one limb of the two.

Mr J.R. Quigley: Yes.

Mr P.A. Katsambanis: Not on the second limb.

Mr J.R. Quigley: So the fake person who goes through all this says, “I’ve tricked the doctor.”

Mr P.A. Katsambanis: And they can receive the medication.

Mr J.R. Quigley: “I’ve tricked the doctor.”

Mr P.A. Katsambanis: Read the bill.

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

The ACTING SPEAKER: Leader of the Opposition.

Mr J.N. Carey: How was the footy?

Mrs L.M. Harvey: It was great; West Coast look like they are smashing it, but I came back because I felt my responsibility was better served here.
With regard to clause 21, at this stage, when the medical practitioner has to notify the board of a first request, it does not look as if there is a requirement here to notify the board of the illnesses or diseases ailing the individual, or indeed the imminence, if you like, of their demise. I am wondering why that would be. I ask that because I understand there is an opportunity to expedite the process for people whose death might be imminent. I would have thought it would be appropriate at that point to let the board know that there is an individual who may have a week or 10 days left to live, and a decision might need to be made urgently. I am wondering why that would not be included at this stage of the notification to the board, and if there is a reason for that.

Mr J.R. Quigley: It is a drafting process; that is all. It is simply a drafting process. When we get to clause 28, which is headed “Recording and notification of outcome of first assessment”, there is a requirement for inclusions in the report. If the member goes to clause 28, she will see it. I am not trying to be slippery with the question.

Mrs L.M. Harvey: No, that is great. One step at a time.

Mr P.A. Katsambanis: I want to step through the process under clause 21, and specifically clause 21(2)(f), which states — if the medical practitioner’s decision is to refuse the first request, the reason for the refusal;

The board is informed of the reason for the refusal. Perhaps the reason for refusal is a concern on the part of the medical practitioner that either the person has a terminal illness or they lack capacity; either/or, or maybe both in some cases. Subsequently, the board receives another notification pursuant to clause 21(1) in which a subsequent medical practitioner has approved a first request. What obligation, or even power, does the board have to take some form of action to investigate if it receives two first request forms from the same individual, one with a refusal because the patient does not qualify under the illness or capacity criteria, and a second first request on which a medical practitioner has signed off and said, “Yes, go ahead”? What would the board do in those circumstances, and where are those powers for action by the board contained in the bill before us?

Mr J.R. Quigley: Once again, I think if we go down this path, the Leader of the Opposition’s Minties packet will expire before the end of the debate.

Mr P.A. Katsambanis: I do not care. She can get another one.

Mr J.R. Quigley: I know the member does not, because that is why the member asked the question.

Mr P.A. Katsambanis: I want an answer.

Mr J.R. Quigley: I am not trying to be slippery again. I was trying to be helpful again, like I was with the member for Scarborough.

Mrs L.M. Harvey: Incredibly helpful, Attorney General.

Mr J.R. Quigley: I thank the member for Scarborough very much. If we jump forward to clause 117, we see that it sets out the functions of the board. It is to monitor the operations of the act. It goes right through the functions of the board. When we reach clause 117, I am more than happy to mine the depths of the member’s question further.

Mr P.A. Katsambanis: We can do it that way. I am asking the threshold question here. If I get a reasonable answer, I will not need to ask it again at clause 117. I thought it was an appropriate request. It is one of the issues that are likely to come up in this sort of area, particularly in relation to people who might be in a state of vulnerability, significant distress, demoralisation or depression. I would have expected an answer that goes beyond, “Oh, there is a list of functions.” I want to know whether the board has the power to conduct an investigation and compare and contrast relating to the receipt of these documents of first request in clause 21 if it has two competing documents of first request before it in a relatively short time frame—one that suggests that the person did not have either the appropriate illness qualification or the capacity to continue the process and one that suggests the exact opposite. The board is likely to encounter that under the formulation of clause 21, in particular because a medical practitioner who refuses a first request has to specify the reason for the request. They will be legitimate reasons. I am not doubting any medical practitioner’s legitimacy in this space. I want to know whether the board has power, whether by reference to clause 117 or some other clause or simply by the operation of common law, if you like, to undertake an investigation to see which of those medical practitioner assessments is the one that should be considered in this space.

Mr J.R. Quigley: With respect, I think the member is conflating first request with assessment, and I will reserve my answer on the board’s powers when we reach clause 117.

Mr P.A. Katsambanis: Obviously, I have not received an answer. I think it is a legitimate question.

Mr J.R. Quigley: The member will receive it at clause 117.

Mr P.A. Katsambanis: The question remains unanswered. Whether it is the Attorney General or someone else in the chair—I do not know who will revolve around. We have had three ministers. There are 14 ministers in this place, so we might have 14 by the end.
Mr J.R. Quigley: I will be here unless I am kicked out.

Mr P.A. Katsambanis: I will be here to ask it again either under that clause or somewhere else, and I will make reference to the Attorney General’s suggestion.

Ms M.M. Quirk: Attorney General, this is a minor observation. I understand there will not be too many regulations. Most of this will be handled administratively, but I was wondering why these criteria were not put in as a prescribed form in the back of the bill, for example. Secondly, is it privacy or some other reason that the person’s illness does not need to be listed. I would have thought that that should be communicated.

Mr J.R. Quigley: Clause 21 is about the first request; it is not about the assessment. Clause 21 deals with the first request and it does not require a form until the person is assessed and that information is registered. A person will not go in there and say, “I want VAD” and the doctor immediately contacts the board. They will say, “First of all, give us a look at your X-rays, toxicology, bloods, biopsy”, yadda yadda yadda, “and then we will send the assessment off to the board.” It is not rocket science.

Ms M.M. Quirk: Clause 21(1) states —

...2... days after deciding to accept or refuse the first request, the medical practitioner must complete the approved form ...

Given that there does not yet seem to be an approved form, why was one not put in a schedule to the legislation? That is question one.

Mr J.R. Quigley: It is because we anticipated that there would be members like the member for Girrawheen who oppose the legislation, so we do not know whether the legislation will pass. We cannot put a form in until the people who are opposed to this legislation vote on it. We are not prepared to devise a form until we hear from the wisdom of this chamber.

Ms M.M. Quirk: To correct the record, I am judging each clause on its merits, so the Attorney General’s answers actually matter. In response to why no condition was listed, it was when no assessment had been made. Presumably, if the request has been made, the person would come in and say, “I have this or that; can I make the request?” Then, obviously, as part of the assessment, that assertion would be confirmed. I can understand if it is for privacy reasons, but in terms of the request being comprehensive, of some, for example, reporting or research bases down the track, it might be helpful to have that information.

Mr J.R. Quigley: As to the first part of the member’s comment, I was neither trying to be trite or insulting when I cast her amongst the noes, because at the calling of the vote on the second reading speech, she voted no. So, I take it that the member told the Parliament she was a no vote, and I respect that. But she is a no vote, and I say to the no votes that although I respect their position, I so respect it that we are not prepared to do a form until we are in receipt of the wisdom of this chamber.

Ms M.M. Quirk: To correct the record, I am judging each clause on its merits, so the Attorney General’s answers actually matter. In response to why no condition was listed, it was when no assessment had been made. Presumably, if the request has been made, the person would come in and say, “I have this or that; can I make the request?” Then, obviously, as part of the assessment, that assertion would be confirmed. I can understand if it is for privacy reasons, but in terms of the request being comprehensive, of some, for example, reporting or research bases down the track, it might be helpful to have that information.

Mr Z.R.F. Kirkup: Attorney General, clause 21(2) states that “the first request form must include” and it lists a range of information that needs to be included. One of the issues I raised with the minister was about Aboriginal people who might not have a fixed address. The subclause notes that the form must include the contact details of the patient. In some cases, as we know, there are Aboriginal people who do not have a date of birth that they recognise. The form will obviously have to be completed to the best of the ability of the practitioner, but if they do not have a fixed address or there is not a full date of birth, that would not prohibit someone from still accessing it.

Mr J.R. Quigley: That is correct.

Mr Z.R.F. Kirkup: Subclause (2)(d) states —

whether the first request was made in person or using audiovisual communication and whether it was made verbally or in another way (for example, by gestures);

If it was made by gesture, will they have to explain each individual gesture, or will it be satisfactory enough for the legislation just to say that it was made by gesture? Will they have to describe in detail what that looks like and how the request was made?

Mr J.R. Quigley: So long as there is a clear and unambiguous gesture. I have witnessed some people, as I am sure the member for South Perth has too—if you live long enough, you see these things —

Mr J.E. McGrath: I have not lived that long!

Mr P.A. Katsambanis: He has only just started!

Mr J.E. McGrath: I am a year younger than Donald Trump!

The ACTING SPEAKER: Okay; move it!
Mr J.R. QUIGLEY: Sir Robert Menzies—gosh!

I have been in hospital. People get things such as, I am sad to say, oesophageal cancer and they cannot otherwise talk. It is terrible. I used to get wheeled in to the treatment room. They could not talk but they could clearly gesture “yes” or “no” to the treatment. That gesture must be unambiguous and it will have to be recorded in the medical notes—that is what doctors do.

Mr Z.R.F. KIRKUP: I appreciate that response. There is not a prescription for them to describe each individual gesture; the practitioner can say it was made by gesture.

Mr J.R. Quigley: Yes.

Mr Z.R.F. KIRKUP: Clause 21(2)(f) relates to the medical practitioner’s reason for refusing the request. If the reason for refusal was that they did not believe the patient had capacity, would that be inserted at that point in time?

Mr J.R. QUIGLEY: No; that is part of the assessment process. But he might refuse because he has booked a holiday to Honolulu. He is not going to give up his trip!

Mr Z.R.F. KIRKUP: Given the Attorney General’s background and his portfolio responsibilities, a recurring theme I see through this is that often, when we require a signature and date from a medical practitioner or the patient, no location is required to be indicated of where that was signed. Was there a deliberate reason that was not included? I imagine that for something like a coronial inquest, the location in which every form was signed might be material to an outcome. Is there a deliberate reason that was not included?

Mr J.R. QUIGLEY: No.

Clause put and passed.

Clause 22: Medical practitioner becomes coordinating practitioner if first request accepted —

Mr Z.R.F. KIRKUP: The Acting Speaker is getting through this with great haste. It is great to see.

The ACTING SPEAKER: It is my job.

Mr Z.R.F. KIRKUP: Clause 22 states —

If the medical practitioner accepts the first request, the practitioner becomes the coordinating practitioner for the patient.

I am going to assume that that is immediately upon the practitioner making the decision and informing the patient. Could the Attorney General provide me with some certainty about this—is that the correct series of events?

Mr J.R. QUIGLEY: Yes.

Mr Z.R.F. KIRKUP: When the practitioner has to inform the board, that is just an additional process—it does not mean that they have to wait. We do not have a situation in which the practitioner is waiting two days before they become the coordinating practitioner because they have not informed the board yet, do we?

Mr J.R. QUIGLEY: No.

Clause put and passed.

Clause 23: First assessment —

Dr D.J. HONEY: I think I reasonably understand how this process will go. One area I have a particular concern about is where the assessment is carried out remotely by audiovisual communication.

Mr J.E. McGrath interjected.

Dr D.J. HONEY: Sorry; the Eagles are winning very comfortably!

If we look at that assessment, the doctor has to assess whether the patient has a terminal illness. They have to assess whether the patient has sufficient soundness of mind and the capacity to make the decision, and they also have to have the capacity to determine whether the patient is subject to undue influence. Could the Attorney General explain to me how he believes that is possible by an audiovisual process?

Mr J.R. QUIGLEY: It would be very, very unprofessional of any medical practitioner to accept at face value, by audiovisual means, that a person is suffering from a terminal disease. Any professional doctor would have to have more information before them before they could say, “You’ve got a terminal disease and, on the balance of probabilities, you will pass away within the next six months.” Making that assessment and signing off on it after looking at a screen would be an act, I would have thought, of gross medical negligence.

Mr J.E. McGrath: He’d have to know that you’re the person, too.

Mr J.R. QUIGLEY: That is right. They would have to know that they are the person and what the disease is, and they can only know what the disease is if they have reports of the disease. That is my answer.

Extracted from finalised Hansard
Dr D.J. Honey: The problem is that the Attorney General has answered only part of the question, and I do not believe that that answer is complete. Although there might be prudent practices, there is no requirement for that in the bill. It is purely the doctor’s opinion and there is no review of that. The Attorney General might say it is not prudent, but they do not have to do the things he said. Let us assume that they have some other tests. They have to determine that the person has the capacity to make that decision and that the patient is not subject to any coercion or any undue influence. How does the Attorney General believe that can be successfully achieved via a remote tele-video link?

Mr J.R. Quigley: I saw this amazing program on ABC television—absolutely amazing—about Royal North Shore Hospital in Sydney, which runs a team of ICU specialists over a 12-hour shift from 8.00 am to 8.00 pm to treat patients in New York, because 8.00 am Sydney time is 8.00 pm New York time. So rather than paying overtime to people in New York, they have staff on live screens in Sydney.

Mr F.M. Logan: Radiologists.

Mr J.R. Quigley: Not just radiologists; I saw intensive care unit specialists. The monitors on patients in New York are read on terminals in Sydney and the doctors in Sydney tell the ICU nurses in New York what to do.

Mrs L.M. Harvey: What kind of magic is that?

Mr J.R. Quigley: It is the twenty-first century! It is fantastic, is it not?

Patients in New York, who have just had a massive myocardial infarction and are lying in ICU connected to a machine, have their heartbeat, pulse rate and oxygen consumption read on a screen in Sydney and the Sydney intensive care unit specialists tell the nurses in New York what to do. Unbelievable, but it is true. If a patient goes to a doctor and says, “I’m as crook as a camp dog. I think I’m dying—give me VAD”, the doctor will want more. He will want biopsies and X-rays. He will want to be able to show that he was not professionally negligent. Doctors can do that by receiving the request remotely. We have to think of people who might be out in the regions. They can go to a community legal centre, or a business centre, and make their request online, closer than New York. The doctor might say, “Hang on. Where are all the biopsies? Where are all those sorts of things?” That is what I am sure any practitioner would do. A practitioner could face gross negligence—it might even be criminal negligence, actually—if they said, “I’m going to write out a script for this, but I’ve never seen a medical report. All I’ve seen is a bloke on TV saying he’s as crook as a butcher’s chook.”

Mr D.T. Redman: I want to pursue the line taken by the member for Cottesloe. Thanks to royalties for regions, we now have emergency telehealth in Western Australia, so we came into the twenty-first century in the last term of government.

Mr J.R. Quigley: Good point, member.

Mr D.T. Redman: Thank you.

Clause 17 makes specific reference to a person who makes a first request. The Attorney General cited clause 156(2)(a), which provides for the use of audiovisual communication. Subclause (3) provides that communication between the medical practitioner and the patient may also take a number of other forms—I assume that includes over the phone, and electronically. I hold probably a slightly different view from that of the member for Cottesloe. He is concerned about a poor assessment. I am trying to look at the opportunities to improve the service in regional Western Australia by utilising audiovisual and other types of technology to achieve those sorts of consults. Would this bill in any way prohibit a consulting practitioner from doing that consultation over some sort of communication platform, recognising that, in doing so, they have to be satisfied professionally that they have enough information? If we look at the eligibility criteria, they do not need to sit in a room to get a biopsy, or to have a conversation; they can glean a whole range of things from the information that they have, albeit they might be 400 kilometres away. Would anything in this bill prohibit practitioners from using technology, as it develops and improves, as a strategy for accessing the opportunity for VAD, as part of doing an assessment as distinct from a first request?

Mr J.R. Quigley: Nothing in the bill would prohibit a doctor from assisting one of the member’s constituents in the regions through the use of audiovisual communication, so long as they could see and hear simultaneously. The practitioner would need enough medical evidence to satisfy himself or herself that the condition was terminal —

Mr D.T. Redman: Absolutely.

Mr J.R. Quigley: — and that it was, on balance, within six months. Nothing in the bill would prohibit that assessment. If in that patient-to-doctor conversation the patient said, “The last doctor I consulted, on planet Mars, said that I’m terminal”, this might alert the doctor to the fact that the patient was one sandwich short of a picnic, and that he needed to do a further assessment, because he was saying that he had been to Mars. People say these sorts of things. Do not worry. I get constituents, as I am sure do other members, who say to me, “I’ve got someone on TV telling me how to live my life.” There are all sorts of people.

Mrs L.M. Harvey: Especially around a full moon.

Extracted from finalised Hansard
Mr J.R. QUIGLEY: The member is quite right. I am encouraged that it is not just in Butler in a full moon; it is everywhere.

The ACTING SPEAKER (Ms J.M. Freeman): We represent all our constituents, minister. Let us move on.

Mr P.A. Katsambanis interjected.

The ACTING SPEAKER: Members, let us move on!

Mr J.R. QUIGLEY: The point I am perhaps labouring is that during the audiovisual contact there might be clues as to capacity, but that would not be enough. I mentioned before treatment from New York to Sydney. That is another thing. I had an X-ray the other day because they are thinking about doing my good knee—what was my good knee! They took it at SKG and I drove to the practice on the north coast. When I got there, the doctor clicked on the screen and there was my knee! I did not have to wait around for an envelope. Do members remember the old days? We had to wait around and got a big manila envelope that was sealed and we wondered whether we could open it without the doctor finding out —

The ACTING SPEAKER: Attorney General, focus!

Mr J.R. QUIGLEY: We can do it with audiovisual technology. The member’s constituents will be catered for by this bill and by developments in electronic communication.

Dr D.J. HONEY: I am getting a sense that the minister is trivialising his response to this. Everyone is well aware that an X-ray can be looked at and images sent online. But the first assessment is a really serious matter. It is not a trivial matter; it is not a question of looking at just an X-ray or some medical results. The doctor has to assess whether the person has the capacity to make the decision. That is not based on an X-ray or a biopsy. It is not a group of doctors sitting around telling someone how to stitch someone up. It is an assessment of that person’s personality, their capacity and all the other factors that go to a person’s mental capacity to make the decision. The second part is that they have to make an assessment as to whether the person is subject to any coercion or undue influence. I find some of the minister’s responses very frustrating. We constantly hear phrases such as “in most circumstances” and “the doctor I saw would not do that”. It is not just the minister; there were some other contributions as well. Our job is to look at those difficult situations that can allow this process to fail.

Mr J.R. QUIGLEY: Allow the process to what?

Dr D.J. HONEY: Fail—as in deliver an outcome that should not otherwise have been delivered.

I believe the Minister for Aboriginal Affairs is here. I can imagine someone out in the Tjuntjuntjara community. They have reasonably good communication. The member for Kalgoorlie can confirm that they have audiovisual communication. In that case there is a high probability of significant cultural differences between the assessing doctor and the patient. The patient may well not wish to come to a major centre to be assessed. My concern is that when it is a remote form of communication, it is not possible to make those other two assessments. I have heard all the assurances that no-one would do that, but it may come to the point that a practitioner is required to do that. They are aware that a person has a terminal illness, but they have to assess other important factors. I assume that the expert panel must have considered this matter. I have not heard anything that the minister has said that gives me any comfort whatsoever that those critical matters can be assessed remotely by an audiovisual means. In fact, my contention is that it would be extraordinarily hard to do that. I want a proper response from the minister, please. I am not worried about someone doing a medical procedure or looking at an X-ray online. It is the crucial personal matters that go to their capacity to make a decision and whether they are subject to any coercion or undue influence. How can that possibly be done by remote audiovisual means?

Mr J.R. QUIGLEY: Certainly. As the member for Warren–Blackwood pointed out earlier, prior to us coming along as government, there was eHealth and it is operating quite well, as members from the regions know. It has provided great facilities. The member asks how capacity can be assessed. Mental illness and depression are treated online. eHealth does a lot of treatment modalities for people in the regions online, and a psychiatrist or a doctor—it does not have to be a psychiatrist—who has gone through the training will have all the questions needed to ask to stress-test capacity. They will ask all of those online and they will be in no less a disadvantageous position than if the patient was sitting in the room. That is the whole purpose of it.

Dr D.J. HONEY: The great difference is that with eHealth, in the great majority of cases a misdiagnosis does not lead to the person dying; however, in this case it could.

Ms A. Sanderson: They are dying anyway.

Dr D.J. HONEY: I will not respond to that, because we covered it amply in other areas. In this case, they have to make that intimate assessment. In my professional life I have participated in many tele-video conferences, and I am sure the minister has as well. Even at the level of business, even at the level of understanding business decisions or technical matters, I know with absolute certainty that having met a person and being at a meeting, in person, versus being at that meeting in the tele-video setting, is fundamentally different. I appreciate that one example is
a clinical setting and one is not; however, when it comes down to me understanding the interaction of the person and the subtleties of it, it simply is not possible, I contend, over a tele-video line. I hope that the minister is correct in saying that there is this highly codified process that he has great confidence in. He has expressed that there is a highly codified process, he has great confidence in it, and even remotely, we will be able to have a high degree of certainty about the mental capacity of that person to make the decision. We move to the next thing, and we do not know. We have not seen this list; we have not seen this test we have been presented with as evidence that would demonstrate that.

Then we go to the important area, and this is a crucial area. I can say that the biggest concern of all the legal practitioners I have spoken to about the possibility of this legislation not working properly is the area of coercion and undue influence, especially when inheritances are involved. I will not go through that debate again, but there was a substantial concern. There could also be cultural differences, but certainly based on communication differences, this practitioner does not have to know that person at all—not at all. A practitioner could be meeting this person for the first time electronically, having never met them at all, yet the minister is saying that using the telecommunications process, such a practitioner, will be able to make an assessment of whether there is undue influence or coercion. I appreciate there is a second practitioner involved, but, equally, that second practitioner is using the same means, especially in the case of a person in a remote community. This is not some idle or trivial point. I think this is pivotal to an area in which there could be the wrong outcome in that assessment, and I have not had reassurance that using a tele-video or remote communication will deal adequately with those areas, in particular, of undue influence and coercion.

Mr J.R. QUIGLEY: I can well understand the member’s question, but it is based on a dodgy proposition. The dodgy proposition is the member’s belief that a person’s capacity cannot be assessed by a medical practitioner online. That is the member’s belief. There is no evidence before this Parliament that that is the case, and, indeed, if we go to the Ministerial Expert Panel on Voluntary Assisted Dying’s examination of this in its report, which included palliative care doctors, they held a contrary position to the member for Cottesloe. Those specialists hold a contrary position. I firstly say that the member is basing this on a false premise—that it cannot be done.

I hope the member’s Minties are holding out, because we have to jump forward to clause 156, if we may. This is going to take a while. Clause 156(3) of the Voluntary Assisted Dying Bill states —

Except as provided in subsection (2)(b), a medical practitioner or other registered health practitioner may give advice or information to, or otherwise communicate with, a person for the purposes of this Act using any method of communication (including electronic communication) that the practitioner considers appropriate.

Having seen the person on the telly, he might say, “I’m not sure now. I’d really have to see that person.” It is up to the medical practitioner, and with the greatest of respect, I defer to them rather than to your good self to elect the appropriate method of communication.

Dr D.J. HONEY: I have not had a response. I will not go down that path. It is late; we are all tired. I have not had a response. Is there any evidence at all that the areas of coercion or undue influence can be picked up? I have not heard any evidence from the Attorney General that the expert panel considered that. In his reply, he talked about the assessment of a person’s capacity. As I said, I am intrigued to see the evidence that it is possible. I appreciate that the Attorney General has practised in a wide range of areas and is widely experienced. He would know that coercion and undue influence are very subtle. However, they can have a highly egregious outcome. People can be and are dispossessed of their worldly possessions. The courts are full of cases of that. Every year in Australia there are multiple cases of people being dispossessed of their worldly possessions and inheritances through coercion and undue influence. That undue influence can be from a loving person; someone who actually loves that person, but —

Mr J.R. Quigley: Wants them dead.

Dr D.J. HONEY: Yes, they may want them dead. They may think that is the best thing for that person. We heard many stories about that, Attorney General. I am not going to go through the stories again here, but we heard stories of people who were well-meaning but influencing someone to consider the end of their life. Those things are highly subtle. These are not obvious things. Did the ministerial expert panel look specifically at the utility of audiovisual means for a doctor determining whether there is coercion or undue influence? I know what the doctor can do, and it comes back to this. We hear all the time what they can do and what they would do, but it is about what they are required to do and whether we have certainty about this method. I know they can do other things, but, again, if someone is in a remote community, such as Tjuntjuntjara, the practitioner is unlikely to go there. There is a high probability. I know that a lot of people want to stay on those communities. That is where they live; that is home. They want to stay around their loved ones, especially if they are sick. That is where they want to be. Was there any evidence that this was a robust means for assessing undue influence and coercion?

Mr J.R. QUIGLEY: The patient will be asked a series of questions to determine whether they have decision-making capacity and whether they are acting voluntarily and without coercion. Merely looking at a person will not answer these questions. It is the responses that a person gives to questions that will form the basis of the doctor’s opinion.

Extracted from finalised Hansard
Mr W.J. JOHNSTON: I would like confirmation that under clause 23(1), which refers to the obligations on the coordinating practitioner to do this assessment, it is not necessary for that coordinating practitioner to make a diagnosis.

Mr J.R. QUIGLEY: That is absolutely correct. Often, they might work from a previous diagnosis from an oncologist who has examined the patient. It will not necessarily be the doctor to whom the first request is made. I would be surprised if it was made to the first oncologist. People go away and mull these things over. They go and see their GP, who says, “John, Dr Swarbrick has written to me and you’re not good.” But Dr Forgione has not even examined me. He is relying on Dr Swarbrick, and Dr Swarbrick, who is a great dermatologist, is relying in turn on a scientist who has done the biopsy that was cut from me, so there is all that chain. When it gets to the GP, the GP will not necessarily be the one who does the diagnosis. The GP—if it is a GP; it does not have to be a GP, as long as it is a medical practitioner with the proper qualifications and proper training—who receives the request might be operating on a report from an oncologist, and the patient has come to see him. I can remember the process I went through. It was brutal. I can always remember this. I will tell a little story. I had a mate who was a psychiatrist and after I got diagnosed—I had been married only six months—I took my wife along to him. She was young—she still is. We sat down and he said, “What do you want?” I said, “I’ve got this diagnosis that I’m terminal.” He said, “I’m a psychiatrist.” I said, “I know, but throughout this journey I might become depressed, and I want to see whether you can help me ward off depression so I don’t weigh her down.” He looked at me and he looked at the diagnosis and said, “You’re going to die. I can’t help you.” Then he turned to my wife and said, “And after he does, you’re going to feel terrible. Come and see me then”!

Mr D.C. Nalder: Is that true?

Mr J.R. QUIGLEY: It is as true as I stand here. It can be a brutal process. Doctors will rely on other people’s assessments. That is the point I seek to make.

Mr W.J. JOHNSTON: I note that the bill contains many provisions that require procedures and issues to be specified by the CEO. In this provision, is there an intention to have any special arrangements for prisoners in Western Australia?

Mr J.R. QUIGLEY: That is a very interesting point. Of course, prisoners in Western Australian are afforded good medical treatment, and when they are very ill they get treatment outside those institutions, in tertiary hospitals. The only additional requirement for prisoners is that even if a person goes through the whole voluntary assisted dying process and the board is informed, and it is all correct, under the Coroners Act anyone who dies in custody by any means must be the subject of a full coronial inquest.

Mr W.J. JOHNSTON: I asked a specific question. I am terribly sorry, Mr Attorney, but I am not sure that you answered. I asked that given the bill contains a whole range of issues that are specified as requirements to be set down by the CEO, are there any specific requirements in respect of prisoners in Western Australia?

Mr J.R. QUIGLEY: No.

Mr W.J. JOHNSTON: Earlier, the Attorney General confirmed that there will be no obligation on a consulting practitioner, when dealing with the matter under clause 23(1), to make a diagnosis of a disease. Will there be any obligation on them to understand how the original diagnosis was entered into?

Mr J.R. QUIGLEY: I am sorry, member, but with the greatest respect, I do not understand what you mean by “how the original diagnosis was entered into”.

Mr W.J. JOHNSTON: My apologies.

Mr J.R. Quigley: No, it is my fault, I’m sure.

Mr W.J. JOHNSTON: That is all right. The Attorney General has confirmed that the coordinating practitioner does not themselves have to make a diagnosis. Is there any obligation on them to have information, understanding or whatever on how the original diagnosis that they are relying on to make the assessment has been created?

Mr J.R. QUIGLEY: No, there is not. But there is a requirement that the coordinating practitioner must be satisfied of the eligibility. To be satisfied as a professional practitioner, he or she will have to have evidence before him or her of that terminal disease. In some cases, he or she might possibly diagnose it himself or herself. Often, in our state, if a person is that ill, they will be referred to a public or private hospital to see a specialist and a diagnosis will result. I have never seen in my practice of law or during my illness that when a specialist reports to a GP, it is just a one-line result of the diagnosis, like “Lung cancer”. It is usually, “We have taken X-rays and it reveals that it is stage 4 and it has metastasised.” Does the member know what I mean?

I have never seen just “lung cancer”. How could we tell whether on the balance of probabilities the person would die within six months? The coordinating doctor could not form that opinion, but the coordinating doctor could read a report from Royal Perth Hospital that says, “Johnny has lung cancer. It is stage 4. It has metastasised. There is secondary in his brain, liver, wherever, and we expect Johnny to pass from this world within six months.” A coordinating doctor in their practice receiving such a report would ordinarily rely on it and will rely on it. Also,
if under a clause to come, if the coordinating doctor—this stretches out the debate a little—is unable to make that assessment, under a clause that we are about debate, but not yet arrived at, clause 25, if the coordinating practitioner is unable to determine whether the patient has the disease or decision-making capacity et cetera —

The coordinating practitioner must —

Under the Acts Interpretation Act, “must” is compulsory and may is discretionary —

refer the patient to a registered health practitioner who has appropriate skills and training to make a determination in relation to the matter.

I am happy to go further into that debate when we get to clause 25, if the member for Dawesville’s Minties last that long.

Clause put and passed.

Clause 24: Coordinating practitioner to have completed approved training —

Mr Z.R.F. KIRKUP: I appreciate that clause 24 states —

The coordinating practitioner must not begin the first assessment unless the practitioner has completed approved training.

Implicit in that clause is that the practitioner has accepted the first request, which obviously leaves some time between when a practitioner could accept a patient’s request and the time they can take to assess it. Of course, there might be some lag between when they get the appropriate online training issued by the CEO. Why can a practitioner accept the patient’s request without having gone through any formal training to do so?

Mr J.R. QUIGLEY: The adviser made a good point. I have great advisers. They work for the public service, and I have learnt that we have a great public service in Western Australia.

The SPEAKER: Minister, it is a long night, so can you keep the one-liners to a minimum?

Mr J.R. QUIGLEY: The answer is this: someone might go to a practitioner and make a first request, but that practitioner might not have done the training. Only a limited number of people might ever make a request under this legislation. When we think of the limited number of doctors compared with the 2.5 million population, an individual practitioner might get only one or two requests in their practice. They might never have thought about going along to get the training because it never occurs to them in their practice. They can receive the request, but they cannot make the assessment.

Mr Z.R.F. KIRKUP: I appreciate that that is the case; that is exactly the point that I made. I anticipate that the training that would be issued by the CEO would be quite an extensive process for the practitioner to be involved in. How long will it take for that training to be satisfied? If a patient who is terminal and might want to expedite a process and make sure that their first and final request happens in the most expeditious fashion, which is nine days, how long do we anticipate the training would take for a practitioner to go through?

Mr J.R. QUIGLEY: I thank the member for that insightful question. We wish to say that the training modules, like in Victoria, will also be available online so that doctors in places such as Wyndham and Kununurra do not have to leave the town and people without a medical practitioner, but they can enter into the training online. It is also done in Victoria in the same way, but in Western Australia we will have a bit of nuance, given our geographical spread. There will be an assessment component in which the practitioner will be required to demonstrate competency to the examiners of the course. The training package in WA will be developed in consultation with the Department of Health; the Royal Australian College of General Practitioners; key medical, nursing and allied health stakeholders; clinical, educational and regulatory experts; palliative care and end-of-life stakeholders and experts; cultural stakeholders and advisers for the Indigenous; and consumer and community representatives. At a minimum the training is likely to address the following. Firstly, it will address a basic introduction to WA’s voluntary assisted dying framework and an overview of the training program. It will introduce an understanding of voluntary assisted dying within the context of the broader end-of-life care and in the unique context of Western Australia. Secondly, it will address the roles associated with the voluntary assisted dying process—that is, coordinating, consulting and administering practitioners; the requirements of medical practitioners and nurse practitioners in relation to qualifications and experience; and it will require an understanding of the functions in the voluntary assisted dying process and how to transfer roles or, for themselves, withdraw from the process. Thirdly, there will also be cultural competency, understanding and being able to appropriately work with patients, families and health services from culturally and linguistically diverse communities. Fourthly, it will address conversations with patients about end of life and choices at end of life, understanding the context in which discussions about voluntary assisted dying may arise, how doctors should respond to a first request, and making a decision whether to participate in voluntary assisted dying. It will also include the reporting requirements. Fifthly, it will address the process steps that must be undertaken during a request and assessment, and how to ensure compliance with requirements and safeguards. Sixthly, it will address the independent assessments of eligibility that must be made by the coordinating and consulting practitioners, providing guidance about the eligibility assessment process, how to assess each of these criteria and when to refer...
for other assessments, including reporting requirements. Seventhly, it will address the process requirements after the eligibility assessment. That includes aspects such as the written declaration, witnessing requirements, the final request and final review.

The SPEAKER: Can I just say, in reading the whole lot out, can you just edit it a bit, because it is a very long process.

Mr J.R. QUIGLEY: I am doing the rest of it as quickly as I can, but it is important for the public to understand, within my limited speaking time, what these doctors will be trained at. The people in the regions watching this, I think, with all due respect, do not want a Quigley-edited version. They want the full wazza out there in the bush, and the Nationals WA are agreeing.

Medication administration decision and prescription training will cover how to determine appropriate medication administration methods and protocols, discussion with the patient, decision-making, information provision to the patient and appointment of contact person. Training to understand the authorised supplier and authorised disposer roles will include the prescription process, medication supply, safe storage, administration planning and medication disposal. It will also include reporting requirements.

Mr D.T. REDMAN: Mr Speaker, I would love to hear the end of what the Attorney General has to say. He is doing such a good job.

Mr J.R. QUIGLEY: Thank you very much. The people in Albany will be very interested in this as well, Mr Speaker.

The SPEAKER: Preamble!

Mr J.R. QUIGLEY: I am sure that some of your constituents will be watching this live on their TV sets.

The SPEAKER: No!

Mr J.R. QUIGLEY: Eighthly, they will also be trained in the process after death; that is, the responsibilities of the coordinating and administering practitioner and the contact person, death certification and reporting requirements.

Ninthly, they will be trained in the protections, the offences and oversight. They will be trained in understanding the protections for those acting within the scope of the act and offences or professional consequences for those acting outside the act. Also included in the training will be an understanding of the role of the Voluntary Assisted Dying Board, the CEO and other agencies that may be referred to.

Lastly, there will be training related to self-care for practitioners and support resources and other resources for those practitioners. It includes reference material and other recommended reading. The training will contain competency assessments, and a successful pass is required for training requirements to be met.

Mr Z.R.F. KIRKUP: I am reluctant to remind the Attorney General, but my question was actually: how long will it take for a practitioner to participate in that training? In the seven-odd minutes that he provided an answer, he did not answer that question. Could the Attorney General enlighten us, after that extensive outline of what the training will consist of, how long is it anticipated a practitioner would take to clear through it?

Mr J.R. QUIGLEY: I am glad, however, that I read all that out for the public, who want to know how this training will go and what doctors will have to cover, especially those people in the regions. Victoria has an online module. It takes six to eight hours of concentrated study to cover all those points that I have read out. Then they will have to demonstrate their competency on those points: how it will be assessed and whether they have achieved that competency. That will be up to the authorities. As a legal practitioner who maintains a legal practice certificate, every year I have to prove competency by attending courses and passing things.

Mr P.A. Katsambanis: You can do them online, too.

Mr J.R. QUIGLEY: The member for Hillarys is right, they can be done online. This will be available online as well, but it will take about six to eight hours. There will be an 18-month period before implementation.

Mrs L.M. HARVEY: Will the training that the Attorney General just mentioned be likely to be organised by the Department of Health or by the Department of Health in consultation with the Australian Medical Association and other stakeholders? How will that training program be put together and who will deliver it?

Mr J.R. QUIGLEY: It is anticipated and proposed that the Department of Health will draw up the training module in close consultation with the Royal Australian College of General Practitioners.

Mrs L.M. HARVEY: Will costs be associated with the training; and, if so, will those costs be borne by GPs or taxpayers via the Department of Health?

Mr J.R. QUIGLEY: There will be no cost to taxpayers for the training.

Mrs L.M. Harvey: Just the taxpayers.

Mr J.R. QUIGLEY: There will be no cost to the practitioners who will be trained at Royal Perth Hospital; it is taxpayers who pay to train those doctors to treat and offer services to patients and it will be just the same in this
case. Taxpayers pay for the training of residents for the benefit of the community. It will be the same in this case, but the costs will be far less than those required to train a resident at Royal Perth Hospital. It will be a six-hour package presented online at minimal cost to Western Australians, 88 per cent of whom want this legislation passed.

Mr D.T. REDMAN: When we had a briefing, one of the questions we asked was whether there will be a central register of doctors who have had the training. From memory, I think the answer was no. The Attorney General will clarify that if I have got that wrong. If a person makes a request, they are given information with a phone number and referral to someone to call. From a regional sense and from what the Attorney General just described, that is reasonably onerous. It is not un-onerous to complete the requirements online, bearing in mind that it is voluntary. A lot of regional practices run pretty hard and taking time out to do this may be in response to demand. There are fewer people in regional Western Australia and it is likely that fewer doctors will volunteer for the training to provide the service for people in regional Western Australia than perhaps in metropolitan Perth. Will there be any tracking or understanding of the doctors who are trained? Will there be any response from a service provision perspective to ensure that those who are in the more isolated parts of the state can access the service, given that it will be voluntary training? Doctors can choose not to do it. If they are pretty busy, they will not do it; therefore, patients will have to go somewhere else to access the service.

Mr J.R. QUIGLEY: That is a good question to ask on behalf of the member’s regional constituents. There will be a register of doctors who have been certified. This register will not be made public because we do not want to embarrass practitioners. In a town with three doctors, one might put up their hand to do the training. When that doctor goes to the bowling club, everyone will know, “He’s the man”, and that doctor might be embarrassed. I do not know why I keep referring to Mukinbudin. Is that one of the member for Central Wheatbelt’s towns?

Ms M.J. Davies: It’s a delightful little town.

Mr J.R. QUIGLEY: I am sure it is a lovely little town.

Ms M.J. Davies: It’s got a brand-new health service.

Mr J.R. QUIGLEY: I had a house in Grass Valley, but that is not in the member’s electorate, is it?

Ms M.J. Davies: Yes.

Mr J.R. QUIGLEY: I had a house in Grass Valley. Grass Valley did not have a medical practitioner.

The SPEAKER: Member, I have a house in Albany, but let us get on with the bill.

Mr J.R. QUIGLEY: In answer to the question, they will be able to access it online. If a patient goes to a medical practice and the practitioner says immediately, “Conscience. No. Go elsewhere. Here’s the pamphlet”, they will ring the people whose number is on the pamphlet and tell them where they are. We can use somewhere else, like Wickepin. If a person goes to a doctor in Wickepin and says, “The doctor said no. Can you assist me?” They will say, “Why don’t you try one of these doctors?” If a person is in Bruce Rock, they might say that the closest one is in Shackleton or something like that. It is probably the other way around. It is probably from Shackleton to Bruce Rock, from my memory of Shackleton. I used to holiday in Shackleton—I did. Not many people would know where Shackleton is. It is about 20 kilometres shy of Bruce Rock.

The SPEAKER: Minister, can you get back to the clause, please.

Mr J.R. QUIGLEY: If they got a refusal, they would be able to ring the number on the pamphlet, and the person on the phone would say, “Why don’t you pop across to Merredin? It’s not far away.” That way the member’s constituents would be given good access, if that is their choice. This is voluntary.

Mr A. KRSTICEVIC: Will the online training be multiple choice, or will it be data entry? What will be the pass mark for going through that training?

Mr J.N. Carey: What a load of rubbish!

Mr A. KRSTICEVIC: How can it be rubbish to know what the assessment would be and what the pass mark would be? It is important information.

Mr J.R. QUIGLEY: Fortunately, as the member sits there, he might be able to get online and look at the Victorian training model, which we are going to follow, in no small measure. There will be differences, because our bill is slightly different. It is more nuanced for Western Australia.

Ms M.M. Quirk interjected.

Mr J.R. QUIGLEY: Sorry? I will take that interjection.

Ms M.M. Quirk: No, no, no.

Mr J.R. QUIGLEY: Is the member withdrawing the interjection? That is a good idea, if I may say so.

The SPEAKER: Yes, you may.

Extracted from finalised Hansard
Mr J.R. QUIGLEY: Thank you.

The SPEAKER: This is a very serious bill, minister.

Mr J.R. QUIGLEY: I am answering a very serious question, Mr Speaker. My answer to that very serious question is this: members can go online and look at what the doctors in Victoria have to go through. So far in Victoria, approximately 200 doctors have completed the online training. Western Australia is a little bit different and more nuanced. We will have more protections, and they will have to be built into the training program. For example, in Victoria, death must be “reasonably foreseeable”. In Western Australia, we are harder, tighter and safer. It must be “on the balance of probabilities”. Those nuances will make it different from what members will see on the training programs on their computer, but the style of presentation will be the same.

Mr A. KRSTICEVIC: I am not sure that the minister answered my question, so I will elaborate, for the member for Perth’s sake. The reason I have asked about the training and the pass mark is that people may say it is okay to get 51 per cent in a training module. However, we are dealing with people’s deaths. I want to know whether this will just be a module that people will have to complete, and whether they will have to pass 100 per cent to qualify, or 80 per cent. I would be very concerned if people did not need to get 100 per cent to qualify. I am trying to understand the process of assessment, and what the pass mark will be. Will they have to get everything 100 per cent correct to qualify to make the decision to end someone’s life? It is a very simple question. I want to know what the benchmark will be. Obviously, for a university degree, some people are happy to get 51 per cent, because then they are qualified.

Mr J.R. QUIGLEY: Not in medicine!

Mr A. KRSTICEVIC: That is right. In this case, I would want to be assured that it was 100 per cent. The minister obviously must know what the assessment process will be and what results will be expected. The public will then know that the people who have gone through this process are 100 per cent on the information they need to know, and not 80 per cent or 70 per cent; and, if there are variations to that, they will pick a doctor who has a higher score rather than one who has a lower score, if it is all about the end of life.

Mr J.R. QUIGLEY: They will have to get a pass mark that would see them get first class honours at the university medical school. I will bet my legal practice certificate that when people select a doctor, they do not check their pass mark at university or whether the next doctor got a higher pass mark. I will bet my legal practice certificate on that proposition. The pass mark will be higher than the training down the road. The pass mark will be the same as it is in Victoria.

Mr A. Krstic: What is it?

Mr J.R. QUIGLEY: It is 90 per cent. People do not have to get 90 per cent down at the University of Western Australia to become a doctor, but they will have to get at least 90 per cent to become qualified under this legislation. It is a higher pass mark than the medical degree.

Mr A. KRSTICEVIC: I have one last point to make on this issue. I disagree with the minister about people not checking the credentials of their doctor. More importantly, the credentials of your —

Mr J.R. QUIGLEY: The pass mark? I’ll bet you never have!

Mr A. KRSTICEVIC: The minister indicated someone would not check the capability or competence of their medical practitioner. That is not true. Lots of people have said to me that when they go for surgery, they talk to nurses and anaesthetists and ask which surgeon they think is better. They say, “I know there are four surgeons to choose from, but which one would you go to?” Nurses may say, “I wouldn’t go to that one, but that is the one I would go to for these reasons.” I have sat in conversations with people who have had those discussions. I think it is misleading for the minister to say that people would not go to the effort. When it comes to end-of-life decisions, people would want to make sure that they had the best doctor to help them make those decisions. A number of them might be competent, but, like lawyers, some are more competent than others. That is why they go to specific doctors for specific reasons. It is misleading to say people would not do those checks, because they would.

I refer to the pass mark of 90 per cent. I will be honest. I have not seen the training modules, but I would assume that 90 per cent is adequate as long as something critical was not failed. Are there any critical aspects of the training that if a practitioner does not pass them, they will not qualify, or are they all equal? I am trying to get that on the record because I think that is important to understand. I am sure that the people who are interjecting, who probably have no idea about what this training is, might learn something if they pay attention.

Mr J.R. QUIGLEY: With the greatest respect, so might the member. He related people going around and asking, “Is this a good obstetrician or is that a good obstetrician?”

Mr A. Krstic: It was a surgeon!

Mr J.R. QUIGLEY: I know! I have been in a family. The wives go around asking who or which. That is not checking pass marks. That is just getting an opinion.

Mr A. Krstic interjected.
Mr Z.R.F. KIRKUP: I appreciate that, Attorney. In that case, given the question from the Leader of the Opposition before about what might lead to the development of the training program—the Department of Health together with the Royal Australian College of General Practitioners and others that the Attorney General mentioned—does the Attorney General anticipate that they would also be charged with the responsibility of developing the continuing professional development courses as time goes on?

Mr J.R. QUIGLEY: Yes.

Mr Z.R.F. KIRKUP: Obviously, so that the Parliament can satisfy itself that that is being undertaken at a later stage, will members be advised what that continuous training will look like? Would that information be made publicly available at any time, such as during the implementation phase? As members of Parliament, we want to make sure that our participating practitioners are consistently up to date with any requirements. I am trying to get insight on how that might occur.

Mr J.R. QUIGLEY: I can say this with the utmost confidence: knowing the manager of opposition business as I do, I anticipate a welter of questions on notice on this issue as it develops. I encourage him to ask those questions and we will fully answer them. Not long after proclamation of the legislation, I expect to be shown by the Minister for Health the member’s first question on notice.

Ms M.M. QUIRK: I was intending to deal with this issue at clause 158, which deals with the CEO approving training, but since we have had an extensive discussion, I will ask my questions at this stage. First of all, I have tried to get into the portal of the Victorian medical training, but I am unable to do so because I do not have an Australian Health Practitioner Regulation Agency ID. I would be grateful if we could be given a copy of the curriculum at some stage.

Secondly, I conscientiously attended the briefings on this legislation, which were kindly provided by the Minister for Health, and I specifically asked about the training. I was told it will be online. I was told it will be about six hours. I was told that the CEO will probably consult with the college of GPs to formulate that training. I specifically asked whether it will be assessable and was told no. I was thinking of the legal CPD, for which people have to answer questions after they have read all the information and then they are assessed, and at a certain level they pass. When I asked the advisers, I was told that no, it will not be assessable. It might be accessible, although in my case it is not, but I asked whether it was assessable! That is the first question. Maybe the Attorney General can answer that and then I have a second matter.

Mr J.R. QUIGLEY: I am on my feet at the ministerial table in the Legislative Assembly of Western Australia and I wish to state that the training module will be assessable and the pass mark will be 90 per cent. Whatever may or may not have been said in the course of any discussions the member has had outside of this chamber, the Attorney General anticipates that the training will be online and they will fully answer them. Not long after proclamation of the legislation, I expect to be shown by the Minister for Health the member’s first question on notice.

Ms M.M. QUIRK: Before I go on to my other point, I say that the problem with that is that we have taken the time to attend the briefings and read various reports, but if we cannot rely on what we have been told in relation to that, one wonders about other assurances or indications we were given. Anyway, that is editorialising.

I have already said to the Minister for Health what I want to say, so I apologise to members who heard me say it before. Had the Minister for Health been here, I would not have had to repeat myself. Assessing capacity is notoriously difficult. Alzheimer’s Western Australia has said that, despite the increase in awareness about Alzheimer’s, the average time to diagnose dementia is between two to three years. A general practitioner who is highly trained is still taking up to three years to diagnose dementia. Given the breadth of the subjects that are being covered by this online module, I really doubt how comprehensive any instruction can be about judging capacity. It is incredibly relevant in this case, because we are not talking just about whether someone is able to make their own breakfast or dress themselves. They are making a very high-level executive decision. Page 21 of the “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report” states —

Decision-making capacity is a term used to describe whether or not someone is capable of making a decision. It is presumed that an adult is able to make decisions unless there is evidence to the contrary.

Extracted from finalised Hansard
It is important to understand that capacity is specific, contextual and can vary over time. Someone may have the capacity to decide what to eat for breakfast but not have the capacity to make complex financial decisions. The crucial question is whether a person has capacity to make a valid decision about voluntary assisted dying.

That is the nub of the matter, Attorney General. We need more information on how that will be addressed. I do not know whether that can be done by providing us with a copy of the curriculum of the training that is undertaken in Victoria, but at this stage, I am by no means confident that can be achieved.

Mr J.R. QUIGLEY: I cavil with the member’s first proposition that she cannot rely on the undertaking that I gave the Legislative Assembly of Western Australia that there will be an assessment process and that the pass mark will be 90 per cent. I cavil with the member’s assertion that she cannot rely upon that being said by the Attorney General at the ministerial table. To go on —

Ms M.M. Quirk interjected.

Mr J.R. QUIGLEY: I do not wish to take interjections.

Ms M.M. Quirk interjected.

The SPEAKER: Member for Girrawheen!

Mr J.R. QUIGLEY: I am not taking interjections during my answer. As to the assessment process, I repeat: people are being treated online for mental health conditions now. As to the issue of capacity and Alzheimer’s, there are two different issues. First, it may take two to three years to diagnose Alzheimer’s. It does not mean that during that two to three-year period, the person does not have capacity. Indeed, recent research has shown—I might be exhibit A—that early Alzheimer’s can kick in soon after 50, but not be confirmed until later in life. I do not know what plaque I have. I turn to the absolutely heart-wrenching interview with the much-respected and loved late Hazel Hawke, after her diagnosis of Alzheimer’s, and the very candid interview that she gave concerning her disease and what she expected to happen in the future. I saw that interview, and there is no doubt that, one, this beautiful woman had Alzheimer’s; two, whilst being interviewed, Mrs Hawke had full capacity. The question of diagnosis of Alzheimer’s and capacity do not intersect at the same point. There is a point when people with Alzheimer’s will lose capacity; that is beyond question. There are people in the community who are a little upset that people with Alzheimer’s will not access this bill, and for a very good reason—because it would not be voluntary if they did not have capacity. The mere early diagnosis of Alzheimer’s does not interfere necessarily with capacity.

Ms M.M. QUIRK: I was not going to get up again, but clearly the Attorney General misunderstood me. I was not challenging his undertaking; I was saying that I can no longer rely on the advice that was provided by advisers because it is at odds with what he is telling us tonight. I am not questioning his sincerity in his undertaking; I am saying that if that advice has moved on or has varied, how can we be confident that any other assurances or advice that we got are also correct? I will leave it at that.

Mr J.R. QUIGLEY: The member, a very experienced lawyer, is here in the Legislative Assembly with full opportunity until the crack of dawn and beyond to cross-examine me on any clauses in this bill. Although what she has been told elsewhere might be helpful or less than helpful, what is said at this ministerial table by me will be the truth.

Clause put and passed.

Clause 25: Referral for determination —

Mr D.T. REDMAN: This clause relates to the circumstance that the Attorney General talked about earlier in which a supply chain of information can contribute to the information that the coordinating practitioner has in order to make the decision on whether all the criteria for eligibility and decision-making capacity are met. I note that clause 25(2) states —

The coordinating practitioner must refer the patient to a registered health practitioner who has appropriate skills and training to make a determination in relation to the matter.

Can the Attorney General clarify whether “training” in this sentence refers simply to the skills that the practitioner has or to the approved training that is required by a coordinating practitioner?

Mr J.R. QUIGLEY: If the coordinating practitioner is unable to determine whether, firstly, the patient has a disease, illness or medical condition that meets the requirements of clause 15 or, secondly; the patient has decision-making capacity, he must refer the patient to a registered health practitioner who has the appropriate skills. That does not have to be someone who has had VAD training. It might be a haematologist, an oncologist or some other practitioner who is able to assist the coordinating practitioner in reaching a determination, but that oncologist or haematologist does not have to have VAD training.

Mr D.T. REDMAN: So the last line of clause 25(2) simply refers to the broader context of training; it does not refer to the formal training that is required for coordinating practitioners.
Mr J.R. QUIGLEY: That is correct. As I said, it might be someone like the wonderful David Joske, the leading haematologist, who looks at a patient’s blood count and says, “That’s multiple myeloma” or something like that. He does not have to have VAD training. He will give the full report back to the general practitioner, and when the coordinating practitioner is making his assessment, he will rely on the full report given by the haematologist.

Mr W.J. JOHNSTON: Is this clause actually required? Look at the eligibility criteria. We are discussing the coordinating practitioner’s assessment. The eligibility criteria specified in clause 15, which the coordinating practitioner is assessing, are compulsory. How can a coordinating practitioner be unable to make a determination? Surely if they are unable to determine these criteria, that means that the patient has not met the eligibility criteria because it is compulsory criteria. Either they are eligible or not eligible, because clause 15 states that the criteria must be met. What is the purpose of this clause, given that the person is clearly not eligible, according to the assessment of the coordinating practitioner, if they cannot determine that they have met the compulsory eligibility criteria? It seems to be a nullity.

Mr J.R. QUIGLEY: Certainly; that is not a difficult one to answer at all. I like lollipops. When the general practitioner hears the person’s rattling cough and sees a little bit of blood on the hanky, they will say, “There’s something deeply wrong with you down there, but I am unable to determine, as a general practitioner, whether it is stage 4 metastasised cancer or not. I will need help.” Therefore, pursuant to clause 25, that coordinating practitioner will be able to refer that person to someone with appropriate training to get the deeper diagnosis as to what is behind that rattling cough and blood on the hanky. It might be just a torn vein in that person’s throat after having had the flu. The doctor would not want to give him that diagnosis if he did not know or could not be sure. Even though it is a compulsory requirement to be sure, he will not have made up his mind—he could say that he wants a second opinion. That is the purpose of the legislation.

Mr W.J. JOHNSTON: No; I think the Attorney General misunderstands the arrangement here. We have already been through this, and I did not believe that I would need to go over it again. This is the coordinating practitioner—read clause 24. I apologise that I have to go over it again, but clearly the Attorney General misunderstands the point I am making. What we are discussing is the coordinating practitioner doing an assessment for a patient. Under clause 22, the medical practitioner accepts the first request to become the coordinating practitioner. What they are doing is assessing the request of the person who is seeking voluntary assisted dying; they are not making a medical diagnosis. As the Attorney General has previously answered, the doctor himself does not have to make a diagnosis. I do not in any way have a problem with the Attorney General’s comment. It is clear that the coordinating practitioner does not themselves have to make a diagnosis. That is why I asked a question previously on that issue. The question I have now is different. This is not the doctor seeking to make a determination of an illness; this is the coordinating practitioner following the assessment process. The assessment is in respect of the eligibility criteria, and the eligibility criteria are compulsory. There are no ifs; it is a “must”. Therefore, if the coordinating practitioner finds a person not eligible, why is there a need to refer anybody off? Clause 25(1) states —

Subsection (2) applies if the coordinating practitioner is unable to determine …

Then there are two paragraphs. Paragraph (a) draws from clause 15(1)(c) and paragraph (b) refers to clause 15(1)(d). But they are compulsory. The coordinating practitioner’s job is not to diagnose the patient; their job is to assess the criteria. They assess the criteria and find that the patient has not satisfied it.

Mr J.R. Quigley: No.

Mr W.J. JOHNSTON: No; Attorney, read the words. It reads, “if the coordinating practitioner is unable to determine”. This is a compulsory criteria. They either meet the criteria or they do not meet the criteria. If the coordinating practitioner has not determined that they are eligible, by definition they are not eligible.

Mr D.T. Redman interjected.

Mr W.J. JOHNSTON: No, there are only two. They are either in or they are out. They are not making a diagnosis for the patient. The Attorney General helped me with this previously. He pointed this out in some detail and took about 10 minutes to answer the question. Here they are not making a diagnosis of the patient. They are assessing the eligibility criteria at clause 15 and they are compulsory. If they are not found, by definition, they are not found. We cannot have it two ways.

Mr J.R. Quigley: I missed that last bit.

Mr W.J. JOHNSTON: Because they are compulsory, they are either met or not met. If the coordinating practitioner is unable to determine that they are met, they are by definition not met. Why does this clause even exist?

Mr J.R. QUIGLEY: The member is conflating two things there.

Mr W.J. Johnston: That is not correct.

Mr J.R. QUIGLEY: I am here to argue with the member. We can have a vote on it. That is how we determine things in this chamber.

Mr S.K. L’Estrange: No, it is not. It is a given.

Extracted from finalised Hansard
Mr J.R. QUIGLEY: It is not by the member for Churchlands using his loudest voice. It is by voting.

The SPEAKER: Members, let us get on with it.

Mr J.R. QUIGLEY: The situation is this: the member is conflating two things. As they go through the assessment process, the doctor gets to a point and says, “Well, I am uncertain at this stage. I will have a closer look at that X-ray” or “I am uncertain at this stage. I want a further look at the bloods.” That does not mean to say that he has assessed the patient as ineligible and it is binary, to which the member for Warren–Blackwood was nodding before. It is not a binary choice as he is going through the eligibility criteria under clause 15. He might say, “Yes, yes, yes” or he might say no or on one of the points he might say, “Not sure. I need to look at the bloods before I can make up my mind to determine the critical question of whether the patient is likely to die on the balance of probabilities inside six months.” Therefore, we have clause 25. They have another look at the bloods and satisfy themselves either way and give an answer on the assessment. We are not going to handcuff general practitioners to whatever is in their first report and say that they cannot ask a question in this assessment process. Of course, they can. A doctor might say, “I am unable to tell from this bloods report whether the patient has multiple myeloma at an advanced stage. I need further information to complete my assessment.” That is clause 25(1).

Mr P.A. KATSAMBANIS: I would like to address clause 25(3), which deals with coercion and whether someone has voluntary capacity. It reads —

If the coordinating practitioner is unable to determine whether the patient is acting voluntarily and without coercion as required by section 15(1)(e), the coordinating practitioner must refer the patient —

That is all well and good so far, but it is very broad —

to another person who has appropriate skills and training to make a determination in relation to the matter. I argue that it is a good thing that it is broad. Could the Attorney General please at the outset give an inclusive list of examples of who could have the appropriate skills and training to make a determination of whether the patient is acting voluntarily and without coercion?

Mr J.R. QUIGLEY: It could be a psychiatrist, a psychologist—those sorts of people. It is a very serious business. These doctors will not refer them to some pop psychologist who runs self-improvement programs or something like that. We are dealing with the medical profession of Western Australia here, thank you very much! If a coordinating practitioner says that they are unable to determine the issue of voluntariness or coercion just sitting there—with the audiovisual simultaneously broadcast and received, asking questions they got from their training—they will have the capacity to refer them to another person with the appropriate training. That might be a psychiatrist or a psychologist. I doubt very much whether it would be a social worker at my parish. Does the member know what I mean? They would not be the appropriate person to independently and unbiasedly mine the question of coercion, because, as the member said earlier, coercion can be subtle. In a cultural community, it can almost be unsaid. It will not be limited to registered health practitioners; it could be a social worker who has been working closely with the family on their journey, or, for example, a Silver Chain nurse, those angels of the road who are looking after the people in their homes and get a real vision and feeling for what that person is going through and what is happening around them, because they are visiting the house every day. It might be those people. The doctor might say, “That nurse is going there every day; I just want to check in with her.” We think that is appropriate.

Mr P.A. KATSAMBANIS: The Attorney General said earlier and I will say now that he has wonderful advisers, because I was worried right at the start when he mentioned the concept of a social worker and he said it would not be a social worker in his parish. I think I understood where he was coming from, but I would agree with his later comment that in this particular assessment, an appropriate social worker could well be the most appropriate person to make that determination. I am glad that ended up on the record. As the Attorney General said, coercion is subtle. It is not just coercion; voluntariness or lack of voluntariness can be done through means other than direct coercion. It could be duress or other factors involved as well as coercion or in addition to coercion. As the Attorney General says, it is subtle; I often say it is pernicious because it has a subtle and also negative quality to the act. I agree with the Attorney General that it could be a social worker, and that is why I asked that question. The Attorney General did rightly distinguish that in relation to clause 15(1)(c) and (d), which are issues around the more direct medical nature, if you like, and require a registered health practitioner, but in clause 25(3) we do not; it is just another person. In some cases, it could be the family priest. It sounds far-fetched, and I am saying it would be unlikely more than likely.

Mr J.R. Quigley: It could be.

Mr P.A. KATSAMBANIS: The Attorney General has thought about it. It would be rare, I would say, almost extreme, but it would require someone who has a little understanding of the history of the person and enough objectivity, but, of course, they would also have to have those other bits, being skills and training. I am glad the Attorney General has clarified that it is not formal health training, which is the sort of training that is required for registration as a health practitioner. I think that is useful.

Dr M.D. NAHAN: Clause 25(3) states that the coordinating practitioner must refer the patient to another person. Coercion could come from the patient’s family, friends and surrounds. Is the scope of the clause wide enough to
allow the investigator, the person who the Attorney General just said could come with a range of skills, to examine other than just the patient, such as to talk to the family or people in the community? Coercion might not be able to be identified from discussion with the patient.

Mr J.R. Quigley: Yes.

Dr M.D. Nah: Is this clause wide enough to allow the person so chosen to go around and talk with people, other than the patient, who might be coercing them?

Mr J.R. Quigley: Thank you for the question, member. This concern is shared by many people. Even a psychiatrist may take about four visits with a person before they can unpick what is happening in their mind; however, a social worker working with the family would have a better, grounded vision of what is happening in terms of coercion. We believe that the clause is wide enough but it does not empower the appropriate person to compel others to answer questions, if the member knows what I mean. A person cannot go into a house and say to a 16-year-old child, “You must tell me what aunty is doing when she is visiting your mum.” They have not got that compulsion, but there is no inhibition.

When I was the primary carer for my father, I found that social workers could tell me stuff about my father’s mind and condition. He passed from this world at the age of 93, God rest his soul, but they could keep me abreast of where his head was at and where he was on his journey. They were in the house every day talking to people. Although it is not coercion, there is certainly no inhibition on the social worker or other person, if that is any help.

Dr M.D. Nah: Thanks for that. My personal experience is that, particularly the equivalent to Silver Chain carers who visit the patient, they know a hell of a lot about what is going on. They sit there and talk with them, their friends and whatnot. What happens if this person advises the coordinating medical practitioner, “I cannot prove anything, but I’m worried there might be coercion through the family”? How would the coordinating medical practitioner respond to that if they cannot compel someone to investigate? If there is a worry, where do they go from there? He or she has to be able to prove that there is no coercion. If there is doubt, what does he or she do? We are now pretty clear on the other issue about medical assessment. As the Attorney General pointed out, there is no power to investigate. What can be done if the advice comes back, “I’m concerned that there is coercion, but I can’t prove it”?

Mr J.R. Quigley: If I can pinch that phrase from Churchill—he used it about Russia of course—that is a riddle within a riddle!

Dr M.D. Nah: It’s life.

Mr J.R. Quigley: That is right—a riddle! I am still battling to unpuzzle it.

Clause 25(1) comes into play only if the coordinating doctor is not satisfied. He will then go to the appropriate person because he is unable to determine the issue of coercion. He will then refer it to the appropriate person and the appropriate person will report back, “I can’t tell either.” Does the member for Cottesloe know what that will result in? It will result in a negative assessment, because as my friend the member for Cannington said, that part is a compulsory requirement and if it is unresolved with the coordinating doctor or the doctor that the coordinating doctor brings in, it is a negative assessment.

The ACTING SPEAKER (Mr S.J. Price): Thank you, Attorney General. Members, I will leave the chair and return in about 10 minutes on the ringing of the bells.

Sitting suspended from 10.10 to 10.25 pm

Dr D.J. Honey: Clause 25 is headed “Referral for determination”. Earlier the member for Dawesville raised a concern about, for want of a better term, VAD practices that are set up by two or more practitioners who refer to each other. That has certainly happened in other jurisdictions. What is the test to determine whether the referral is appropriate? We heard that a doctor can refer the patient to another specialist, but the test is really just appropriate skills. As the Premier would know, medical practitioners are qualified in a wide range of areas. For example, they may have a Bachelor of Medicine and a Bachelor of Surgery. Some doctors will test the limits of those qualifications. What test is there in this process of a doctor referring a patient to an appropriate person? Without relying on the likely good intentions of the doctor, what is the actual test in the process to validate that the medical practitioner to whom the patient is referred is indeed appropriate?

Mr M. McGowan: The ability to refer is consistent with the current Australian medical practice and ensures that the patient has access to the highest standards of assessment in the voluntary assisted dying process. This is yet another safeguard in the process, without placing undue strain on a specialist to undertake the role of a coordinating or consulting practitioner. If a coordinating practitioner refers a patient under this provision, in relation to the particular criterion, they may adopt the determination of the person to whom they referred the patient. I think that, as the Attorney General outlined, if the coordinating practitioner was of the view that they cannot determine whether the person had been forced, they could refer on. I think that is what the member is asking me. But that would happen currently for a range of potential medical procedures.

Extracted from finalised Hansard
Dr D.J. HONEY: I appreciate that the Premier is trying to answer my question properly. My question is: what is the test of the appropriateness of the medical practitioner to whom the person is being referred? I think the Premier can guess where I am going—he has heard my line of questioning on a number of occasions. I am not concerned about the best of circumstances, where people are following the intent of the bill, as the Premier has just outlined. I am not even suggesting that there might be any malice in this process. A coordinating practitioner might refer the person to someone who is not qualified to give that advice. Perhaps we are heading to the end of the spectrum, where there could be some problem if doctors were running a VAD practice and were simply alternating the roles of the coordinating and referring practitioner because they believe they have skills in that area. How would that be picked up? There are two situations. The first is that the person is referred to someone who is inappropriate, and that person might be quite prepared to do it and say, “Yes, I’m fine to do it.” The second is when doctors in a practice are referring between themselves because they believe in this very strongly. I am not saying they are trying to do something malicious. They believe that they are perfectly qualified to assess all these things. However, a person or a professional body that was looking at this externally might say, “Hang on. This isn’t right. That isn’t an appropriate and qualified person.” In terms of the checks and balances that the Premier mentioned, what check and balance would be used to detect and intercede in that situation?

Mr M. McGOWAN: The persons to whom the patient might be referred might include a social worker, a police officer, another health practitioner, or a medical practitioner. It would depend on the circumstances. I heard the Attorney General talk about it before. Each individual family circumstance would be different. It might be a person who has been interacting with the family for a considerable time and would know whether someone is being coerced because of that interaction. It would depend upon each individual case. I am not sure I can provide the member with a more definitive answer than that.

Dr D.J. HONEY: I thank the Premier. I understand that part. It sounds as though that is a reasonable approach—that it could be someone other than a medical practitioner. My core concern is that that other party might not be appropriate. As I have said, this does not need to be done through malice. It might be done through lack of knowledge, or lack of skill. As I have said, people in a practice might be just referring to each other, because they wish to specialise in this area. My question is about the external oversight, and about the check and balance that will ensure that the person to whom the patient is referred is appropriate.

I accept that that person could be a social worker or someone else who has the right knowledge. It was reassuring to hear that. I am asking about the check and balance when that is not occurring appropriately or, as I said, a custom or practice might develop in which medical practitioners refer to each other in different roles. I am not trying to be obtuse. I am asking about the check and balance.

Mr M. McGOWAN: I have faith in the medical profession. The doctor will make a decision about whom they might refer to. That individual, from the categories I have referred to, will have to adhere to their own professional practice standards in each category, whether it is a social worker or police officer or whatever it might be. That will be referred back to the medical practitioner, who can either accept or reject the judgement of the person to whom they referred the patient. There will be a whole range of assessments during that process, as there is every single day for every member of the medical profession who deals with the public. They make these judgements every single day on a range of matters. A lot of those matters are not serious, but some are very serious and some are life and death, and they currently do it.

The ACTING SPEAKER (Mr S.J. Price): Member for Cottesloe, this is starting to become a little repetitious. If you are going down the same line of questioning, the Premier has given you multiple answers in response to the same question. It has been addressed previously as well.

Dr D.J. HONEY: Mr Acting Speaker, with all due respect, this question has not been answered before. I am not trying to be cute. I am not trying to stretch this out. I am trying to understand the check and balance on that. Perhaps I can lead with a question. It does not look like we are going anywhere or will get an answer to it but, for example, will the board look into the appropriateness of the referrals—is that a proper role for the board?

Mr M. McGowan: No.

Dr D.J. HONEY: Am I to take it that, in fact, there will be no oversight? I appreciate what the Premier has said. In good circumstances, not just the best of circumstances, people will treat this properly, but as the Premier knows, things go wrong and are not always done properly. My concern is: how will that be picked up or reviewed? If there is no oversight, there could be inappropriate referrals for a long time. I am not talking about the ordinary good circumstance. I am talking about when this is not done properly. I am wondering how that will be picked up. If the Premier could answer that, I would be very grateful.

Mr M. McGowan: The answer is no. The functions of the board are under clause 117.

Ms M.M. QUIRK: I have an amendment to move shortly, but in relation to clause 25, I think the Premier has fleshed out that it might be appropriate to refer someone to a police officer who has the skills to judge whether or not the decision was made voluntarily or without coercion. That begs the question of whether the coordinating practitioner
Mr M. McGOWAN: The training will have an element of determining whether someone has been subject to coercion, but this clause allows for the medical practitioner to refer the patient for further assessment on that point to a range of other disciplines, if you like. I also add that doctors have done a six-year medical degree and a minimum of 10 years practice before they can deal with one of these matters. They would have broad experience of dealing with whether a patient has been coerced on a range of matters through the practice and the training they have undertaken to get to that point.

Ms M.M. QUIRK: The other issue that the member for Cottesloe dealt with really relates to the word “appropriate” in this clause and is the subject of my amendment, because the word “appropriate” is a little loose. Before I move the amendment, can I comment that there is some onus from the medical practitioners to complete the paperwork in a short time, and then they may have to seek out an appropriate expert. I wonder what assistance will be given to the coordinating practitioner to locate an appropriate expert. Will there be a list or register of police officers, social workers or specialists in particular areas? Otherwise, the practitioners then have the onus of seeking out a person with the appropriate skills.

Mr M. McGOWAN: Clause 25(2) states —

The coordinating practitioner must refer the patient to a registered health practitioner who has appropriate skills and training to make a determination in relation to the matter.

Ms M.M. QUIRK: I appreciate that with, shall we say, allied health, but for example, police officers have registered days off and are often transferred to other stations, so they might not develop such a relationship with a local doctor that would allow the doctor to know whether they are experienced in assessing coercion. I make the point that this is a little onerous in the short time frame for the coordinating practitioner to have to do. I respectfully suggest that Health should have some sort of register so this does not become a real chore for the medicos, but I appreciate what the Premier is saying. In the normal course of things, there should be geriatricians, psychiatrists or neurodegenerative experts, but I really do think that they may find some of the ones on the margins difficult. Anyway, I do not need to comment; I am just editorialising. I move —

Page 17, lines 25 to 27 — To delete the lines and substitute —

(2) The coordinating practitioner must refer the patient to a registered health practitioner who has relevant expertise and experience in the disease, illness or medical condition expected to cause the patient’s death and otherwise has the appropriate skills and training to make a determination in relation to the matter.

Members, I think people understand this is about teasing out what is meant by “appropriate skills” and what the focus of any referral needs to be. It is self-explanatory; I will not take up any more time.

Mrs A.K. HAYDEN: I want to talk briefly on the amendment. I note that in Victoria, if either practitioner is unable to determine whether the person has decision-making capacity, for example, due to a past or recurrent mental illness, they must refer to a health practitioner who has appropriate skills and training, such as a psychiatrist. In Western Australia, there is no mention of mental illness or a psychiatrist in relation to capacity, as has already been raised during the debate in this place. Surely, a referral to a psychiatrist or someone who can help with mental illness should be in there. It is on that note that I support this amendment.

Mr W.R. MARMION: I, too, rise to support this amendment. I think this clarifies the clause. One would hope that this is what one would do anyway, under clause 25(2), so I would like the Premier to explain why he does not support this amendment. I think it clarifies what one would expect a coordinating practitioner to undertake, in seeking out someone with the relevant expertise and experience in that disease to get the right determination. Perhaps both I and the mover of the motion are seeking to understand why anyone would not support this amendment.

Mr M. McGOWAN: I appreciate the sentiment behind the amendment. The reason it is not accepted is that the referral should be directed to the most appropriately skilled and experienced health practitioner for the determination.
we spoke about it again on Wednesday. I just think, unfortunately, the way clauses 15(1)(c) and 15(1)(d) have been
Unless we want to unpick this and create new subclauses (1A) and (1B) and new subclauses (2A) and (2B), I am torn,
particular assessment.

Mr M. McGOWAN: If I can just explain again, clause 25(1) refers to two things—paragraph (a) refers to a disease, illness or medical condition and paragraph (b) refers to decision-making capacity. Subclause (2) requires that the patient be referred to a health practitioner with the appropriate skills and training. That means, under clause 25(1)(a), a person with the appropriate skills in relation to the disease or illness or, under clause 25(1)(b), an appropriate professional who can determine whether someone has decision-making capacity. Clause 25(2) is a broader clause that allows for the provisions of both paragraphs (a) and (b) to be covered. The amendment would mean that only the provisions of clause 25(1)(a) were covered. It is a narrowing of and a reduction in the protection, if you like, of the patient and the advice that might be sought.

Mr W.J. JOHNSTON: I understand the Premier’s argument now; however, that is not what the words say. At the moment, under paragraph (b), the only person the coordinating practitioner can refer someone to is a registered health practitioner. The Premier said in his answer that they might be referred to a person other than a health practitioner to determine decision-making capacity. But that is not right, because it is a health practitioner who has appropriate skills and training to make a determination on the matter. It is not possible under the current provision to refer them to somebody who is not a health practitioner. The member for Girrawheen is seeking to clarify that arrangement. The amendment says—

… has relevant expertise and experience in the disease, illness or medical condition expected to cause the patient’s death …

Those words are drawn from clause 15(1); they are the exact words used in that provision. The amendment then says—

… and otherwise has the appropriate skills and training to make a determination in relation to the matter.

It is saying that if they are not the health practitioner in respect of the disease, illness or medical condition, it is someone who otherwise has the appropriate skills and training. Therefore, that is, by definition, the health practitioner who is referred to in paragraph (b). What the member for Girrawheen is trying to do, and I think would achieve—if there are better words, we should look at them—is make it clear that the health practitioner referred to in paragraph (a) has to be somebody related to the issues that are being determined rather than just anyone else. Remember, this is a “must”. The clause should not be in the bill, because if the coordinating practitioner has determined that the “must” has not been met, the application fails. But if we are going to have something that allows for a second opinion, if you like, even though the application has failed, surely it should be somebody who knows what they are talking about.

Mr P.A. KATSAMBANIS: I do not want to interrupt the Premier if he has something to add to that. I know it is late and I do not do this lightheartedly, but I am going to speak at what some people would call the crossbenchers on this one. I agree entirely with the sentiment of the amendment that has been moved by the member for Girrawheen, but because of the way that subclauses (1) and (2) have been drafted, I also agree with the summation of the Premier about how the proposed amendment would probably not be appropriate in relation to the matter of decision-making capacity raised in clause 25(1)(b). The problem occurs because of the way these two clauses have been drafted to interact. I agree 100 per cent with the member for Girrawheen. I believe that in an assessment of whether “the patient has a disease, illness or medical condition that meets the requirements of section 15(1)(c)”, the referral should be to a registered health practitioner “who has relevant expertise and experience in the disease, illness or medical condition expected to cause the patient’s death”. However, I also agree that that person may not be the right person to make the decision about decision-making capacity.

When we read clauses 25(1)(a) and(b) together, and have only one clause in relation to who ought to be the health practitioner, which these two separate and distinct matters ought to be referred to, the current formulation in the bill in clause 25(2) is all-encompassing. However, it still fails that test, in my opinion—this is my opinion only. I would expect someone specialised and expert in the disease, illness or medical condition to make that particular assessment.

Unless we want to unpick this and create new subclauses (1A) and (1B) and new subclauses (2A) and (2B), I am torn, because I genuinely think the sentiment is right. We spoke about it earlier in the debate—on Tuesday night and I think we spoke about it again on Wednesday. I just think, unfortunately, the way clauses 15(1)(c) and 15(1)(d) have been

Extracted from finalised Hansard
put together with one test, replacing that test with a test contained in the amendment would cover off on making the assessment around clause 15(1)(c) but would leave the assessment on clause 15(1)(d) wanting. I hope that makes sense and provides some clarity for members. If it does not, and if it confuses members, I apologise.

Mrs L.M. HARVEY: Premier, I think there is an error in clause 25(1)(b). It states —

(b) the patient has decision-making capacity in relation to voluntary assisted dying as required by section 15(1)(d).

The decision-making capacity of a person wanting to access voluntary assisted dying is determined by clause 6. Clause 15(1)(d) refers to a decision-making capacity as per clause (6). Clause 15(1)(d) states —

(d) the person has decision-making capacity in relation to voluntary assisted dying;

But that decision-making capacity is actually determined by clause 6.

I seek some advice as to whether we are referring to the right clause. It seems as though we are referring to clause 15, which is determined by clause 6. That is leading to some confusion with respect to who should appropriately be dealing with these two matters.

Mr M. McGOWAN: I will deal with all the points that have been made. In relation to the last point made, clause 6 is the definition. The definition of “decision-making capacity” is contained in clause 6(2). “Decision-making capacity” appears in a range of locations throughout the bill. The clause as it currently stands is drafted correctly. The reference to clause 15(1)(d) in clause 25 is correct.

In relation to the other point, as I said earlier—I will be as crystal clear as I can be—the amendment would reduce the protections available to patients because it would mean that a person whose decision-making capacity is under question would be referred to the wrong health professional. That is why it is a mistaken amendment. Clause 25(2) will ensure that someone with a disease, illness or medical condition will be referred to someone who has, and I quote —

… appropriate skills and training to make a determination in relation to the matter.

If there is a question about a disease, illness or medical condition, the coordinating doctor will send that patient to a person with appropriate qualifications.

Ms M.M. QUIRK: In relation to comments that have been made, I accept that this amendment is inelegantly drafted. The amendment uses the word “appropriate”, and that is somewhat rubbery, so I have replaced it with the words “or otherwise”, which is probably equally rubbery. I will leave the discussion of this amendment with the observation that a good example would be of an overseas-trained doctor who is not overly familiar with Aboriginal culture, and he or she may feel unable to properly assess capacity or communicate in a way in which they could make a meaningful determination. I suppose it is up to the coordinating practitioner to make that judgement, but it is a not-too-remote possibility that something like that could occur, and this clause needs to allow for that.

Amendment put and negatived.

Mr Z.R.F. KIRKUP: One of the referrals that can be given by a coordinating practitioner is one to assess coercion. I appreciate the language the Premier used before and the trust that is invested in medical practitioners. However, is there anything that stops the person who is now in receipt of the referral to assess coercion from being related to the person who is being assessed? Could any conflict of interest arise? For example, I am assuming that in a very small town there might be family members who are the professionals in any given area. Is there nothing under this legislation that would stop them from being referred to a family member to assess coercion or anything like that?

Mr M. McGOWAN: All these professions—the medical profession and the legal profession—have rules about these sorts of things, which apply in all circumstances. As I have said on a couple of occasions now, doctors deal with life and death every day. They currently deal with these issues. As I understand it, a doctor cannot, or should not, deal with their own family member. Those rules are already in place.

Mr Z.R.F. KIRKUP: I appreciate that, Premier. A patient has been referred to a specialist to assess coercion—to see whether the patient is acting voluntarily and free of coercion. That specialist could be a family member or be financially related to the patient—that is what I am trying to assess. I appreciate the Premier’s point about the practitioner being a family member, but I am talking about the specialist who has been tasked to assess whether the patient is being coerced. Can they have a relationship with the patient?

Mr M. McGOWAN: The professional standards of the medical profession ensure that when they make any referral of this nature, they do not refer to people who might be conflicted.

Mrs L.M. HARVEY: Clause 25(4) states —

If the coordinating practitioner makes a referral under subsection (2) or (3), the coordinating practitioner may adopt the determination of the registered health practitioner or other person, as the case requires, in relation to the matter in respect of which the referral was made.

Could the Premier please explain who other persons might be, besides registered health professionals?
Mr M. McGOWAN: That allows for a referral to, as we discussed at length and I think members agreed to, social workers or police officers, and I think the Attorney General referred to Silver Chain people.

A member interjected.

Mr M. McGOWAN: As the Attorney General said before, “other person” refers to social worker, police officer, Silver Chain and those sorts of things.

Clause put and passed.

Clause 26: Information to be provided if patient assessed as meeting eligibility criteria —

Dr D.J. HONEY: Clause 26(1)(d) reads —

the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be …

Et cetera. Is the Premier able to outline to the house those risks or what some of those risks are?

Mr M. McGOWAN: As I understand it, whenever people take medication, there are certain risks. Obviously, this medication has an outcome. People might bring up oral medications. I suspect it refers to that. It might be the outcome that people have difficulty holding down medication, which is a commonplace thing.

Dr D.J. HONEY: Premier, I am not going to labour this point past this second question. My understanding is that the list of likely prescribed substances is small. I assume that the expert committee has looked at this and tried to get some dimension of the likelihood of adverse outcomes and I am asking whether the Premier is aware of any of those particular adverse outcomes. I appreciate that other substances can be prescribed. I understand that there is likely to be a known short list of the substances to be prescribed.

Mr M. McGOWAN: The choice of medication will be a clinical decision made by the coordinating practitioner from an approved list of only schedule 4 or 8 poisons. The CEO of Health will have the authority to approve the schedule 4 or 8 poisons for inclusion on the approved list. It is intended as part of the implementation of the bill that a clinical panel will be convened to determine the schedule 4 and schedule 8 medication protocols suitable for voluntary assisted dying in Western Australia. Obviously, depending upon a person’s condition, age or whatever it might be, certain medications might be more appropriate for a person in those circumstances. As I said before, the clause itself requires the coordinating practitioner to inform the patient about the potential risk of self-administration and a whole range of other matters, which I think is entirely appropriate. As I said, one risk I am aware of with self-administering oral medication is that a patient may have difficulty, depending upon their condition. I think someone was referring to oesophageal illnesses, which make it difficult for someone to swallow. Obviously there is a risk there, so obviously that information will be provided to the patient.

Dr D.J. HONEY: I move on to clause 26(1)(h) on page 19 about the appointment of a contact person. Will there be any qualification for a contact person? Under this legislation, the contact person has an extremely important role. Obviously, that contact person will be the person who, in the case they have been appointed, will receive the prescribed substance, but also that contact person will be there to witness that it has been taken and will then be responsible for making sure that any unused portions of the prescribed substance are returned to the appropriate location. Are there any parameters that define who that person can be, given the very serious nature of the role they will play in this?

Mr M. McGOWAN: The details of what is required for a contact person are contained under clauses 64, 65, 66 and 67.

Mrs A.K. HAYDEN: I go back to clause 26(1)(d), on which the Premier talked about the potential risk of self-administering or being administered. I will link it into paragraph (b) as well, so I do not have to get up twice and be accused of repeating. Paragraph (b) states —

the treatment options available to the patient and the likely outcomes of that treatment;

The Premier has explained that with self-administering, swallowing can be an issue. Obviously, the option for that treatment will be in liquid form, I am guessing, or tablet form. Can we get that one established? The alternative option, if it is not self-administered, is for the substance to be administered by a practitioner in a hospital. Can the Premier explain how it will actually be administered? Will it be a liquid form, a drip or an injection? What would be the potential risks that are mentioned in paragraph (d) with the substance being administered as opposed to self-administered?

Mr M. McGOWAN: It depends on the patient. As I said, some people have trouble swallowing. Some people might have certain conditions that mean that one form of medication is a better option for them than another form of medication. No decisions have been made as yet about the types of medications that will be available, but obviously, as I said earlier, an expert panel will work through those issues and work through the options that will be made available.
Mrs A.K. HAYDEN: If we do not know the answer, that is fine, but has it been determined how it will be taken? The paragraph refers to the options available to the patient. We know the options will be for it to be administered or self-administered. Do we know whether it will be a liquid form, a tablet, an injection or a drip? Do we know any of that?

Mr M. McGOWAN: That will be determined by the expert clinical panel.

Dr D.J. HONEY: Thank you very much for the answer to my previous question. I did refer to the clauses that the Premier mentioned. The only qualification I can see for the person who is appointed as the contact person—outside of the fact that they are appointed—is that they are 18 years of age. I am happy if the Premier can direct me to something else, but there is no other qualification for the person other than they have reached 18 years of age; obviously, 18 years and older is the implication. Otherwise, there is no test of the ability of that person to carry out such a responsible role in this matter. Is there another qualification that tests the person’s responsibility?

Mr M. McGowan interjected.

Dr D.J. HONEY: Sure. The Premier referred to that in his answer.

The DEPUTY SPEAKER: Sorry, member, we are now dealing with clause 26. You need to restrict your questions to clause 26.

Dr D.J. HONEY: Thank you. I am happy to do that. Deputy Speaker, I did ask how it would be determined that they were an appropriate person.

The DEPUTY SPEAKER: Sure. We can get to that one.

Dr D.J. HONEY: The only other question I have on this, Premier, relates to clause 26(1)(j). This goes to a number of issues that we have discussed before. The pertinent word is in the third sentence where it says the patient is “encouraged” to inform the medical practitioner of the patient’s request for access to voluntary assisted dying. I will not labour the point about the issues of undue influence, coercion and mental health—a number of members have discussed that. Some of these issues, which are critical issues that we need to ensure are resolved, will likely be known only to someone who has known the patient for a long time. In many cases—it will not be in every case—that will be the patient’s own medical practitioner. Why is it not a requirement? Rather than “encouraged”, why is it not “must” inform the medical practitioner of the patient’s request? If we are talking about safeguards, by necessity that would make the coordinating practitioner more informed in this matter. Particularly for those issues of coercion and undue influence, the medical practitioner is likely to be much more aware of it. To me, a much more reassuring safeguard would be “must” inform the medical practitioner rather than “encouraged”.

Mr M. McGOWAN: In the government’s view, and I think the entire medical profession’s view, a patient should not be required to inform their GP of whatever condition they might be going through.

Dr D.J. HONEY: I think that is a fair point, Premier. Perhaps the way I should have put it was that the coordinating medical practitioner must inform the medical practitioner of the patient, rather than compelling the patient themselves.

The DEPUTY SPEAKER: So there is no question, member.

Dr D.J. Honey: It was a question.

Mrs A.K. HAYDEN: Clause 26(2)(a) refers to “all relevant clinical guidelines”. I did not hear the answer. I know the member for Cottesloe talked about paragraph (b) in respect to a plan. Subclause (2) states —

In addition to informing the patient about the matters referred to in subsection (1), the coordinating practitioner must take all reasonable steps to fully explain to the patient or, if the patient consents, another person nominated by the patient —

(a) all relevant clinical guidelines; and

Have those guidelines been outlined yet, Premier, or are they to be determined after the passing of this legislation?

Mr M. McGOWAN: Clinical guidelines already exist and they refer to a whole range of matters, although not voluntary assisted dying, obviously. I do not think they are going to be created as part of this because there are already numerous clinical guidelines for doctors to implement, but some might be specifically created in the next 18 months for this process.

I will just correct what I said earlier. There are already clinical guidelines for a range of things but some relevant clinical guidelines relating to this matter will be created in the next 18 months.

Mrs A.K. HAYDEN: Are the existing clinical guidelines available for us to see on a website link or whatever?

Several members interjected.

Extracted from finalised Hansard
Mrs L.M. HARVEY: I am not being cute. This is new legislation and the clinical guidelines do not always cover new legislation. Surely the government has identified the gaps that need to be filled; if it has not, that is a bit scary. Surely the government has some idea of what is out there and the gaps that need to be filled.

Mr M. McGOWAN: I am advised that doctors have to deal with a great many clinical guidelines for every single illness and condition. There are guidelines for everything. This refers to what is current practice, but obviously voluntary assisted dying is a new thing, so new clinical guidelines relating to voluntary assisted dying will be created over the course of the next 18 months.

Mrs L.M. HARVEY: I have a question about subclause (2), but before I get to that, I refer to subclause (1)(g) and the written declaration that is to be signed in the presence of two witnesses. Is that the written declaration identified in clause 41?

Mr M. McGowan: Yes.

Mrs L.M. HARVEY: Okay. Subclause (2) states —

In addition to informing the patient about the matters referred to in subsection (1), the coordinating practitioner must take all reasonable steps to fully explain to the patient or, if the patient consents, another person nominated by the patient —

(a) all relevant clinical guidelines; and

(b) a plan in respect of the administration of a voluntary assisted dying substance.

Why does the provision read “reasonable steps to fully explain to the patient or, if the patient consents, another person nominated by the patient”? It seems to me that instead of “or” it should read “and”, because it reads as though the patient can handball the explanation of the relevant clinical guidelines and the plan for the administration of a voluntary assisted dying substance to another person, which would then leave the patient potentially uninformed because they would have handballed the explanation about what is going to happen to them to another person. I want to understand why it has been worded this way. It seems to me that a patient will not be fully informed about what they are taking on if they handball a significant part of it to somebody else to be informed on their behalf.

Mr M. McGOWAN: It goes to subclause (1). The patient will be referred to all the matters contained in paragraphs (a) through to (j), which is a whole range of matters. Under subclause (2), the patient can receive information about the clinical guidelines and administration of the voluntary assisted dying substance, but it is up to the patient whether they wish, after giving fully informed consent, to hear that other information. It is a matter of patient choice.

Mrs L.M. HARVEY: Could the Premier please explain a little further? Perhaps my interpretation of this is wrong, but a plan for the administration of a voluntary assisted dying substance involves whether the patient will take a substance orally or by an injection or whether it will be self-administered or practitioner administered. That is a very important decision and the patient should be involved in that plan. They should not handball the putting together of their plan to somebody else to do it on their behalf. This is all about a patient choosing how and when they die, so surely they should be part of the planning for that process.

Mr M. McGOWAN: It is a matter of personal autonomy and the patient making the decision about what information on those matters they wish to hear. As awful as this might sound, it might involve a conversation about what might happen to the person’s body after they die, and the patient might not wish to hear that. What we are doing is saying that the patient can choose to hear that information or the patient can elect—their own personal choice, individual freedom, individual choice—what they wish to hear, or whether they wish to nominate someone else to hear that information.

Mrs A.K. HAYDEN: I refer to subclause (2) and the words “or, if the patient consents”. Section 19 of the Victorian legislation has a similar section, which includes that a member of the patient’s family be provided with information about the clinical guidelines and the plan for administration. I note that is not in this legislation. Obviously, that has been left out deliberately. I am not saying that that is right or wrong; I just want to understand. Does that mean that, right now, my husband could say—I hope he does not do this—“I’m going to access this” and I would be none the wiser? Does that mean that a partner, a loved one or a family member could seek VAD and the family is unaware of it?

Mr M. McGOWAN: In Victoria, it indicates that the family can hear the information, but not the patient. In other words, we are giving the patient the right to hear the information. It is actually giving the patient more rights here than they have in Victoria.

Mrs L.M. HARVEY: I want to go back to the Premier’s answer. Can the Premier explain a bit more fully what a plan for the administration of a voluntary assisted dying substance would look like? Perhaps I am a bit more OCD than the drafter, but, to me, a plan for the administration of a voluntary assisted dying substance would include a time and a place, who would be around me, and what I would like to have happen at the time. Perhaps
I am way off track here, but, to me, a plan is putting together a timeline and a process. I would have thought that a person who was accessing voluntary assisted dying and wanted to choose the time and date when they die would want to be involved in the planning for it. Subclause (2)(b) states —

a plan in respect of the administration of a voluntary assisted dying substance.

I would have thought that would involve a plan around taking the substance, and that it would be pretty critical that the patient would be part of that process.

Several members interjected.

Mrs L.M. Harvey: When members opposite are sitting over here, I will answer their questions.

Mr M. McGowan: I will repeat it for the benefit of members. We will give the patient the opportunity to make the choice. As I said, in Victoria, the patient can consent to family members, but apparently the patient cannot hear the information themselves. We will give the patient more choice than is available in Victoria. The patient will be able to decide themselves whether they want the information or want another person to have that information. An elderly wife who is terminally ill and has weeks to live might like her husband to hear that information because she would like her husband to make those decisions. It is a matter of personal choice. We want to give the person the maximum number of choices and freedoms. It is not about setting a timeline; it is about explaining the circumstances of the administration of the substance. It is not saying that it has to be issued or taken on a certain date or anything of that nature. It is just explaining to the patient or the person nominated by the patient what will happen around the event.

Mrs L.M. Harvey: So that I can understand how this might work, I ask: once a patient satisfies the criteria under subclause (1) and chooses to take the voluntary assisted dying substance, can they ask their partner to find out all the details and take it from there?

The Deputy Speaker: Member, I think we have heard that from the Premier several times. Premier, do you want to answer that?

Mrs L.M. Harvey: With respect, Madam Deputy Speaker, I am not clear about this.

The Deputy Speaker: I understand.

Mrs L.M. Harvey: The Premier has said that it gives the patient autonomy and choice. I do not understand how it will give the patient autonomy and choice of how and when they will take the substance, because they will have given that responsibility to somebody else at that point. That is what I am not clear on. They will have satisfied the criteria and decided that they want to take a voluntary assisted dying substance, but my reading of this provision is that they will be able to handball the detail from that point on to someone else. They might be three weeks from death or two weeks from death. I know they have to have the choice, presumably, to take the substance orally. If they choose to take it intravenously, the way this provision reads—although the Premier says that I am wrong—it sounds as if I could ask my partner, because we have made a decision, to make a plan about when I am going to be injected because it is all too hard. That is what I am trying to work out.

Mr M. McGowan: That’s not correct.

Mrs A.K. Hayden: I had not finished my line of questioning about family members under the Victorian legislation. One of my concerns is that if a person takes the substance home and decides to self-administer, the family may be unaware of that. That is my concern. Is there anything in this legislation that will make the family aware of that? That is my main concern. If one of my loved ones was choosing to go down this path, I would like to know about it, particularly if they chose to bring the substance home and do it at home. I think the family should be aware that that is about to happen and that a poison is in the home.

Mr M. McGowan: It has been a principle of medicine for hundreds of years that there is patient confidentiality and that patients make their own decisions about themselves.

Mrs A.K. Hayden: I understand about confidentiality, but we will be allowing someone to take a substance—a poison—into someone’s home, where there are family members, children or grandchildren. There could be anyone or there could be no-one. I think it is a massive risk if that household is unaware that that substance has been taken home. People on the back bench may laugh—and they are on the back bench!—but it is a risk. This legislation is about making sure there are no risks. If a substance that can kill someone goes into a home and the people who live there are unaware of that, I think that is a risk.

Mr M. McGowan: Individual circumstances differ. I would expect that in the overwhelming majority of cases the patient themselves would inform the family and family members would know. Some people are estranged from their sons and daughters, some people are estranged from their husbands and wives, and some people are estranged from their parents. They might not want them to know. That is an individual choice. That is the basis on which medicine works.
Mrs L.M. HARVEY: I go back to my point about clause 26(2), which states —

... the coordinating practitioner must take all reasonable steps to fully explain to the patient or, if the patient consents, another person nominated by the patient —

I draw the Premier’s attention to the explanatory memorandum, which says —

Subclause (2) requires the coordinating practitioner to take all reasonable steps to fully explain to the patient, and if the patient consents, to another person nominated by the person, all relevant clinical guidelines and a plan in respect of the administration of the voluntary assisted dying substance. This is because it is vital that the patient is supported throughout the process of voluntary assisted dying.

Going back to my original point, I believe that the word “or” in this subclause should be changed to “and”, and the explanatory memorandum explains it thus. I think this is a drafting error that should be corrected.

Mr M. McGOWAN: As I have said at other times, it is about giving the person the opportunity to make their own decisions about what information they want to hear, in particular around the circumstances of what might happen to their body after death. A lot of people do not want to know about that, so it gives the person the choice about whether they wish to hear that or they wish someone else to hear that. It is a matter of individual choice. The patient will already be hearing about all the matters contained in clauses 26(1)(a) to (j).

Mrs L.M. HARVEY: I suggest to the Premier that this is going to be amended in the other place, because the explanatory memorandum says something completely different from the legislation. The explanatory memorandum says —

... and if the patient consents, to another person nominated by the person, all relevant clinical guidelines and a plan in respect of the administration of the voluntary assisted dying substance. This is because it is vital that the patient is supported throughout the process of voluntary assisted dying.

It is not about autonomy and making a choice about someone else. This is definitely a problem, because the explanatory memorandum does not reflect the legislation.

Mr M. McGOWAN: I have answered the question.

Mr A. KRSTICEVIC: Clause 26(1)(i) says —

that the patient may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying;

Can the Premier explain to me whether there are any procedures or processes in place if, for example, someone has received poison, the substance or, as the Attorney General refers to it, the “syrup”, and they are sitting at home in the country in the middle of Australia, they have three or four months to go, the medication is in the fridge and they change their mind and say that they are not going to take it anymore? What legal or administrative processes do they need to go through to return that medication? How do they return it to where it came from? What happens if they do nothing—if they just leave it there and ignore it and it just sits there—and they pass away in their home and someone else potentially has access to that medication, with whatever outcomes there might be? I want to know what the process is if someone has the medication at home. What are the consequences to them if they do not return it?

Mr M. McGOWAN: It is a fair point. There are numerous clauses later on that deal with those matters under division 4 of part 4.

Mrs L.M. HARVEY: Further to the issue that I raised before about subclause (2), I move —

Page 19, line 13 — To delete “or” and substitute —

and

I am moving this amendment for the reason that I have already highlighted. Clearly, the explanatory memorandum has a completely different context from what is in the legislation. I believe it is a drafting error and I want to correct it. I do not think this clause is about giving the patient autonomy. I think that a mistake has been made in the drafting. The explanatory memorandum explicitly states under clause 26 —

Subclause (2) requires the coordinating practitioner to take all reasonable steps to fully explain to the patient, and if the patient consents, to another person nominated by the person, all relevant clinical guidelines and a plan in respect of the administration of the voluntary assisted dying substance. This is because it is vital that the patient is supported throughout the process of voluntary assisted dying.

I think the explanatory memorandum makes eminent sense, and I would hope that the Premier would accept my amendment, because I believe it corrects a drafting error.

Extracted from finalised Hansard
Amendment put and a division taken, the Deputy Speaker casting her vote with the noes, with the following result —

Ayes (13)

Mrs L.M. Harvey  Mr A. Krsticevic  Dr M.D. Nahan  Mrs A.K. Hayden (Teller)
Dr D.J. Honey  Mr S.K. L'Estrange  Mr D.C. Nalder
Mr P.A. Katsambanis  Mr W.R. Marmion  Mr K. O'Donnell
Mr Z.R.F. Kirkup  Ms L. Mettam  Ms M.M. Quirk

Noes (36)

Ms L.L. Baker  Mr W.J. Johnston  Mr M.P. Murray  Ms J.J. Shaw
Dr A.D. Buti  Mr D.J. Kelly  Mrs L.M. O'Malley  Mrs J.M.C. Stojkovski
Mr J.N. Carey  Mr F.M. Logan  Mr P. Papalia  Mr C.J. Tallentire
Mrs R.M.J. Clarke  Mr M. McGowan  Mr S.F. McGurk  Mr J.R. Quigley
Mr R.H. Cook  Mr J.E. McGrath  Mr D.T. Punch  Mr P.C. Tinley
Mr M.J. Folkard  Ms S.F. McGurk  Mr J.R. Quigley  Mr R.R. Whitby
Ms J.M. Freeman  Mr D.R. Michael  Mr D.T. Redman  Ms S.E. Winton
Mr T.J. Healy  Mr S.A. Millman  Ms C.M. Rowe  Mr B.S. Wyatt
Mr M. Hughes  Mr Y. Mubarakai  Ms R. Saffioti  Ms A. Sanderson (Teller)

Amendment thus negatived.

Ms M.M. QUIRK: This is a slightly different tack and it is only a question of understanding the process a bit better.

Under clause 26(1)(d), the coordinating practitioner must advise the patient of the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under this legislation for the purposes of causing the patient’s death. Am I to infer from that, because we know that a range of substances could be prescribed depending on the patient’s circumstances, that somewhere between the first assessment and the information being provided to the patient, the coordinating practitioner has made a determination or satisfied himself that one drug is preferable to others for that particular patient?

Mr M. McGOWAN: At the first assessment, the doctor will inform the patient about the risks of self-administering. I do not think it is at that point that they will discuss the exact medication, but they will describe the risks that might be involved in the various forms of administration to the patient so that the patient is fully aware.

Mr P.A. KATSAMBANIS: Clause 26(1) requires the coordinating practitioner to provide 10 pieces of information. A lot of those pieces of information are about the process around assisted dying, so we would expect that he or she is the right person to provide that information. I have a few concerns with paragraph (a), which refers to the patient’s diagnosis and prognosis, and paragraph (b), which refers to the treatment options available to the patient and the likely outcomes of that treatment. I would like the Premier to clarify for me, if he can, how this would work in circumstances in which the coordinating practitioner is not the treating practitioner in relation to the diagnosis or prognosis.

Clause 25 foreshadows that the coordinating practitioner may need to refer to another practitioner to find out all that information.

The last piece of information contained in clause 26(1)(j) does not require the coordinating practitioner to communicate with that diagnosing or treating practitioner in any way; it simply encourages a patient to do so. If the coordinating practitioner is the person who has diagnosed the issue and is treating the person for that illness or disease, that is fine and good, because there will be one set of information. But if the coordinating practitioner providing information and the treating practitioner is providing slightly different information, or vastly different information as the case may be, the concern is that a patient who is already vulnerable and already under a fair amount of suffering may end up getting even more confused than they already are.

How would this sort of provision of information work in the context in which a specialist—it could be an oncologist or a kidney disease specialist—has already provided a diagnosis and prognosis and is already delivering treatment?

Mr M. McGOWAN: In practice, this would not have been the first time the patient would have been informed of the diagnosis and treatment options. The coordinating practitioner may refer to information provided by the treating practitioner.

Mr P.A. KATSAMBANIS: The word “may” concerns me. The coordinating practitioner may provide the same information, but they may not. They may have completely different opinions on anything from the prognosis through to treatment options. There has been some significant media publicity, particularly in relation to high-profile brain surgeons, for instance, in which competing diagnoses and prognoses and treatment options are
suggested by different specialists, let alone general practitioners. Often, there is a lot of debate in the medical community itself about some diseases. I appreciate that it is difficult, because we are trying to create a framework that fits all sizes. But in that instance, would it not be appropriate to include somewhere in this framework a provision that would compel the coordinating practitioner to liaise on the provision of that information referred to in paragraphs (a) and (b)—I am not talking about the rest of the information—with any other treating medical practitioner involved in that process so that information is provided to the patient in a coordinated manner and does not confuse them in any way?

Mr M. McGOWAN: Clause 26(1)(a) and (b)—I think we are going way off track on what this clause is about—reads, in part—

… the coordinating practitioner must inform the patient about the following matters —

(a) the patient’s diagnosis and prognosis;

(b) the treatment options available to the patient and the likely outcomes of that treatment;

That is what we are saying the doctor must provide to the patient. I do not really understand the point the member is making. It is really a matter for medical practitioners about what consultation they engage in between each other and what the patient consents to.

Mr P.A. KATSAMBANIS: I think that is just one more gap in the drafting of this legislation, and I will just leave it on the table. It has been proven throughout the entire debate that any suggested improvements to tidy up the drafting are simply going to be batted away on the numbers, so I will leave it there, and I hope in due course to reconsider it when it returns to us.

Ms M.M. QUIRK: There are a few questions I want to ask in relation to clause 26(1). The first is in relation to clause 26(1)(c), which reads —

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

This, presumably, is one outcome. I just wondered what else we could contemplate under that paragraph.

Mr M. McGOWAN: The clause states —

… the coordinating practitioner must inform the patient about the following matters —

…

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

There are a range of matters surrounding that, other than the certainty of death, and they might be pain management, comfort, services available, the time the patient is expected to spend in palliative care, preparing the family and the things the patient needs to get in order while in palliative care—all those sorts of things.

Ms M.M. QUIRK: Clause 26(1)(e) states —

that the expected outcome of self-administering or being administered a substance referred to in paragraph (d) is death;

Is there also the requirement to inform the patient that they may, in fact, not die? Is that included in the advice?

Mr M. McGOWAN: This entire clause is about providing the patient with as much information as possible about all the matters contained within it. One of them is to advise the patient that if they take the substance, the very likely outcome is that they will pass away. I suppose there is a need to inform the patient that they are going to die, but there is a very slim chance that the substance may not work in whatever circumstance it might be. It is just to be totally clear with the patient that, if they take the substance, they will pass away.

Ms M.M. QUIRK: I should have asked this question before. Clause 26 (1)(c) refers to the palliative care and treatment options. We have debated at length why palliative care is not defined anywhere in the bill, including discussion about the fact that palliative care is about timing and psychosocial interaction with the patient. I am asking about the extent to which details of available palliative care is mentioned to a patient, bearing in mind it is near the end and the patient has already said that they want to access VAD.

Mr M. McGOWAN: I am not sure that I can add much to what I said before. The advice provided by the doctor is around all the aspects surrounding palliative care. I suspect that doctors provide that advice all the time, to be honest. It is making sure that the person is fully informed of all aspects surrounding the choices that they are making.
Division

Clause put and a division taken, the Acting Speaker (Ms S.E. Winton) casting her vote with the ayes, with the following result —

Ayes (38)

Ms L.L. Baker  Mr W.J. Johnston  Mr K. O’Donnell  Mrs J.M.C. Stojkovski
Dr A.D. Buti  Mr D.J. Kelly  Mrs L.M. O’Malley  Mr C.J. Tallentire
Mr J.N. Carey  Mr F.M. Logan  Mr P. Papalia  Mr D.A. Templeman
Mrs R.M.J. Clarke  Mr M. McGowan  Mr S.J. Price  Mr P.C. Tinley
Mr R.H. Cook  Mr J.E. McGrath  Mr D.T. Punch  Mr R.R. Whitby
Mr M.J. Folkard  Ms S.F. McGurk  Mr J.R. Quigley  Ms S.E. Winton
Ms J.M. Freeman  Mr D.R. Michael  Mr D.T. Redman  Mr B.S. Wyatt
Mr T.J. Healy  Mr Y. Mubarakai  Ms R. Saffioti  Ms A. Sanderson (Teller)
Mr M. Hughes  Mr M.P. Murray  Ms J.J. Shaw

Noes (12)

Mrs L.M. Harvey  Mr Z.R.F. Kirkup  Mr W.R. Marmion  Mr D.C. Nalder
Dr D.J. Honey  Mr A. Krsticevic  Ms L. Mettam  Ms M.M. Quirk
Mr P.A. Katsambanis  Mr S.K. L’Estrange  Dr M.D. Nahan  Mrs A.K. Hayden (Teller)

Clause thus passed.

The ACTING SPEAKER (Ms S.E. Winton): A very happy birthday to the member for Belmont!

Members: Hear, hear!

Clause 27: Outcome of first assessment —

Mr P.A. KATSAMBANIS: Clause 27 relates to the outcome of the first assessment. Subclause (2) states —

If the coordinating practitioner is not satisfied as to any matter in subsection (1) —

(a) the coordinating practitioner must assess the patient as ineligible for access to voluntary assisted dying; and

(b) the request and assessment process ends.

In that case in which the process does end, for how long does the patient have to wait before they can request access to commence the process again from another coordinating practitioner? Just for clarity, they could leave that practitioner’s office and walk down the street and go to another one and start again.

Mr M. McGOWAN: It is consistent with any other medical issue.

Dr D.J. HONEY: How many times can a person go through this process? Subclause (2)(b) states that the process ends, but of course it is only the assessment that ends. Is there any restriction whatsoever on the number of times someone can go through this process?

Mr M. McGOWAN: No.

Dr D.J. HONEY: Does the Premier think that that is appropriate? For example, someone might go through this process twice. They might have gone through the assessment and been assessed as not being eligible. Surely there has to be some practical limit to this. I am anticipating perhaps some interjections or an answer that most normal people would not do that —

Mr D.J. Kelly interjected.

Dr D.J. HONEY: I was not anticipating an interjection from the Minister for Water but I am glad to see him in the chamber. Welcome!

Mr J.N. Carey interjected.

Dr D.J. HONEY: There we go, member for Perth—a valuable contribution to this place.

The ACTING SPEAKER: Thank you, members! Thank you, member for Cottesloe. Let us get to your question.

Dr D.J. HONEY: I am getting to the question. If a patient were to be assessed twice, one may say that perhaps they were dissatisfied with the first doctor. If it were to happen five times, surely there would be a fundamental problem. But if it were to happen 10 times, there would have to be a major issue and that person would be simply shopping around until they found someone who assessed them as eligible when patently they would not qualify. Might I say that the doctors are all compelled to go through this process and there is a cost to the system for doing that. Surely there has to be some limit to the number of assessments. Further to that, is there any review or overview or any point at which the Voluntary Assisted Dying Board will review the matter and say that there is something
fundamentally wrong and that that patient is clearly not eligible and is simply wasting the resources of the state with those multiple visits? I am not suggesting that that would happen, but surely there has to be some limit when it becomes a ridiculous process. I appreciate that that is not going to be the case for most people, Premier, and minister who is interjecting. However, there could be some cases in which that will happen and I want to know whether there will be some control over that, please?

Mr M. McGOWAN: If a patient is assessed as ineligible by a coordinating practitioner, they may commence a new request and assessment with another registered medical practitioner to act as their coordinating practitioner. This is consistent with any person seeking a second, or even third, medical opinion from different doctors. It happens all the time, every single day. In the context of voluntary assisted dying, there will be circumstances in which it is entirely appropriate for the person to approach another medical practitioner with a first request—for example, if they have difficulty finding a practitioner willing to be involved in voluntary assisted dying or if their prognosis has changed. Therefore, the use of the term “doctor shopping” is a misnomer.

Given the monitoring role of the Voluntary Assisted Dying Board and the rigorous eligibility criteria that must be satisfied before a patient may be deemed an eligible applicant for voluntary assisted dying, the practical risk of frivolous doctor shopping is very small. As part of its reporting and advisory function, the board is able to advise the CEO of Health when the board is of the view that there is a pattern of doctor shopping amongst people deemed ineligible for access to voluntary assisted dying. In this way, the Department of Health may be able to look into how other areas of care support may be better developed. It may be that these patients require linkage to another part of the healthcare system for care and support. A patient cannot seek another consulting practitioner, as it is the coordinating practitioner who makes the referral to the consulting practitioner.

The use of the term “doctor shopping” in relation to voluntary assisted dying creates negative connotations around the integrity and skill of the medical practitioners involved in the voluntary assisted dying process. These practitioners will be experienced doctors who must have undergone and successfully passed mandatory education. That process also requires two independent assessments of eligibility, which is a further safeguard against most perceived risks of doctor shopping.

Dr D.J. HONEY: As we just heard in a previous answer to the member for Hillarys, there is in fact no requirement of any time limit between consultations. The person could go to multiple doctors in a day or over a few days when there is no likely material change in the person’s condition. As I say, we are not talking about this as a normal thing, but it is entirely possible that they could go doctor shopping in that circumstance. As we have discussed in this place several times, there is a variety of capabilities. I hear arguments that doctors are somehow universally at the same skill level; that simply defies logic, in the same way that not all engineers or architects, or any other professionals, are at the same skill level. I am sure even Navy lawyers are not all at the same skill level; some are outstanding and some less so. It may be that an individual could go and find a doctor who is compliant. I was reassured by the Premier’s statement that the board would monitor this, if you like, but I do not think it is fanciful to suggest that someone could go through the process of going to multiple doctors—not just one or two, but many.

Clause put and passed.

Clause 28: Recording and notification of outcome of first assessment —

Mr A. KRSTICEVIC: In clause 28 there is a whole list of things that need to be notified. I just want to have an understanding of what happens with people who have a very poor grasp of the English language, either because of their multicultural background or poor understanding. Is there a requirement to have someone there to translate who has the professional skills to explain to them what is going on? How will whether they actually understand what they have been told be assessed? Is it just a matter of the practitioner rattling off the list and it does not really matter whether the patient actually understands the outcomes?

If they bring in a relative with them to interpret, how will we know that the relative passes on the right information to the patient? I would like some clarity around those points.

Mr M. McGOWAN: This clause relates to the coordinating practitioner’s notification requirements following their first assessment. Obviously, during that process, the coordinating practitioner will determine whether someone had difficulty with English or otherwise and whether an interpreter was needed or anything of that nature. The coordinating practitioner is the person who will fill out the form, not the patient.

Mr A. KRSTICEVIC: What skills or qualifications would the coordinating practitioner have to determine whether people from different ethnic backgrounds, different cultures and different traditions understand what is being explained to them? It is being put onto the practitioner to make that judgement. Is that based on some level of training in this area to make that judgement or are those cultural and ethnic factors that are all unique to many different cultures being discounted?

Mr M. McGOWAN: As part of the training, there would be an element of cultural competency. If there is a requirement for an interpreter, that is a matter that doctors deal with regularly now. They deal with it now; they deal with it every day. Often, if there is an issue with language, medical practitioners might be located in an area in

Extracted from finalised Hansard
which they have those language skills. Under the assessment process, in the previous clause, there is a requirement that the patient understand all the information. Doctors deal with this every day. I remind the member that doctors normally top their high school. They will have done six years at university and 10 years of practice and there is a requirement for two of them, so that is a minimum of 32 years’ training or practical experience between the two of them. That is pretty significant. They deal with these matters every day with patients.

Mr A. KRSTICEVIC: The Premier may not know this but regularly, when elderly people go to the doctor, they take family members with them to interpret for them. Obviously, those family members do not have the right technical qualifications to act as interpreters but the doctors will gladly accept a relative, son, daughter, cousin or friend to go along and do that interpretation. When all the other factors of coercion and everything else are in play and based on the common practice the Premier has just indicated whereby doctors do this every day—I know they do it every day—they definitely do not use trained interpreters; they use whoever comes along to explain it to them. I think it is a bit dangerous to accept that doctors know what is going on when I know that they regularly take shortcuts by using those sorts of people. As I said, it is very concerning to me, especially when people are aged and are less cognisant in that space.

Mr M. McGOWAN: Clause 160 explains the requirements for interpreters. An interpreter has to be accredited and it cannot be a family member.

Mr W.J. JOHNSTON: As I understand it, research shows that a third of the number of patients who are approved for voluntary assisted dying choose not to avail themselves of the procedure. Is there a time limit on the assessment report? If a patient does not access voluntary assisted dying—as I say, as I understand the research, a third of patients do not choose to follow through on that action—is there a time limit for the assessment? Does it have to be reconvened later? Does it expire after six months or something like that, or 12 months for a neurodegenerative illness? The patient is supposed to be six months from death and may choose not to access voluntary assisted dying—that is their choice. What if they live beyond the six-month period for which they were supposed to have been eligible for voluntary assisted dying? Do they have to go back to have a fresh assessment because, clearly, the original assessment must have been incorrect?

Mr M. McGOWAN: I am not sure that that matter is contained within this clause. This clause is about recording a notification of the outcome of the first assessment. I am not sure where the matter the member is referring to would be considered, but, certainly, I do not think it is relevant under this clause.

Mr Z.R.F. KIRKUP: I want to pick up on the minister’s point. The concern is that to go through a first request and first assessment phase, there is a requirement of eligibility. Eligibility means that they have a prognosis, as the Premier appreciates, that they might pass away—that there is a high likelihood that the person will be deceased within six months. If more than that time elapses, is there no requirement for them to go through and reiterate their first request and the first assessment phase, even though the eligibility requirement would effectively have been void because they have not, on the balance of probabilities, passed away?

Mr M. McGOWAN: As I understand it, this question has been answered before and the answer is no. We cannot put in place an arbitrary requirement for review because that would probably pressure the person to take the medication when they might not be ready.

Ms M.M. QUIRK: I am just wondering about the use of this information in years to come for research purposes—I can see a PhD topic here for someone. This information, admittedly with a code number on it and the identity removed, would be highly useful for a researcher who wants to examine the regime. What status does this information have in terms of the provision of access for research purposes?

Mr M. McGOWAN: I am advised that the clause that deals with research purposes is clause 150. Clause 150 deals with matters of the disclosure of information, other than personal information, “for the purposes of education or research”.

Mr Z.R.F. KIRKUP: I am conscious of the previous comments by the Premier, so I will be very quick. Just a simple yes or no is fine. I imagine that the first assessment report form will be in a similar format to the first request form and the practitioner will fill it out online.

Mr M. McGOWAN: Yes.

Mr Z.R.F. KIRKUP: Thank you. Will there be any issues if the full contact details of the patient are not provided, such as if that person is an Aboriginal resident or homeless or whatever the case might be? Nothing will stop that proceeding.

Mr M. McGOWAN: It depends upon the individual circumstances, and the contact details of the person might be different.

Mr Z.R.F. KIRKUP: It is similar to the previous forms so I want to guarantee through this process that if someone does not have a full address, they can still proceed with accessing the voluntary assisted dying process—for example, if they are from the lands.
Mr M. McGOWAN: Yes.

Mr Z.R.F. KIRKUP: Additionally, the last part of the question is on the language used in subclause (1) — “as soon as practicable”. I realise that in all likelihood that will be a very short time, but is there a maximum limit that the government envisages will be allowable as part of that?

Mr M. McGOWAN: No.

Mrs L.M. HARVEY: I seek some clarification on this clause. Clause 28(1) states —

The coordinating practitioner must inform the patient of the outcome of the first assessment as soon as practicable after its completion.

I draw the Premier’s attention to clause 28(3)(g), which refers to what the assessment report form must include, which is —

the outcome of the first assessment, including the coordinating practitioner’s decision in respect of each of the eligibility criteria;

That information will be supplied to the board. Will the patient get a copy of the report that is provided to the board or will the patient be entitled only to the outcome of the first assessment? It would seem to me that the board will get a lot more information. This legislation requires that the coordinating practitioner gives a lot more information to the board than they are required to give to the patient. It would seem to me that the decision on the eligibility criteria, particularly if the patient who wants to access the voluntary assisted dying process has been rejected, would be of interest to the patient. This legislation does not seem to compel the coordinating practitioner to provide the patient with the same report that will be provided to the board. I seek some clarification on whether the information the patient will get will be as comprehensive as the information that the board will receive about them.

Mr M. McGOWAN: As the member saw earlier in the legislation, there is a requirement for all sorts of information to be provided to the patient that is very comprehensive. The form going to the board will have a whole bunch of information within it that the patient will already know. They will not inform the patient of their gender, their nationality or their date of birth; they will already know all those sorts of things. There are clauses that require all sorts of information to be provided to the patient that is as comprehensive or more comprehensive.

Mrs L.M. HARVEY: I was not referring to the information about gender, nationality et cetera; I was referring to subclause (3)(g), which states that the board will be provided with —

the outcome of the first assessment, including the coordinating practitioner’s decision in respect of each of the eligibility criteria;

Clause 28(1) states —

The coordinating practitioner must inform the patient of the outcome of the first assessment as soon as practicable …

But the legislation does not require the “coordinating practitioner’s decision in respect of each of the eligibility criteria”, it is just whether the patient will understand that they are ineligible for various different reasons. Or will they just be told that they are ineligible? If I were the patient and somebody did a report about me and provided it to the board, I would want all the information in the report. The legislation does not appear to compel that. I feel like it is a bit of a failure if a patient is getting less information about themselves than the coordinating practitioner is providing to the board. We all know that doctors like to keep information to themselves. I know many people in here, like me, have probably been to the doctor and had various different tests. The doctor might verbally tell them those tests results. Indeed, I had a CT scan on my knee and was told by the radiological clinic that they would not provide me with a copy of the scan and that it was going to go straight to my general practitioner and the GP could tell me what was in it, which I thought was a bit condescending, to be quite honest. I want to look at scans of my knee at home by myself, or even on my phone through an app, as is available through some other providers. Some doctors are quite paternalistic with patients and some coordinating practitioners would probably be like that and treat patients as if they should be on a need-to-know basis. It is really important that if a coordinating practitioner is giving information about me to the board, that that coordinating practitioner is compelled to provide me with the same information. I want to know whether there is anything in the legislation that compels that level of transparency for patients, because I think that it is important.

Mr M. McGOWAN: The requirement under clause 28(1) is to —

… inform the patient of the outcome of the first assessment as soon as practicable after its completion. I would expect, as is normal practice, that a large amount of information will be provided to the patient.

Mr P.A. KATSAMBANIS: The Premier can take this as a question or as a comment, if he wishes, but subclause (3) requires a first assessment report to include a whole series of things. It must include, but it is not limited to that. It can include other things, too. I can understand from the perspective of the Department of Health that it may want to

Extracted from finalised Hansard
require a few other things as well. I am concerned that this is a significant departure from the Victorian legislation whereby its first assessment report form—as it is called, with capitals on each of those letters; our is in lower case, but I do not think that matters—is included in its act as a schedule so that there is clarity right from the outset that shows what the form will look like. Given we have already been informed by what Victoria has done—we do not have to take it 100 per cent; we might want to include other things—I thought it would be better if that were done in our legislation as well so the general public was fully aware of what the form would look like.

The other issue I have here is a matter that the member for Carine touched on in his contribution; that is, there is no requirement for the form to include information about the actual use of a translator or interpreter, as the case may be, or the qualifications or other identifying features of who that translator or interpreter was. I hope that that is included when the form is produced. I think it is a bit of a failing that it is not stipulated as one of the things that must be included in the form. It should apply even if, in the case of many patients, the response of the coordinating practitioner was, “Not applicable.” The question might be, “Did you use a translator or interpreter?” The answer would be either yes or no. The answer to “Who was it?” would then be, “Not applicable.” That is a failing on two counts: firstly, that the form is not incorporated as a schedule; and, secondly, that the legislation does not require that this form must include information about the use of a translator or interpreter.

Mr M. McGOWAN: The content of the form, rather than the presentation of the form, is, I think, more important. The information under clause 28(3) contains the detail that would go into the form as a minimum. It would involve an online portal with a far quicker turnaround than the Victorian model, which is seven days. The Western Australian requirement will be two days.

Mr P.A. KATSAMBANIS: Will the Premier or the Minister for Health at least take on board that suggestion that even though it is not stipulated in the legislation, they would give strong consideration to including a field about a translator or an interpreter? That is information that ought to be known.

Mr M. McGowan interjected.

Mr P.A. KATSAMBANIS: Thank you. I appreciate that the Premier gave the answer as yes.

Mr Z.R.F. KIRKUP: The last thing I want to cover off on is the statement confirming that the coordinating practitioner meets the requirements. Does that need to be stipulated on the form that goes back to the board? Is there a particular form of words or will it simply be that they have met the requirements and that is it? Does the board have to advise of any concerns or nuances as part of that assessment process?

Mr M. McGowan: Was the member’s question related to clause 28(3)(d)?

Mr Z.R.F. Kirkup: Yes.

Mr M. McGowan: It refers to “confirming that the coordinating practitioner meets the requirements of section 16(2)”; that is, the person has done the relevant training, has the qualifications and experience and the like, and it has not expired.

Mrs L.M. HARVEY: In keeping with my earlier comments about the patient being provided with all the information that will be provided to the board, I would like to move an amendment to clause 28. I move —

Page 20, line 3 — To insert after “assessment” —

and provide a copy of the first assessment report form

The reason that I am moving this amendment is that I believe there needs to be consistency with the information that is provided to the patient along with the information that is provided to the board. As I said earlier, if the coordinating practitioner puts together a report about a patient’s eligibility to access voluntary assisted dying, a report of an assessment of the outcome of a referral of a patient who was deemed ineligible by virtue of coercion or ineligibility with respect to the advancement of their disease et cetera should be provided to that patient. Certainly, if a board assessing a patient’s eligibility for voluntary assisted dying has a suite of information about them—their personal health information, their mental health information potentially, information about their eligibility to access voluntary assisted dying—they should have access to exactly the same information as a public entity, such as the board convened to assess a patient’s eligibility for voluntary assisted dying. The patient is entitled to all the information about their circumstances that is provided to the board. I do not think I need to labour the point. What I have said is pretty sensible. I think most patients who deal with doctors who may or may not be as forthright with information about their health as they could be would probably agree with me. In moving that amendment and explaining why I have done so, I leave it to the Premier to accept the amendment.

Dr D.J. HONEY: I rise to support the amendment moved by the Leader of the Opposition. Throughout the debate, we have heard that the patient and their rights are at the centre of this bill, yet this clause, not to be trite, has the ability for the machine to give a no response—that is, the doctor says no. They may or may not tell the patient. I think the points that the Leader of the Opposition made earlier are entirely cogent in this debate. If the patient is at the centre of this, the patient deserves to have the information that is available to other medical practitioners and that should not

Extracted from finalised Hansard
be optional. This is an entirely appropriate and reasonable amendment. I encourage all members to support it and not
take the dogmatic approach that we are seeing whereby no matter the sense of an amendment, it is rejected. That is,
to be frank, a bloody-minded attitude and it means that this is not an open and fair-minded discussion of this bill.
Rather, it is simply a straight partisan, “No, we’re not going to change a single thing” and I think that is inappropriate.
The reasons given by the Leader of the Opposition for this amendment are entirely proper and appropriate.

Mr Z.R.F. KIRKUP: I stand in support of the amendment moved by the Leader of the Opposition. It is very
important that the patient has ready access to the range of information that will be provided to a third party that, in all
likelihood, the patient will never come across or meet in real life. The third party in this case, the Voluntary Assisted
Dying Board, is constituted under part 9 of the legislation and comprises five individuals and devolved staff
beneath them. A range of individuals will receive information about a patient’s condition, such as whether they have
a disability and how they were assessed against the criteria, which is very personal information. It is only prudent
that the patient has access to that. Of course, it might be optional for the patient to request that information of their
practitioner, but the practitioner is not compelled to provide that information to a patient.

I think it is only appropriate that the patient is provided with the same information that will be provided to the
VAD board and the government, more generally speaking, as part of this scheme. I think it is an outstanding
amendment moved by the Leader of the Opposition. As the member for Cottesloe rightly pointed out, I hope that
the government, with the patient-centred focus that it has been continuing to prosecute as part of this very important
legislation, will accept the amendment in good faith. I think it will help inform the patient about their condition,
and help family members to be part of that process, or something like that, because they will all be fully aware of
what has occurred to date.

Mr M. McGOWAN: I understand the sentiments behind the proposed amendment. The information provided to
patients will be comprehensive, as members can see from earlier clauses of the bill. The advice I have is that the
information provided is different from some of the eligibility criteria. There is a difference—I suspect that far more
information will be provided to the patient than is in the eligibility criteria. However, in any event, we will not
accept the amendment now, on the run. We will consult about what the member is proposing between here and the
upper house, which is the right way to deal with legislation.

Division

Amendment put and a division taken, the Acting Speaker (Ms S.E. Winton) casting her vote with the noes, with
the following result —

Ayes (13)

Mrs L.M. Harvey  Mr A. Krsticevic  Dr M.D. Nahan  Mrs A.K. Hayden (Teller)
Dr D.J. Honey  Mr S.K. L’Estrange  Mr D.C. Naider
Mr P.A. Katsambanis  Mr W.R. Marnion  Mr K. O’Donnell
Mr Z.R.F. Kirkup  Ms L. Mettam  Ms M.M. Quirk

Noes (34)

Ms L.L. Baker  Mr M. Hughes  Mrs L.M. O’Malley  Mr C.J. Tallentire
Dr A.D. Buti  Mr D.J. Kelly  Mr P. Papalia  Mr D.A. Templeman
Mr J.N. Carey  Mr F.M. Logan  Mr S.J. Price  Mr R.C. Tanley
Mrs R.M.J. Clarke  Mr M. McGowan  Mr D.T. Punch  Mr R.R. Whitty
Mr R.H. Cook  Mr J.E. McGrath  Mr J.R. Quigley  Ms S.E. Winton
Mr M.J. Folkard  Mr D.R. Michael  Mr D.T. Redman  Mr B.S. Wyatt
Ms J.M. Freeman  Mr S.A. Millman  Ms C.M. Rowe  Ms A. Sanderson (Teller)
Ms E.L. Hamilton  Mr Y. Mubarakai  Ms J.J. Shaw
Mr T.J. Healy  Mr M.P. Murray  Mrs J.M.C. Stojkovski

Amendment thus negatived.

Mr A. KRSTICEVIC: Clause 28(2) mentions the two business days within which the form will need to be given
to the board. What will happen if the internet goes down, the NBN is not working or the practitioner is working
wirelessly? This may happen in regional Western Australia. What will happen if they cannot do it within two days—
or even a week—because of issues with communication? Will there be some exceptions to this part of the legislation?

Mr M. McGOWAN: You cannot help acts of God.

Mr A. KRSTICEVIC: Does that mean that somewhere in this legislation it states that acts of God cannot be
helped, as the Premier has just indicated.

Mr M. McGOWAN: It is well understood that if there is a flood, a fire, an earthquake, a tidal wave, a tsunami, or
the internet goes down, they are all catastrophes. Some people find the internet going down to be a catastrophe,
but these days it is pretty reliable. But you cannot help acts of God.

Extracted from finalised Hansard
Clause 29: Referral for consulting assessment if patient assessed as eligible —

If the coordinating practitioner assesses the patient as eligible for access to voluntary assisted dying, the practitioner must refer the patient to another medical practitioner for a consulting assessment.

We know, because the upcoming clause 35 tells us so, that that consulting practitioner cannot begin the consulting assessment until the practitioner has completed approved training. Is there going to be a list available, either as a public list or on this closed loop that the first assessment report forms will be delivered through, for a coordinating practitioner to access appropriate medical practitioners who qualify to provide consulting assessment, or are they likely to refer to a practitioner who, although they might want to participate in the regime, simply has not done the assessment and so causes a delay for the patient in accessing the consulting assessment, because the practitioner who has been referred to to provide that assessment will need to complete the training before they can do so?

Mr R.H. COOK: Yes, there will be an appropriate list.

Mr P.A. KATSAMBANIS: Will that be a publicly available list or a list distributed amongst all medical practitioners who have completed the training?

Mr R.H. COOK: The list will be held by the chief executive officer of Health; it will not be publicly available.

Mr P.A. KATSAMBANIS: How would a coordinating practitioner access that list in order to make the referral if the list is held by the director general of Health?

Mr R.H. COOK: They would refer to the central service to get the closest other consultant who could fulfil the role of consulting practitioner.

Mr P.A. KATSAMBANIS: I want to be clear about the central service. First we have the director general and now we get the central service. How would that happen? Would it be by a phone call? Would they have access through a portal? Would they send an email and wait for a reply? How would this actually happen in practice? I think it is critically important; we are obviously dealing with time-critical issues here.

Mr R.H. COOK: I think that will be handled in an administrative capacity from the chief executive officer.

Mr D.T. REDMAN: I have asked a question about the register before and I know the register is not public, but there is a register. The focus of a lot of the discussion has been on patients having a choice about what happens. The way this clause reads suggests that the coordinating practitioner refers the patient to a consultant practitioner of the coordinating practitioner’s choice, as distinct from perhaps offering some options for the patient about who it might be. Can I get clarification about whether the patient has any choice in who the consultant practitioner is?

Mr R.H. COOK: Again, member, in the normal course of events, the coordinating practitioner would contact the Department of Health, it would provide a list of eligible consulting practitioners nearby and the department would choose the closest, most convenient and available consulting practitioner to the patient, and so on. Obviously, this process is undertaken as part of the normal provision of clinical services. I assume there would be back and forth communications with the patient as well. But this provides the minimum, and basically provides a step between clause 28 and clause 30.

Mrs L.M. HARVEY: The bill requires the coordinating practitioner to assess the right of the patient as eligible to access voluntary assisted dying, and then refer the patient to another medical practitioner for a consulting assessment. Is there anything to prevent the coordinating practitioner and the medical practitioner who is doing the consulting assessment from being in the same practice; for example, they could be next door to each other? As this legislation gets bedded down and the process starts to be worked out, it would seem to me that a consulting practitioner who...
is in favour of voluntary assisted dying would not go to the CEO to get a referral for a medical practitioner to do a consulting assessment. They would find out fairly quickly who is willing to do those assessments. I want to know whether they can be in the same medical practice and financially connected.

**Mr R.H. COOK:** This was canvassed extensively earlier in the evening when answering questions from the members for Hillarys and Dawesville. It is possible for them both to be from the same practice.

**Dr D.J. HONEY:** The Minister for Mines and Petroleum, the member for Forrestfield and, I believe, the Minister for Emergency Services, would all know that there is an occupational hygiene rule that when someone has worked for more than 16 hours, it is compulsory that there is a fatigue management plan to ensure the safety of those workers. We have now been in this chamber for over 16 hours. We were told by the minister that this would be done in a respectful way. It is not respectful to the members of this house who want to interrogate this bill properly to do this. This is simply an attempt to bludgeon into submission the people who want to interrogate this bill. This is not a time-bound bill. I believe that it is entirely improper and unsafe for members of this house, who have been here interrogating this bill, to be forced to sit here and continue. I believe it is the responsible action of this minister to follow the rules that this government applies in every other workplace, and that we should cease these proceedings forthwith.

**Mr W.J. JOHNSTON:** The member is confused, because we are not employees. We are not covered by the Occupational Safety and Health Act. I would expect that the Parliament is properly managing its staff, but we are not employees. I remind people that it was regular practice in this house to sit until dawn during the passage of the Industrial Relations Act amendments in the 1990s, and it was also practice —

Several members interjected.

**Mr W.J. JOHNSTON:** Yes, when the Liberal Party was in government.

Several members interjected.

**The ACTING SPEAKER (Ms S.E. Winton):** Thank you, members. I think it is reasonable to hear points of order in silence.

**Mr W.J. JOHNSTON:** It was also the practice for the house to sit —

**The ACTING SPEAKER:** Thank you, minister; just wait until I am finished. Let us not pick which side to deal with first. We have heard a point of order from the member for Cottesloe. The minister is having his say.

**Mr W.J. JOHNSTON:** It was also the practice for the house to sit very long hours during the debate on the reforms to gay and lesbian law reform in Western Australia. It is common practice in Westminster Parliaments to sit all night. As it happens, I, of course, do not support this bill, but we all wear the consequences of our own behaviour and part of that is late-night sittings. It is not something I find joyful, but it is appropriate.

**The ACTING SPEAKER:** Thank you. It is not a point of order. Members, the house determines how long it sits. That is not covered by the Occupational Safety and Health Act.

**Mrs A.K. HAYDEN:** I would just like to remind the manager of business of the agreement we had to have a short comfort break of 15 minutes every three hours.

**Debate Resumed**

**Ms M.M. QUIRK:** It is fortuitous that the minister has returned to the chamber, because I do not need to labour the point; he knows what I am going to say, but of course I need to get it on the record. Clause 29 deals with the referral for consulting assessment if the patient is assessed as eligible. The last line of the explanatory memorandum on this clause states —

A further assessment is required to be done, independently of the first assessment, against the eligibility criteria. Where does the word “independently” appear in the bill?

**Mr R.H. COOK:** I am referring to my notes, which are now very familiar to me, because, as the member has acknowledged, we have covered this territory before.

**Ms M.M. Quirk:** I expect to be thanked when the bill is improved!

**Mr R.H. COOK:** As I have explained to the house on a number of occasions, the independence is related to the assessment. The assessment itself has to stand alone. The assessment is taken by two different practitioners on two different occasions. The independence that the member is seeking is by virtue of the requirement set out in each of the assessments undertaken by the coordinating practitioner and then the consulting practitioner.

**Ms M.M. QUIRK:** I just make the point that the second-last line of clause 29 says “refer the patient to another medical practitioner”, not “refer the patient to another or an independent medical practitioner”.

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: I welcome the minister back. He is looking fresh.

Mr R.H. Cook: I am feeling fresh.

Mr Z.R.F. KIRKUP: Indeed.

Mr R.H. Cook: And chock-full of energy.

Mr Z.R.F. KIRKUP: Chock-full of energy indeed.

I am keen to confirm—I may have missed it because I have just gone to the bathroom—when we talk about referring the patient to another medical practitioner, will the patient still have the ability to decide which other practitioner they wish to be referred to? They are not bound necessarily, are they? It would be done in concert, I imagine, with their coordinating practitioner. Will they have the ability to decide themselves or not?

Mr R.H. COOK: The member would be familiar with the process if he has been referred to a specialist by his GP.

Mr Z.R.F. Kirkup: No.

Mr R.H. COOK: In this instance, as I explained to the member for Warren–Blackwood, a central list will be held by the Department of Health, which the coordinating practitioner will refer to. That list will include eligible consulting practitioners who are nearby or within the vicinity, in particular, close to where the patient lives or can get to. Remember that this patient will be, on the balance of probabilities, within six months of death, so, as the member can imagine, they are probably not the most mobile of folk. But in the usual process of clinical practice, I imagine that will be part of a conversation between the coordinating practitioner and the patient.

Mr Z.R.F. KIRKUP: I appreciate that clarification. If, for whatever reason, the consulting practitioner as per division 4, which we are about to come to, does not agree, all the other issues will come up. If a patient goes back to their coordinating practitioner, I imagine the exact rules will apply all over again. Will they just reset to the start, back to this point?

Mr R.H. COOK: Yes.

Clause put and passed.

Clause 30: Medical practitioner to accept or refuse referral for consulting assessment —

Mr W.J. JOHNSTON: As I keep saying, I am interested only in getting some information; I am not here to make political statements. I understand that the consulting practitioner will be drawn from a list, as the minister has described. How will a person end up on the list if they have a conscientious objection to being involved in voluntary assisted dying?

Mr R.H. COOK: Obviously, if they are on the list that is held by the Department of Health, they will be consultants or medical practitioners who have undertaken the mandatory training to be eligible as a consulting practitioner. From that perspective, the list would not include all medical practitioners, but would simply include those who are eligible to be a consulting practitioner.

Mr S.K. L’ESTRANGE: I note that clause 30(4) states —

Unless subsection (5) applies, the medical practitioner must, within 2 business days after receiving the referral, inform the patient and the coordinating practitioner …

But if they have a conscientious objection, as is in paragraph (5), they must inform the patient immediately. Why does one subclause state “within 2 business days” and the other “immediately”?

Mr R.H. COOK: The reason there are two different time frames is because if a consultant is a conscientious objector, the medical practitioner will know that they are a conscientious objector and can provide that information straightaway. There are other reasons they may not be eligible to undertake the role of consulting practitioner. For instance, they may refer to their diary and realise a holiday is coming up in a few months’ time and it is unsafe to take on a new patient in that intensive period. We can contemplate a range of reasons someone could not take on a particular patient. In the event that they are not taking that patient on because they want to conscientiously object, that would be immediately apparent.

Mr S.K. L’ESTRANGE: Can the minister accept, however, that in some circumstances a practitioner may not be a conscientious objector, but may have a patient in front of them who forms in the doctor’s conscience a conscientious objection at that point of a consultation. They may not yet know themselves whether they are a conscientious objector because they need time to reflect on the situation presented to them by that patient. Why is it that in that circumstance they must make a decision immediately when, in fairness to the practitioner, they need the same amount of time for any of the other reasons?

Mr R.H. COOK: The member is absolutely right. If they had the patient in front of them and that patient left the room, or the medical practitioner has an opportunity to reflect and realises that they cannot, in all good conscience,
participate as the consultant practitioner, at that point in time they would know that they are a conscientious objector, and that is the point at which they should then go straight back to the patient. But if the patient comes in front of them, and they realise immediately, they must communicate that immediately.

Mr S.K. L’ESTRANGE: I find that answer logical, but it does not match the bill, because if the point of reflection occurred five hours, 10 hours or 20 hours later, and the minister is saying in his answer just then that that is the point of immediate, that may end up outside the scope of the other recommendations. I am just wondering how we could maybe capture that. I am not suggesting an amendment here but, given the minister’s answer, I am wondering whether we are moving away from what is written in the bill now with that answer.

Mr R.H. COOK: In relation to subclause (5), if a medical practitioner finds themselves as a conscientious objector, it would be unusual for them to be on the list to start with anyway. Maybe they have undertaken the mandatory training, and their name is entered on the register, they are contacted—understand this would not happen every other week; we are talking about a small cohort of patients—and they realise at that point that they are still on the list but this is not their thing anymore, and they are going to conscientiously object. At that point that it occurs to them—that germinating moment in their minds with the patient in front of them—they should communicate it straightaway. Obviously, if they are on the list, it is unlikely that they are going to be a conscientious objector, and they would be captured under clause 4. There might be some other reason why they cannot assist the patient. It captures two different scenarios—one fairly likely; one very unlikely—but it is there as one of the 102 safeguards that I heard the Attorney General remind the chamber about on a number of occasions.

Mr S.K. L’ESTRANGE: I think what I am hearing here is that the whole point of conscientious objection is that if the practitioner goes away and reflects, and maybe lies awake at night, and then thinks, “Do you know what? That patient doesn’t fit what I was on the list to be a provider for. That particular patient does not fit, and I want to apply the conscientious objection to that patient even though I might still be on the list.” I think, because the bill uses the words “must, immediately” that does not give the opportunity for that practitioner to reflect. I think that is a weakness, that time frame being either zero, because it must be immediate, or according to the minister’s earlier answer, at any time when the reflection causes them to think that they should object, and that becomes the point of “immediate”, which is interesting in itself. The minister has given an answer, but I do not know whether he is going to recognise the difficulty that exists here for a practitioner, but I will draw the minister’s attention to the Victorian equivalent of this clause, which has a time frame of seven days. I wonder why the Western Australian bill has a significantly shorter time frame than the Victorian legislation, going from seven days to two days, and then significantly tighter—again, I question this notion of what is immediate.

Mr R.H. COOK: The ministerial expert panel was very clear to us that it did not think that the patient should be allowed to sit around wondering whether they would receive assistance from the consulting practitioner. We used the terminology “immediate”, knowing in reality that immediate may mean the transference of an email or some other form of communication. The Victorian legislation contemplates only conscientious objection, not that someone will not participate for some other reason. In that context, our legislation is more workable. I should point out that the reason we use the time frame of two business days is that, as part of our safety-conscious model, we want oversight and communication to take place between practitioners and between practitioners and the board throughout the entire process, rather than people being informed after the fact.

Mr S.K. L’ESTRANGE: I just want to wrap up here.

Mr R.H. Cook: Member, by way of interjection, I am sorry, but I misinformed the house just then; the Victorian model allows for both. I think I said the Victorian model allows only for conscientious objection; that is not correct.

Mr S.K. L’ESTRANGE: Given that the minister now understands that the Victorian model has seven days and this legislation has two days or is immediate, which is a significant difference, and the minister said that the ministerial expert panel made the decision to make it two days instead of seven because patients needed a quick answer, was any data taken or a scientific approach used to come up with this need for the time frame to be reduced from seven days to two days?

Mr R.H. COOK: Member, the ministerial expert panel did not make that decision, the government did. It is government legislation. We were informed by the ministerial expert panel, which in turn was informed by very widespread consultations. The expert panel was also made up of a number of doctors and other people involved in the health sector. In fact, six of the panel members were doctors, and we were very much informed by the experience and expertise they brought to the process.

Mrs A.K. HAYDEN: The member for Churchlands raised a very valid point about reducing the time period for practitioners from seven days to two days. If a practitioner receives a referral for a consulting assessment, they may require time to consider whether they want to undergo training. If the practitioner decides to do the training, they have two days to get back to the client who wants to go down this path. If it takes two days to undergo training, does that mean that this practitioner would be trained up and able to tell that patient within two days?
that they are ready to go? Can the practitioner do the training within two days? Will that be sufficient time for
them to undergo the training and have all the required qualifications to be able to assist patients and deliver on
this very important decision?

Mr R.H. COOK: If a medical practitioner meets the minimum requirements other than having done the mandatory
training on voluntary assisted dying, they are able to do so after the referral request and prior to undertaking the
consulting assessment.

Mrs A.K. HAYDEN: Can the minister clarify that he said that if someone wants to undergo training, it could be
done within two days?

Mr R.H. COOK: No, that is not what I said, member. I said that they can accept the referral but, prior to undertaking
the consulting assessment, they must undertake the training. It may be two days. Obviously, as we discussed on
an earlier clause in the bill, it would be subject to the implementation phase in terms of how long the mandatory
training will take.

Dr D.J. HONEY: I am happy to defer.

Mr Z.R.F. KIRKUP: I appreciate that Dr Honey. I have two questions on this clause, minister. One is that under
subclause (3), the medical practitioner must refuse a referral if they are not eligible to receive it. I assume that they
would have to be trained in order to receive the referral. If they are not trained, then they would have to immediately
refuse the referral. Is that not correct?

Mr R.H. COOK: They have to be trained to do the assessment.

Mr Z.R.F. KIRKUP: My best read of that provision is that they cannot accept the referral unless they are trained.
If they are not trained, they must refuse it.

Mr R.H. COOK: I am informed that the medical practitioner must refuse the referral if the practitioner is not eligible
to act as a consulting practitioner. Again, it comes down to the minimum requirements that were described in clause 16,
and the provision does not necessarily refer to the need to undertake the mandatory training. The practitioner is
able to accept the referral but they cannot undertake the assessment until they have undertaken mandatory training.

Dr D.J. HONEY: In the minister’s response to, I believe, the member for Churchlands, I heard the comment that
the two-day period would speed up communication between the board and the doctors. My understanding is that
the board will not play an active role in this process. The coordinating medical practitioner and the consulting
practitioner will go through this process and, in effect, satisfy each other, and the board will simply receive that
communication in the form of completed paperwork. Is that the case or will the board play some other active role?

Mr R.H. COOK: That is correct. The member for Churchlands asked in broad terms why the Victorian legislation
uses seven days and we will use two days. I used the example of the referral of forms and other such things to the board
that must be done within two days because we take a more contemporaneous perspective on the process compared
with Victoria, which takes a more stand-off approach. That is why throughout the Victorian act it refers to seven days
and this bill refers to two days. In this context, one of the principles of medical practice is that processes should not
unnecessarily stand in the way of a patient receiving the care that they have requested. That is why the ministerial
expert panel was particularly keen to make sure there is a minimum period before a patient is informed about whether
they are going to be taken on board or whether they will need to seek help from another medical practitioner.

Dr D.J. HONEY: The minister would appreciate that as these hours wind on, my brain, at least, will slow down.
My understanding is that the board is not required to take any particular action.

Mr R.H. Cook interjected.

Dr D.J. HONEY: Yes. I have a follow on question, and if the minister has been asked this before, I apologise for
repeating it. In relation to the 48-hour period, what is the consequence of oversight in the submission of those forms?
If it takes longer than 48 hours—it may take a week—what are the consequences for the medical practitioner of
what is not a wilful disobedience but simply an oversight in this matter?

Mr R.H. COOK: In the normal course of events there are obviously requirements on people, under a range of
legislation, to act within a particular period of time. The member will understand that something like that will be
considered at the very minor end, and would probably go to the effect of the chief executive officer reminding the
medical practitioner of their obligations. In reference to other aspects of the process, under clause 107 a failure to
give a form to a board, for instance, has a penalty of up to $10,000. In this case, the member is talking about the
communication between the medical practitioner and the patient. The 48 hours is there to say that it would be fair
to come back within 48 hours. I can understand that if it went to slightly longer than that and it was an isolated
incident, there would be very little consequence. The member will remember that clause 10 provides that
contraventions of this legislation may constitute an act of misconduct or unprofessional conduct under the national
health regulation laws. Technically, there may be a misdemeanour or something to that effect, but that is really
about the regulation of the medical profession.

Extracted from finalised Hansard
Mrs A.K. HAYDEN: If I may go back to the line of questioning we were on a moment ago, can the minister explain whether there is a time requirement between accepting a referral and the assessment?

Mr R.H. COOK: No, it would be part of the conversation with the patient.

Mrs A.K. HAYDEN: We are talking about two days after accepting a referral within which a practitioner can decide to undergo training, and if so, they have to reply within two days. Can the process of replying, accepting the referral and actually doing the assessment all be done within two days?

Mr R.H. COOK: Technically, yes, it would be possible. Obviously there are realities and from that point of view it would really depend upon the practitioner and the patient.

Clause put and passed.

Clause 31: Medical practitioner to record referral and acceptance or refusal —

Mr Z.R.F. KIRKUP: Clause 31 states, in part —

The medical practitioner must record the following in the patient’s medical record —

I just want to clarify something, because we have mentioned this a number of times. In the event that the practitioner has not met the patient in person, are medical records still established? There is the opportunity to do this audiovisually; I assume that in that case there would still be the normal process of establishing a medical record. Is that right?

Mr R.H. COOK: That is right, member. It would simply be the patient’s medical record that the doctor would be required to keep by virtue of all their interactions with the patient.

Clause put and passed.

Clause 32: Medical practitioner to notify Board of referral —

Mr Z.R.F. KIRKUP: Previously, under a similar clause relating to the first assessment form, the Leader of the Opposition raised a very valid point about the information contained within that form being provided to the patient. We divided on that question because the government did not accept it. I note that a similar level of information is now being collected in the same form, the consultation referral form. Not to reflect on the Premier, but now that the minister is in the chair and is more intimately involved in the health portfolio on a regular basis, I ask: is there any capacity for the patient to access this form and the information contained within it?

Mr R.H. COOK: There may or may not be; I will take some advice shortly. One of the issues was overlooked in the last discussion we had; I was here for most of that debate. This clause is about making sure that the board has the information it needs to be able to oversee the process. Obviously, the patient would be given and be in control of a mountain of information. The purpose of this clause is to make sure that the board can fulfil its role of oversight. As a result, it is in this form to make sure that information makes its way to the board so that it can complete its task.

Mr Z.R.F. KIRKUP: I thought the minister was going to make an undertaking to provide some more information about whether a patient could access that.

Mr R.H. COOK: I took the extra advice there member because I am aware that often patients put in a freedom of information request because they want to find out all the information that is out there in the Department of Health or hospital land and so on. That is not uncommon. I wanted to get some clarity on that, so, technically, that is possible. Again, I emphasise that the patient themselves would probably have this information plus a whole bunch more. That is the normal process we would expect from the doctor–patient relationship. Again, this clause is here not to deny the patient the information but to set out exactly what the board needs to fulfil its role.

Mr Z.R.F. KIRKUP: I want to confirm that a copy of this form will be submitted to the board via the website, portal or however the previous forms would have been filled out. Is that consistent with previous practice?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: Excellent, thank you. I want to continue to clarify throughout this process that if the contact details are not fully populated—an individual does not have a fixed address or something like that—it will not prohibit this from continuing.

Mr R.H. Cook: No.

Mr Z.R.F. KIRKUP: Thank you.

Mr J.R. Quigley interjected.

Mr Z.R.F. KIRKUP: Thank you, Attorney General; as always, a salient objection. In relation to the—I have lost my train of thought. My apologies.

Dr M.D. Nahan: It’s time to sit down.
Mr Z.R.F. KIRKUP: Thank you very much, member for Riverton.

Mr R.H. Cook: You have four minutes, eight seconds.

Mr Z.R.F. KIRKUP: I do not want to keep it going.

Mr P.A. Katsambanis: Keep going.

Mr Z.R.F. KIRKUP: I cannot. I am going to sit down; I appreciate the minister’s help.

Mrs A.K. HAYDEN: I will assist the member for Dawesville and ask a question so that he can collect his thoughts. I know we touched on it, but I think the minister indicated it would come up in this clause and to wait until then. Why do we need the refusing medical practitioner to complete a form to the board?

Mr R.H. COOK: As we have said before, one of the important roles of the board is to have oversight and insight into the process of patients accessing voluntary assisted dying. Those insights, through research and data, form the basis of the annual report that it will provide to Parliament each year so that Parliament and government can ultimately see how many patients have applied, how many were refused, how many were accepted and the reasons for that acceptance. It is part of the oversight. Again, this clause, like the earlier clause, sets out the sort of information that the board will require to fulfil its roles.

Mrs A.K. HAYDEN: Thank you very much for that. I am trying to understand why the information on refusal is needed. What sort of data will that provide, why is the data needed and what will the data be used for? If they are refusing the service, I do not understand why we need that data. Earlier, we discussed the fact that the history of the patient is not required either, so it is not as though it is being done to find out how many times that patient has asked and been refused, because the history of the patient does not need to be included in the actual process if they go to another practitioner. I do not understand why the refusal needs to be in there. I know there are a lot of questions, but I am trying to get them all out at once so the minister does not have to keep getting up and down.

Mr R.H. COOK: As we have discussed, there are a whole range of reasons why there would be a refusal. For instance, if a range of patients who live in regional areas were refused because of medical practitioner unavailability, those are the sorts of insights that the board would want to have in order to say, “Well, clearly, this isn’t working for people living in regional areas.” Again, it is about making sure the board has all the necessary information for it to make recommendations about how well the act is working.

Mr Z.R.F. KIRKUP: Minister, in relation to the thing I had forgotten and have since remembered, the CEO will approve the forms that need to be filled out by all practitioners, as best as I understand it. There is some power for that to occur through this legislation. If the board, through its oversight mechanism, determines that it needs more information as part of the forms that have been collected, is there the capacity, without amending the bill, for that to be collated or for the form to be altered and for more information to be garnered without going back and revisiting this clause or any other clause in which there is a form that had to be filled out to satisfy the board’s requirements for whatever new information it deemed necessary?

Mr R.H. COOK: Clause 149 states —

(1) The Board may request any person (including the contact person for a patient) to give information to the Board to assist it in performing … its functions.

Mr Z.R.F. KIRKUP: I looked at clause 149. I was not aware that it bound the practitioner, just the patient. Is that right, or was my reading of that wrong? My apologies.

Mr R.H. COOK: It is any person.

Mr Z.R.F. KIRKUP: It is any person. Thank you.

Dr D.J. HONEY: It is morning! It is as though I am a farmer and I am getting up early to start ploughing. We are all getting garrulous now. In relation to the information provided to the board by the consulting practitioner, is there any contemplation that there will be two-way communication back to the consulting practitioner; and, if that is contemplated, what would that communication comprise?

Mr R.H. COOK: Could the member ask that again? Is the member talking about communication from the board back to the practitioner?

Dr D.J. HONEY: I will continue. The practitioner is required to submit a form to the board.

Mr R.H. COOK: Yes.

Dr D.J. HONEY: That is the communication. There is information. The practitioner explains why they did not wish to participate in the process. Is there any contemplation that the board will communicate directly back to that practitioner to follow up on that or is this purely a one-way process?
Mr R.H. COOK: Member, we cannot locate it at the moment, but there is a requirement for the board to then notify the practitioner that it has received the form. It is not a substantial part of the bill because, clearly, it is quite hard to find. I will come back to the member if it does pop up. But, yes, that is the form in which the two-way discussion would take place.

The ACTING SPEAKER (Mr T.J. Healy): Before the member stands up, to avoid bedsores, I think we will take a comfort break for 10 minutes. I will vacate the chair until 1.55 am.

Sitting suspended from 1.44 to 1.58 am

Mr R.H. COOK: Before the break, we were trying to locate a clause that referred to the obligations on the board to respond to communications. Clause 148, “Board to send information to contact person for patient”, sets out some of the instances in which the board should respond to communications, as well as of course acknowledging notifications.

Dr D.J. HONEY: Perhaps saying it is a concern is too strong, but my interest in this is whether the board will communicate to the assessing or referred practitioner and whether it will provide feedback or coaching. From what the minister indicated, that will not occur.

Mr R.H. COOK: That is right. If it helps, member, the role of the board is to oversee the process, not to play coach or provide constant feedback to medical practitioners. From that perspective, if the board thinks that something needs to be followed up because, for example, it spots a pattern of irregularities, it will refer to the chief executive officer, who has obligations to follow those things up.

Clause put and passed.

Clause 33: Medical practitioner becomes consulting practitioner if referral accepted —

Mr Z.R.F. KIRKUP: Clause 33 reads —

If the medical practitioner accepts the referral, the practitioner becomes the consulting practitioner for the patient.

That is obviously quite a straightforward role. Once the practitioner makes that decision, they become the consulting practitioner instantly. Is there no requirement for them to inform the board or the patient? Is it their decision to become the practitioner?

Mr R.H. Cook: That is correct.

Mr P.A. KATSAMBANIS: After the practitioner has made the decision to accept the referral, is there a process by which the practitioner can then decline to continue to act in that role; and, if so, where is that included in the bill?

Mr R.H. COOK: As the member has probably witnessed as a patient, if for some reason a medical practitioner to whom a patient is referred by their GP decides, after meeting with the patient, that for some reason they cannot assist that patient, they would refer the patient back to the assisting referring practitioners. In this sense, the patient would be referred back to the coordinator practitioner.

Mr P.A. KATSAMBANIS: Through the operation of which clause will that happen?

Mr R.H. COOK: Through the usual process of clinical practice.

Mr Z.R.F. KIRKUP: If the consulting practitioner does an assessment and then, for whatever reason, cannot proceed with the finalisation of the process or something happens to them, does the patient have to go back to their coordinating practitioner to find a new consulting practitioner and revisit the assessment process or will the previously undertaken assessment by the consulting practitioner who is no longer able to fulfil their duty still stand?

Mr R.H. COOK: The primary role of the consulting practitioner is the second assessment. If they have undertaken a second assessment, without sounding brutal their job is at an end. They undertake the second assessment and report back to the coordinating practitioner. They may be called upon at a later date but that is pretty much it.

Clause put and passed.

Clause 34: Consulting assessment —

Dr D.J. HONEY: Minister, earlier we discussed the initial assessment, but now we are looking at the consulting assessment. I have a concern that there is a much higher probability that the consulting assessor will not have any particular knowledge of the patient, this being a person who is picked out because they have some particular knowledge. Subclause (2) states —

For the purposes of subsection (1), the consulting practitioner must make a decision in respect of each of the eligibility criteria.

This is not just because they have some particular specialist knowledge. The minister will know that when we discussed the coordinating practitioner, I raised concerns about the ability of the coordinating practitioner to properly assess the

Extracted from finalised Hansard
Mr R.H. COOK: The member may have those concerns, but we have safeguards baked into this legislation. I appreciate that the member might think that. This a high bar for a consulting practitioner to jump. If they have to take extra care in making the assessment of the patient against all the eligibility criteria, so be it. The member will see, further down the page, that clause 36 provides that a consulting practitioner must seek further advice if they are unable to make that assessment.

Mr W.J. JOHNSTON: I want to get confirmation, minister, that effectively the consulting practitioner is assessing the evidence that is presented to them on paper, as it were, not necessarily the patient themselves.

Mr R.H. COOK: The consulting practitioner would obviously have patient records and other information that is pertinent to their decision. I believe that in order for a consulting practitioner to be convinced of these things, there would need to be a process, and obviously discussions, but clearly they would avail themselves of all the information that is pertinent.

Dr D.J. HONEY: I am grateful to the Minister for Mines and Petroleum for asking that question, because I cannot contemplate how the consulting practitioner could possibly assess each of the eligibility criteria. I am happy for the minister to answer this by way of interjection, but would that be the criteria listed in clause 15?

Mr R.H. Cook: Yes.

Dr D.J. HONEY: In that case, surely the consulting practitioner must either physically meet with the patient or consult directly with the patient via some audiovisual means.

Mr R.H. COOK: Yes.

Clause put and passed.

Clause 35: Consulting practitioner to have completed approved training —

Mrs L.M. HARVEY: I would like the minister to clarify one thing about training. We sought some information from the Premier earlier. I want to check. Obviously, the consulting practitioner and the coordinating practitioner will have different roles in this process. I want to clarify whether the training that will be provided for practitioners who operate within the model will equip them with all the information they will need for the responsibilities they will need to perform both as the coordinating practitioner and as the consulting practitioner.

Mr R.H. COOK: Yes. The CEO will approve training for the roles of practitioners and their obligations under the act. That will include both as the coordinating practitioner and as the consulting practitioner.

Mrs L.M. HARVEY: I would like to clarify that. If a practitioner has completed the module of training, and they achieve—I think the Premier said 90 per cent —

Mr S.K. L’Estrange: The Attorney General.

Mrs L.M. HARVEY: The Attorney General said they have to achieve a 90 per cent score. After that process, will they be qualified to perform either a coordinating or a consulting practitioner role, or will there be different modules for the two different roles?

Mr R.H. COOK: These are issues that will be clarified in the implementation phase. The member is right that they have different roles under the act. The CEO may decide that he or she wants to have a specific module for someone who will play the coordinating role. I think that might be likely because, as the member knows through her examination of the bill, the coordinating practitioner has a very important role in this process as opposed to the consulting practitioner. Those matters will be resolved in the implementation.

Mrs L.M. HARVEY: Will it be possible for a practitioner to operate as a consulting practitioner for one patient and a coordinating practitioner for another patient at the same time?

Mr R.H. COOK: Yes, if they have undertaken the appropriate training.

Mr Z.R.F. KIRKUP: I would like to clarify that and expand on the Leader of the Opposition’s point. There will not be separate training for the consulting practitioner and the coordinating practitioner; it will be rolled into one, effectively. Is that right?

Mr R.H. COOK: No, that is not what I said. The chief executive officer will be responsible for approving the course or courses. It will be up to the CEO to make a decision about that. It is important that the medical practitioners understand their roles according to the act. The training will be put together as a result of an examination of those responsibilities.

Clause put and passed.
Clause 36: Referral for determination —

Mr P.A. KATSAMBANIS: We traversed the operation of these provisions during consideration of clause 25, so I do not intend to repeat a lot of that. This clause covers the circumstance in which the consulting practitioner is unable to determine whether a person has a disease, illness or medical condition; whether they have decision-making capacity; or whether they are acting voluntarily and without coercion, which is covered in subclause (3), and they want to refer the case. I seek clarity about whether the consulting practitioner will be compelled to use someone other than a person who had been used by the coordinating practitioner in order to make this determination under clause 36. Would they be compelled to use the same person who had been used by the coordinating practitioner, or would it be left open to them to choose whether to use the same practitioner or another practitioner?

Mr R.H. COOK: It would be the third of those options. The practitioners will be utilising all their training, skills, clinical experience and further qualifications that they have achieved and will be staking their reputation on the assessment. In that context they will essentially be vouching for the decision. The consulting practitioner may go to someone whom the coordinating practitioner has used but, ultimately, they are the ones who will have to be convinced and will be certifying, relying on all the skills that they bring to bear to the process, that the patient is eligible and meets all the necessary criteria.

Mr P.A. KATSAMBANIS: That answer consolidates in my mind the fear about how this legislation can be exploited, and I use that word advisedly, because it creates the opportunity for a closed loop. We have already found out that a coordinating practitioner can refer to a consulting practitioner who may be operating in the same building, under the same roof, and may well be operating under the same banner of a medical centre or some other type of practice. Now we are told that they effectively can use the same people to assist them in making a determination, which creates a very closed loop. Essentially, two or three people who may not necessarily be independent—or even if they are technically independent, may not be seen to be independent in practice—could sign off on these determinations to the detriment of a vulnerable person. I do not know whether the minister wants to comment on that or whether he wants to take this as a comment from me, but at the end of the day I think this just verifies one of the strong concerns that there may be people out there who take advantage of the looseness of the drafting of this legislation—the permissiveness of this legislation—to create a closed loop that may not necessarily provide appropriate outcomes for the vulnerable people we are dealing with.

Dr M.D. NAHAN: It is late at night, so first of all I want to clarify —

Dr D.J. Honey: It’s early in the morning!

Dr M.D. NAHAN: Yes, it is early in the morning. The member for Cottesloe is okay; he is out there ploughing.

Dr D.J. Honey interjected.

Dr M.D. NAHAN: Yes.

Dr D.J. Honey: You’ve got the horses out!

Dr M.D. NAHAN: Yes, I have got my horses out.

Dr D.J. Honey interjected.

The ACTING SPEAKER: What is your question, member for Riverton?

Dr M.D. NAHAN: Just to clarify, is the consulting practitioner primarily verifying and looking through the information that the medical practitioner has provided to him or her? The medical practitioner goes through the whole process, makes an assessment about the eligibility or otherwise of the patient and then provides it to a consulting practitioner. Does the consulting practitioner duplicate the assessment done by the medical practitioner or use the material provided to him or her?

Mr R.H. COOK: Yes, very strongly. They are not there to assess the coordinating practitioner’s assessment; they are there to make their own assessment and draw upon their own information in reaching that conclusion.

Dr M.D. NAHAN: They would therefore have to have personal contact with the patient directly or through video like the medical practitioner.

Mr R.H. Cook: Yes.

Dr M.D. NAHAN: So, should the consulting practitioner essentially duplicate to the extent he or she thinks necessary what the medical practitioner has done in the assessment?

Mr R.H. COOK: Yes, to convince themselves of the patient’s eligibility and suitability.

Dr M.D. NAHAN: I can see that a lot of the data on the medical side would be similar—that could not be altered. I am more concerned about the coercion that we discussed. Perhaps someone outside of the medical sphere with some knowledge and long-term contact with the family—not always; sometimes it is not relevant—needs to be sought. When the Attorney General was leading the debate from the minister’s chair, we went through it in some
detail. We agreed that when necessary, when the consulting physician or medical practitioner believes there is a risk of coercion, they have to bring in an outside person, who has some contact with the family perhaps, to identify a concern of coercion and, if there is a concern, the extent of the coercion. I believe that under clause 36, the consulting practitioner has to do the same thing.

Mr R.H. Cook: Yes, member.

Mr Z.R.F. Kirkup: I asked the Premier some questions in relation to coercion under the previous clause on coordinating practitioners. Obviously, this clause is on the consulting practitioner. I am conscious of my previous comments; I am a bit more confident in the minister’s stewardship of the health portfolio.

Several members interjected.

The ACTING SPEAKER (Ms J.M. Freeman): Members! What is your question?

Mr Z.R.F. Kirkup: On the issue of coercion, I appreciate there has to be a referral to someone who has the specialisation to understand coercion to ensure that someone can assess that a patient is making a voluntary decision. Is there a possibility that the person the patient is referred to could be in a familial or financially dependent relationship with the patient? There is nothing that restricts the referral to somebody else, so if the patient has been referred to someone to assess whether there is coercion, can the person carrying out that assessment have a financial relationship with the patient? Is there anything in this legislation that explicitly rules that out?

Mr R.H. Cook: Again, member, this is about the consulting practitioner coming to the same assessment as the coordinating practitioner. In the context of that, if they need further evidence to convince them, they would speak to any number of people. They might speak to both people who know and do not know the patient. If somebody does not know the patient but is undertaking an academic or an arms-length review, they might hold that evidence as being more informative than the evidence of a close relative, and things of that nature. It will be a requirement that the coordinating practitioner and the consulting practitioner draw upon their skills and their training, as well as the ethics that they are bound by, to make that assessment. This is what we are doing in this bill. We are acknowledging that doctors play a really important role in our society. Every day, doctors make decisions about life and death and the full ethical ecosystem that sits around that. From that point of view, we expect a lot from them. I note the earlier observations of the member for Hillarys. We hold doctors in a much higher esteem in that context. That is not to be critical of the member for Hillarys, but to say that this bill relies upon all that training and clinical experience to make sure that we are confident of the assessments.

Mr Z.R.F. Kirkup: Is there any reason the minister would not seek to limit any commerciality that might exist? I appreciate what the minister has said, but the referral under clause 36(3) sounds quite official to me; that is —

… the consulting practitioner must refer the patient to another person who has appropriate skills and training to make a determination …

That does not sound like the consulting practitioner is weighing up the evidence; it sounds like there is a very official referral process. It is a decision-making process with someone who is qualified to make that decision. If there is nothing in the legislation that explicitly rules out that the person who is assessing coercion has a financial relationship with the patient, I think that might leave it open to exploitation. I agree with the minister on a number of safeguards that have been built into the legislation in other areas. It is a decision-making process with someone who is qualified to make that decision. If there is nothing in the legislation that explicitly rules out that the person who is assessing coercion has a financial relationship with the patient, I think that might leave it open to exploitation. I agree with the minister on a number of safeguards that have been built into the legislation in other areas. I just do not know why, especially when it comes to coercion, this would not be made explicit—that the person making the assessment is independent of the patient who has been referred to them.

Mr R.H. Cook: Essentially, member, the coordinating practitioner cannot delegate their powers under this legislation to someone else in the context of making the assessment. The ultimate assessment has to be theirs and theirs alone. They can invite all kinds of information in the context of that—some strong and some potentially weaker. But it is ultimately down to them to make the call.

Mr Z.R.F. Kirkup: This is my last question on this. I am going to imagine a regional setting where there is a consulting practitioner and a coordinating practitioner. Feasibly, under this legislation, could the person to whom both practitioners had referred the patient to assess coercion be the same individual? The Premier used the example of the town police officer assessing coercion. Could that be the same person for both the coordinating and consulting practitioner? Obviously, under the process that we are seeking to set up with this legislation, there is very clear independence between the two. Could that converge in the assessment for coercion if the person is referred to the same individual to make that determination?

Mr R.H. Cook: Again, they are bound by the ethical standards that they have sworn to observe. They would need to make sure that they are aware of any potential flaws in the context of reaching their assessment.

Mr Z.R.F. Kirkup: My understanding is that the consulting practitioner will not see the information that has been provided to the coordinating practitioner, so how will the consulting practitioner know whom they have been referred to?

Extracted from finalised Hansard
Mr R.H. COOK: The member was talking about a very small town. The consulting practitioner must, as I have said, come to a separate assessment and must form that view on the basis of a whole range of issues, and that includes, if they are unsure, seeking advice. The member observed the appropriate skills and training. Potentially, it could come down to there being some overlap. The coordinating practitioner would not pick up the phone and say, “Hi; by the way, do you reckon such and such has got their marbles?” They would have a more nuanced conversation, because they have to have a very deep level of understanding of them in that process.

The ACTING SPEAKER: Member for Dawesville.

Mr Z.R.F. KIRKUP: I sense the terseness in your voice, Acting Speaker, so I will not keep labouring the point.

The ACTING SPEAKER: That would be good, member for Dawesville.

Mr Z.R.F. KIRKUP: I would just like to underline my concern. I would appreciate it if, as part of the implementation, there could be a bit more clarity to empower the CEO to ensure that there is a level of understanding of the independence that would be required, because I do not think it is very healthy if, under the legislation, the same person were making the assessment about coercion for both the consulting and the coordinating practitioner. For everything else to this point, there has been the necessary firewall, as it were, between the two processes. It might converge there. I think it might be prudent for us to be aware of that issue in the implementation, in whatever form it might take.

Dr M.D. NAHAN: I have two questions. First, let us say that the consultant is concerned about coercion, but he is in Perth and the patient is in a distant place, and they decide that they have to send somebody out there to investigate to see what is going on in the community. Will the state pay for that? Will the state say, “It’s up to you to decide what needs to be done and you just go ahead and do it and we’ll pay for it”?

Mr R.H. COOK: Just as people access any medical services at the moment, there is probably of range of people they would get those services from—some as an outpatient, in which case the state would pay for it, some through the local GP and some in a community setting, in which case it would be a Medicare benefit arrangement. In this context, it is the responsibility of the Department of Health to make sure that members of the community can access voluntary assisted dying services and the responsibility of the CEO to make sure that those services are in place so that people can access them.

Dr M.D. NAHAN: If a consulting practitioner needs someone to go out to a rural community and they have to fly and spend some time there, will the Department of Health pick up the tab? Medicare will not do that.

Mr R.H. COOK: That is right. As is usually the way with the inadequacies of Medicare, we will pick up the tab.

Dr M.D. NAHAN: Is it possible that everybody involved—the medical practitioner, the coordinating practitioner and other independent experts—could all be in the same medical practice?

Mr R.H. COOK: I assume the member is contemplating a practice with a range of interdisciplinary professions?

Dr M.D. Nah an: Yes; a lot of them.

Mr R.H. COOK: I guess that is a hypothetical. Technically, yes; practically, probably not, because ethical issues would impact upon the way that they conduct themselves in relation to that. I am not a health ethicist, so forgive me if this sounds clumsy. Medical practitioners have to be convinced that the information is provided, sourced and assessed inside an ethical framework. Yes, technically they could be inside the same bricks and mortar, but ultimately the information has to be—I think the expression the member for Dawesville used—firewalled. That is probably not appropriate, but the information needs to come from independent sources.

Dr M.D. NAHAN: I am referring to not just the same bricks and mortar, but potentially the same commercial entity. It could be a business—they operate on many different models, so I am generalising—that has been set up to provide a complete set of services for the purposes of this legislation.

Mr R.H. COOK: As we have discussed before, the experience in other jurisdictions with these sorts of voluntary assisted dying models suggests that it represents about 0.4 per cent of people. It would have to be a humdinger of a business model for people to be able to make a living out of that.

Dr M.D. Nahan: Not fully, but partially.

Mr R.H. COOK: Yes; but it will be a very rare experience indeed.

Mr Z.R.F. KIRKUP: Subclause (4) states —

If the consulting practitioner makes a referral under subsection (2) or (3), the consulting practitioner may adopt the determination of the registered health practitioner or other person, as the case requires, in relation to the matter in respect of which the referral was made.

Will that mean that the practitioner does not have to accept that advice; and, if so, why would that be the case?

Mr R.H. COOK: Because it is their call. They are the ones who have to make the assessment. As I said before, some evidence they would consider highly; other evidence they would not rely on as heavily.
Ms M.M. QUIRK: The fourth paragraph on page 13 of the explanatory memorandum contains a bit of editorialising. It states —

This ability to refer is consistent with current Australian medical practice and ensures that the patient has access to the highest standard of assessment in the voluntary assisted dying process.

How can that be extrapolated from what is contained in clause 36? There is provision for referral, but I do not know how we can be assured that it will be of the highest standard.

Mr R.H. COOK: We expect a high standard from all our medical practitioners, and obviously we would expect them to carry out their work to the very highest of standards. The reason why, as the member says, they may be editorialising to that effect, is that the onus on the medical practitioner in this context is quite high, and they need to be able to make an assessment in that context, drawing upon all their studies, their clinical experience and their training.

Ms M.M. QUIRK: From what the minister is saying, that paragraph in the explanatory memorandum was superfluous or, alternatively, if the minister is saying that he expects the highest standards from the consulting practitioner, that is not necessarily mandated in this clause.

Mr R.H. COOK: Clause 36 deals with referral to determination, and I guess the explanatory memorandum is underscoring the importance of the point made in subclause (3); that is, the consulting practitioner must refer the patient to another person who has the appropriate skills and training to make a determination in relation to that matter. Obviously, we would expect the consulting practitioner to be able to form an assessment that that person is of the highest quality in order to be able to make the determination.

Ms M.M. QUIRK: That is a very convenient segue to the next question that I wanted to ask, and that is that, in the equivalent legislation in Victoria, instead of “Referral for determination”, the heading is “Referral for specialist opinion”. Section 27(1) of that act reads —

If the consulting medical practitioner is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person, the consulting medical practitioner must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.

Section 27(2) reads —

If the consulting medical practitioner is unable to determine whether the person’s disease, illness or medical condition meets the requirements of the eligibility criteria, the consulting medical practitioner must refer the person to a specialist registered medical practitioner who has appropriate skills and training in that disease, illness or medical condition.

The bill before the house is slightly less prescriptive, in that it reads, in clause 36(3) —

… has appropriate skills and training to make a determination in relation to the matter.

I think the provision relating to mental illness is a lot stronger in the Victorian legislation, and more prescriptive. What is the reason for not having the same standards or level of safeguard? Is it because, in regional and remote Western Australia, such specialists are a bit thin on the ground? Is there a particular reason why we do not have the same level of prescription as the Victorian legislation?

Mr R.H. COOK: Every time I look at the Victorian legislation, I thank goodness that I am in Western Australia. Its language is really unclear. The member may say that our terminology or our language is less prescriptive, but it is certainly no less effective, and covers the full range of issues and expertise that the consulting practitioner must refer to in order to reach a determination.

Clause put and passed.

Clause 37: Information to be provided if patient assessed as meeting eligibility criteria —

Mrs L.M. HARVEY: I refer to clause 37(2), which states —

Nothing in this section affects any duty a medical practitioner has at common law or under any other enactment.

Can the minister explain why that is in the bill?

Mr R.H. COOK: This clause does not affect a medical practitioner’s duty at common law or under any other enactment. It is not intended to displace or limit the existing boundaries of informed consent but is intended to operate as an extra safeguard alongside existing requirements.

Mrs L.M. HARVEY: Can the minister explain why it has been put in the bill? I refer to clause 37(1), which states —

If the consulting practitioner is satisfied that the patient meets all of the eligibility criteria, the consulting practitioner must inform the patient about the matters referred to in section 26(1).

Extracted from finalised Hansard
Proposed section 26(1) refers to the eligibility criteria. This reads as somewhat of a caveat. I do not understand why we need clause 37(2) in the legislation, because how could any action occurring or arising out of the requirement of the consulting practitioner in clause 37(1) have any impact on the existing boundaries of informed consent?

Mr R.H. COOK: To reiterate and to repeat, it is intended to operate as an extra safeguard alongside existing requirements. Clause 37(1), as the member observed, relates to all those issues we discussed a short while ago about the matters that must be raised or discussed with a patient. The clause is saying that notwithstanding a person meeting the requirements in clause 26(1), there may be other issues that a practitioner wishes to or should raise in the normal course of events with a patient. It is to provide extra clarity to say that just because the practitioner is undertaking the role of the consulting practitioner in the process, that does not mean that that is their only responsibility to the patient in the context of the broader range of responsibilities and obligations they have as a medical practitioner.

Mrs L.M. HARVEY: Just to be clear, when the consulting practitioner is performing the consultation with the patient to see whether they meet the eligibility criteria to access voluntary assisted dying, the practitioner would need to fulfil their role, for example, if they thought that patient had hypertension or might have an infection of some sort or whatever it might be. They would be required to fulfil their duties as a medical practitioner to ensure that those immediate needs of the patient were being cared for and managed, notwithstanding that they are undergoing a consultation to assess their eligibility for voluntary assisted dying.

Mr R.H. COOK: Let me emphasise that it is about providing information. There may be other ethical reasons that they bring up other issues, but this clause specifically relates to the provision of information. I do not know whether the example the Leader of the Opposition gave is absolutely accurate, but I think the way that she characterised it is; that is, practitioners should not think they are in a vacuum solely undertaking the role of a consulting practitioner; they still have other responsibilities and issues that they may—not “must”—wish to discuss.

Mr W.J. JOHNSTON: This provision is written in exactly the same form as clause 26(3). I was not here when that was debated and I apologise if this question was asked at that time. My question is simply: are there any examples or issues that the minister thinks might conflict with any of these other provisions? Is subclause (2) included because of some question that has arisen during the drafting of the bill that has led to the need to import the existing common law right or other enactment into this legislation, or is it just a catch-all in case something has been missed that the government does not want to dispose of? Does it make clear that the government is not trying to set aside other rights? Is that the purpose of this provision, or was something specific identified that the government wants to protect?

Mr R.H. COOK: There is no specific example but, as I said in my initial remarks, it is an extra safeguard alongside the existing requirements. The member would be aware that a specific range of issues must be discussed with the patient. This is essentially an extra safeguard to ensure that the consultant practitioner can raise other issues that ordinarily should be raised, such as issues around welfare or something of that matter. It is in there to make clear that there is absolutely no intent to limit that discussion.

Clause put and passed.

Clause 38: Outcome of consulting assessment —

Mr D.T. REDMAN: There are probably five clauses that lead up to this clause, which largely mirrors those previous five clauses that refer to the processes for the coordinating practitioner, with the exception that this clause does not contain the provision under clause 27(2). That provision refers to the instance in which the coordinating practitioner is not satisfied that all the conditions have been met for voluntary assisted dying and the process is then essentially shut down. Under this clause, in the case of the consulting practitioner, the process does not shut down then. The consulting practitioner can deem that the patient is not eligible for voluntary assisted dying. I assume that the reason for this clause not containing that last provision is that under clause 40, which we will be dealing with in a little while, the patient can then be referred to another consulting practitioner as a matter of practice. If someone going through this process has less than six months to live, they would be lucky if they get the first assessment completed, which gets them through to this stage, and then they just have to keep chasing down other consultants to get the second stage completed in order to meet the full quota, if you like, to access voluntary assisted dying. If someone has an assessment carried out by a consulting practitioner and is deemed to be not eligible, does this assessment time out or does it simply sit there until the patient gets the coordinating practitioner to refer them to another consulting practitioner to have another assessment? Does the consulting assessment time out or does it simply sit there until a referral is made to another consulting practitioner with other experience to do another assessment?

Mr R.H. COOK: In the event that the consulting practitioner forms a negative assessment, they will inform the coordinating practitioner and the coordinating practitioner will have a conversation with the patient: “What do you want to do now?” The patient might say, “Well, is there someone else I can speak to?” “Yes, I am allowed to do that, under the act, and I can now refer you to someone else to see whether they agree with me that you are eligible.” From that point of view, it is the normal course of events that that clinical relationship takes. If the patient is not happy with the outcome, they can seek a further opinion.

Extracted from finalised Hansard
Mr W.J. JOHNSTON: This is just a question of drafting. Clause 38(1)(b) refers to “section 37(1)”. If we read clause 37(1), it actually refers to the matters in clause 26(1). I just wondered why it was put that way, rather than directly back to clause 26(1).

Mr R.H. COOK: It is about understanding that the issues dealt with under clause 38(1)(b) refer to the act that takes place under clause 37. The minister is quite right; that is based upon the information detailed in clause 26(1).

Dr D.J. HONEY: The member for Warren–Blackwood has already headed down this path, so I assume it is okay with the minister if we do this because of the intrinsic tie-in with clause 40. Actually, I am happy to defer to my colleague from Darling Range if she wishes to handle these separately.

Clause put and passed.

Clause 39: Recording and notification of outcome of consulting assessment —

Mr Z.R.F. KIRKUP: I will go through the similar question routine I have been asking around all contact form requirements. Just very quickly, I think the minister already knows where I am going with a lot of this stuff, but just in case, I want to confirm again that this will be the same type of form that will be submitted, consistent with all the other forms, through the portal that has been set up for implementation.

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: Thank you. If the contact details of the patient are not fulfilled because they might not have a fixed address or an address cannot be ascertained, that does not prevent them from accessing this; is it the same thing with regard to date of birth?

Mr R.H. Cook: Yes. We just need to establish that they’re over 18.

Mr Z.R.F. KIRKUP: Sure, okay. In relation to the dates, there is no reference to a location that is required. That is satisfactory for the requirements of the board, but if it were to seek additional information at a later point in time, the CEO can amend the form with regard to things like location or anything else that is required. I think it is similar to the amendment moved by the Leader of the Opposition. In the past there have been concerns about accessibility and patients not gaining access to this data. I am keen to understand why the government has not chosen to go down that path, similar to the other forms.

Mr R.H. COOK: Again, this is the same answer I gave last time: this is not about information that we want to withhold from the patient; it is about the information that the board needs to be able to carry out its functions.

Mrs L.M. HARVEY: Further to the matter raised by the member for Dawesville, I think we raised this matter under clause 26, when we identified some other drafting errors; it will be interesting to see whether they are detected in the other place. Under clause 39, the consulting assessment is conducted with the patient, assessing the eligibility of the patient to access voluntary assisted dying. The patient is to be advised of the outcome of the consulting assessment as soon as practicable after its completion. The consulting practitioner has two business days to complete an approved form, a consulting assessment report form and a report of the assessment and give a copy of it to the board. The detail that must be included in the form, as we would expect, is the name, date of birth and contact details of the patient; the name and contact details of the consulting practitioner; a statement confirming the consulting practitioner meets the requirements of proposed section 16(2); the date when the first request was made; the date when the referral from the consulting assessment was made; the date when the referral from the consulting assessment was received; when the assessment was completed; the outcome of the consulting assessment, including the consulting practitioner’s decision in respect of each of the eligibility criteria; the date when the patient was informed of the outcome of the consulting assessment; the date when the coordinating practitioner for the patient was informed of the outcome of the consulting assessment; if the patient was referred under proposed section 36(2) or (3), the outcome of the referral—to refresh the minister’s memory, that is a referral because the practitioner could not determine whether the patient was eligible to access voluntary assisted dying either by virtue of their disease status being obscure or because there was a suspicion of coercion—and the signature of the consulting practitioner and the date when the form is signed.

It seems to me that the outcome of the referral when an individual is deemed ineligible to access voluntary assisted dying is relevant and valuable information for the patient to have. However, all that is required here—similarly at the first assessment—is that the consulting practitioner let the patient know of the outcome of the assessment, not the detail of it.

The ACTING SPEAKER (Ms J.M. Freeman): Leader of the Opposition, can you get to your question.

Mrs L.M. HARVEY: My question is: why will it not be a requirement for the consulting practitioner to provide the patient, two days after the consult, with the contents of the consulting assessment report form—the information about the patient, the private medical information that is provided to a board that is managed by government?

Mr R.H. COOK: It is the same as the answer I gave the member for Dawesville just now and previously. This clause is about what the board needs to carry out its functions under the act. Obviously, the patient will be given
a mountain of information, both this sort of information and other information on the relationship they have with the medical practitioner. This specific clause is about the obligation of the medical practitioner to share information with the board so that the board can carry out its functions.

Mrs L.M. HARVEY: I know the minister will not accept this amendment, but I will move it because it will flag that this is an issue that I would like the Legislative Council to visit and perhaps the parliamentary secretary representing the minister in that place might be more amenable to seeing improvements to the bill. To that end, I move —

Page 25, line 2 — To delete “.” and substitute —

and the patient.

I am seeking to include this, minister, because I think it is extremely important that the patient is advised and aware of all the information that the consulting practitioner provides to the board. I think it is important that all the elements of that information are made available to the patient for a number of reasons. One of those reasons is, should the consulting practitioner rule that the individual is ineligible to access voluntary assisted dying, the patient could find the information within the report quite valuable, because the patient will likely be seeking a further consulting practitioner assessment. It might be worthwhile for the patient to understand why they were refused access to voluntary assisted dying when they applied and what the consulting practitioner found within that consultation that ruled them ineligible, or, indeed, ruled them eligible, particularly around the coercion aspect. It may well be that the consulting practitioner has it completely wrong and that some nuance in the way that the patient behaved had the consultant practitioner feel that the patient had been coerced. There could be a range of matters that are relevant to a patient. Given all the information that is provided to a government agency in this day and age of privacy of information and data storage et cetera, it is important that the patient has the report containing all the information about themselves that has been made available to the board.

Earlier, when we were talking about exactly the same issue in clause 26, I made the point that a lot of doctors are very paternalistic and give patients information on a need-to-know basis and on what they perceive the patient can cope with knowing. It is done out of goodwill and I do not necessarily have a criticism of doctors behaving in that way, but I think that this information should be provided to the patient. The patient may show that information to other family members. In the context of the patient trying to access voluntary assisted dying, there may be differences of opinion amongst that patient’s family about whether it is appropriate. If that patient is furnished with a copy of a report that says that they are either eligible or ineligible to access voluntary assisted dying—the information that is provided to the board—it may well be that that patient says to one of their children, who has not been part of the process to date, “I got rejected for this and I don’t understand why”, or, indeed, they may say, “I have been accepted for this, for these reasons. I wonder what you feel about that.” It could be that coercion is not picked up and when that report is given to the patient, it may be that they seek further advice, with all the information in front of them, from another family member, who might then say, “Goodness me. Why are you talking about doing this? I didn’t know anything about this.”

I think it is very important that all the information and data collected and provided to the board, which is a government-appointed entity, should be provided to the patient as well within two business days. An email could be sent with a copy of the report. It would be really easy. I hope that the minister will consider accepting a sensible amendment.

Mr R.H. COOK: Like the Premier, I understand the intent of what the member is trying to do. I have provided what I think is a very reasonable and appropriate response. This is not about withholding information from the patient; this is about making sure that this clause has a single intent and that is to make sure that the board has the information it needs to carry out its functions. I will reflect upon a theme that seems to be emerging through this—that is, the intrinsic distrust of our medical workforce.

Several members interjected.

The DEPUTY SPEAKER: Members!

Mr R.H. COOK: A constant theme that comes through is: Would a doctor not be tempted to do this? Would a doctor not be tempted to do that? Would they not hide this information from the patients?

Several members interjected.

The DEPUTY SPEAKER: Member for Dawesville and member for Perth!

Mr R.H. COOK: The member for Dawesville might find it absurd, but it is the truth. This is based on the doctor–patient relationship that has emerged over thousands of years of medical practice, which is defined inside both the ethical and the regulatory regime in which doctors operate. In answer to the member for Dawesville when he asked whether this information would be given to the patient, I think there would be this information and much more, because that is the nature of the relationship between the doctor and the patient. I understand what the member for Scarborough is trying to say through this amendment. I respect that she wants an open system in which the patient is given all the information, but hidden beneath her argument is this constant theme. I want to know why the logic fundamentally sitting behind the comments of the member for Cottesloe and other members is that element of distrust of doctors. I think members do doctors an injustice through that distrust.

Extracted from finalised Hansard
Mrs L.M. Harvey: I have a deep distrust of the legislation because we have found drafting errors and flaws in it.

Mr R.H. Cook: Like the previous one, we will not be accepting the amendment. I respect the member for Scarborough’s intent in wanting to ensure that the system is open for patients. I reject the logic that that has driven the amendment and we will respectfully oppose it.

Dr D.J. Honey: I am used to this place and the member for Perth being offensive because he does that constantly.

The Deputy Speaker: Member, if you want to get off the subject, I will sit you down. Keep on the subject.

Several members interjected.

The Deputy Speaker: Minister!

Mr Z.R.F. Kirkup: Withdraw that now.

The Deputy Speaker: Minister, enough! Go ahead, member for Cottesloe.

Dr D.J. Honey: I am extremely disappointed by the offensive comments made by the minister in this matter. Our job here is not to assess the best possible circumstances or to assume that every medical practitioner will be perfect. Our job is to make sure that the unforeseen circumstances are captured and dealt with by this bill. That is the only point we are making on that. This constant attempt to try to verbal us on this matter —

Several members interjected.

The Deputy Speaker: Members!

Dr D.J. Honey: The constant attempt to try to verbal us or make that implication is profoundly offensive to me and my colleague and, as the member for Riverton pointed out, it is profoundly wrong. We recognise that everyone, including members in this place, has a diversity of skills and talents. We recognise that sometimes people may overtly —

The Deputy Speaker: Member, I pull you back to the point you are making.

Dr D.J. Honey: I am talking directly to this clause.

The Deputy Speaker: No, you are talking about the members. Would you talk about the clause.

Dr D.J. Honey: No, I am talking directly to the amendment moved by the Leader of the Opposition.

The Deputy Speaker: Get on with it then.

Dr D.J. Honey: The Leader of the Opposition recognises, as I do, that not all doctors provide the information to the patient. The Leader of the Opposition, the member for Scarborough, gave a personal example of when she had not received adequate information and the doctor had refused to do it. Not all doctors do the right thing in every circumstance. This is not a general criticism of doctors. It is a concern that some doctors will not always do the right thing and will not always be as well qualified in an area. That is behind this amendment, not the offensive assertion that there is any general criticism of most doctors.

Mr A. Krsticевич: I, too, would like to support this amendment moved by the Leader of the Opposition because it is about openness and transparency, which is very important. We are talking about end-of-life choices and we need to be open and transparent with patients. The minister has indicated some underlying issues, but let us not forget that the minister said there are 102 protections in this bill. He has said that many times. Who is he protecting people against? He is obviously scared of someone because he has put 102 protections in the bill, and now he is trying to imply that we are saying that we do not trust doctors, when he has 102 safeguards in there. Who is he safeguarding it from? Of course, we know they are not safeguards; they are eligibility criteria, but he is trying to sell them as safeguards.

Mr J.N. Carey interjected.

The Deputy Speaker: Member for Perth, it is late and that is not helpful. Go ahead.

Mr A. Krsticевич: This amendment is nothing more than sharing information that the patient should have. I think that is a fair request.

Mr M. Hughes interjected.

The Deputy Speaker: Member for Kalamunda!

Mr A. Krsticевич: It is very harsh for the minister to try to twist that into something other than what it genuinely is. The Leader of the Opposition expressed her views on this matter very clearly and there is no underlying message. There is always concern with every piece of legislation, because there are always people out there who will do the wrong thing. We need to make sure, especially when talking about end-of-life choices, that we put the right checks and balances in place for those one or two people who will do the wrong thing. It is more than fair to do that and to try to tighten that up. If the minister has a concern about us raising these questions, I am concerned that he has 102 checks and balances. He is obviously fearful of someone, otherwise he would not have them in
there. I hope that he will support this amendment because it is about nothing more than sharing information that should be available. It is open and transparent. I know that the government is not into that these days, but it is a good opportunity to start right here and right now.

**The DEPUTY SPEAKER:** Member for Carine, I think the minister put on record that he is not supporting the amendment.

**Mr M. HUGHES:** It is an unnecessary inclusion that a matter that is essentially reporting matters to the board should be confused by the opposition in this way.

Several members interjected.

**Mr M. HUGHES:** I am saying that about those who are clearly opposed to the substance of the bill. Making a requirement that the patient be informed of what is essentially a matter reporting a procedure to the board is a confusion. It should not in fact be allowed to infect the clarity of the purposes of this particular clause and it should be opposed.

**Mr Z.R.F. KIRKUP:** I, too, stand to support very quickly the amendment moved by the Leader of the Opposition. The matter is to remove the dot point and insert the words “and the patient”. I think it is eminently sensible, if this is a patient-centric piece of legislation, that the patient will be provided with a copy of the record that will go to the Voluntary Assisted Dying Board. That is essentially all we are asking for. As part of the orchestrated attacks from the government against members on this side who choose to try to do our jobs, I find it fascinating that the member for Kalamunda spoke of clarity at this point in time. He accused us of not being clear on this. We are very clear. All of us on this side are trying to ensure that patients will be furnished with all the information that will be relevant to them. We believe that is the reason that this amendment should be supported by the government.

**Mr M. Hughes** interjected.

**The DEPUTY SPEAKER:** Member for Kalamunda!

**Mr Z.R.F. KIRKUP:** I will not accept any attack by the minister, one of the most well rested individuals in this place who has had six hours bed rest while he was here.

**The DEPUTY SPEAKER:** I do not know that that is relevant, member.

**Mr Z.R.F. KIRKUP:** He now has an imbued spirit of energy and is attacking the opposition because we seek to do our job. I reject that entirely. We are here to support doctors and patients and their relationships. We are here to support doctors and patients.

Several members interjected.

**The DEPUTY SPEAKER:** Members!

**Mr Z.R.F. KIRKUP:** You are not even in your chair, mate! I support doctors and patients and their relationships—all opposition members do—and we hope the government accepts our amendment.

Amendment put and a division taken, the Deputy Speaker casting her vote with the noes, with the following result —

Ayes (13)
- Mrs L.M. Harvey
- Mr A. Krsticevic
- Dr M.D. Nahan
- Mrs A.K. Hayden
- Mr A. Krsticevic
- Dr M.D. Nahan
- Mrs A.K. Hayden
- Mr A. Krsticevic
- Dr M.D. Nahan
- Mrs A.K. Hayden
- Mr A. Krsticevic
- Dr M.D. Nahan
- Mrs A.K. Hayden

Noes (36)
- Ms L.L. Baker
- Mr M. Hughes
- Mr M.P. Murray
- Ms J.J. Shaw
- Dr A.D. Buti
- Mr D.J. Kelly
- Mrs L.M. O’Malley
- Mrs J.M.C. Stojkovski
- Mr J.N. Carey
- Mr F.M. Logan
- Mr P. Papalia
- Mr C.J. Tallentire
- Mrs R.M.J. Clarke
- Mr M. McGowan
- Mr S.J. Price
- Mr D.A. Templeman
- Mr R.H. Cook
- Mr J.E. McGrath
- Mr D.T. Punch
- Mr P.C. Tinley
- Mr M.J. Folkard
- Ms S.F. McGurk
- Mr R.R. Whitty
- Mr P.C. Tinley
- Ms J.M. Freeman
- Mr D.R. Michael
- Mr D.T. Redman
- Ms S.E. Winton
- Ms E.L. Hamilton
- Mr S.A. Millman
- Ms C.M. Rowe
- Mr B.S. Wyatt
- Mr T.J. Healy
- Mr Y. Mubarakai
- Ms R. Saffioti
- Ms A. Sanderson

Amendment thus negatived.

Clause put and passed.

*Extracted from finalised Hansard*
Clause 40: Referral for further consulting assessment if patient assessed as ineligible —

Mr W.J. JOHNSTON: I would like to have an understanding of why the provision is the way it is. I understand exactly why the government wants to allow the referral for a second assessment. I am not raising that as an issue. Given the eligibility criteria, there are matters that require a medical opinion as required by clause 15(1)(c). I fully understand why the government is asking for effectively a second opinion from another consulting practitioner. But in respect of the matters that are provided for in clause 15(1)—for example, the age of a person—why would matters in clause 15(1)(b) be referred to a new consultant? The point here is that if the consulting practitioner finds that there are matters in respect of clause 15(1), other than those in paragraph (c), why would those matters need to be further considered by another consulting practitioner—effectively, the non-medical issues? Why would it be better to have a second person’s opinion on those matters of facts rather than the medical opinions that are outlined in paragraph (c)?

Mr J.R. QUIGLEY: Instead of having a discrete itemisation of everything in clause 15, it just says that the patient can go off and get a second opinion. It is hardly likely that they will need a second opinion on their birth certificate or address. The first doctor who is the coordinating doctor has to be satisfied that on the balance of probabilities the terminal illness will cause death within six months. He might need a second opinion as to whether the patient fits that eligibility criteria—send him off; send the file off. They just need to send off the file. They will not cut the file out and just look at a little bit. The file will be sent to the doctor, as it was in the first case, to get a second opinion. That is the government’s position.

Mrs A.K. HAYDEN: Following that line of questioning, this clause will enable the consulting practitioner to assess the patient as ineligible to access voluntary assisted dying. The patient’s coordinating practitioner may then refer the patient to another medical practitioner. One practitioner may say that the patient is ineligible and the coordinator can refer the patient to another medical practitioner to get further consultation assessment. How many times can this referral be passed on if the patient continues to be found ineligible by a consulting practitioner? How many times can that be repeated?

Mr J.R. QUIGLEY: The clause is consistent with any person seeking a second or even third medical opinion from different doctors. It is a basic component of Australian health care that people obtain a second opinion of their volition. If the consulting practitioner receives a request and assesses the patient as ineligible because in his or her opinion, on the balance of probabilities, death will not occur within six months, the patient can be sent off for a second opinion to see whether the consulting practitioner has made the right call. The person is suffering so send them off for a second opinion; send the file off for a second opinion. If it comes back, “Don’t know, we’ll get another haematologist to check it again”, what is the problem? There is no problem there. People can voluntarily take as many opinions as the member can on her health, dental health or anything as she cares to do. Why should a person who is dying not have the same rights in respect of their health?

Mrs A.K. HAYDEN: From my understanding, the Attorney General has just said, basically, that the consulting practitioner can keep referring to a medical consultant, until they find someone who says, “Yes, this person is eligible.” That could be done two times, four times, 10 times, 100 times or 200 times. There is no limit; the person can keep referring. At some point, this process must be exhausted, otherwise it is just doctor shopping; they can keep going around until they find a doctor who says yes. If 200 doctors say, “No, that is not correct”, and they finally get one who says yes, I am guessing that the 200 doctors who said no would be the safer bet to go with.

Mr J.R. QUIGLEY: That would be an impossibility, as the member would well appreciate. The person will need to be, within the balance of probabilities, six months from death, which, by my count, is 183 days. To suggest that they would go to 200 doctors in 183 days is preposterous.

Ms M.M. QUIRK: Attorney, I have never looked as closely at an explanatory memorandum as I have for this bill, because, yet again, there is an assertion in the explanatory memorandum that does not match up with the actual wording of the bill. It states —

Where a further consulting assessment is required to be done, it must be done independently of the first assessment and previous consulting assessment, against the eligibility criteria at clause 15.

That is not in the bill itself.

Mr J.R. QUIGLEY: There is no express reference in the bill to the first and second assessments as being independent.

Ms M.M. Quirk: Yes.

Mr J.R. QUIGLEY: However, it is implicit, because of the following reasons. First, each of the coordinating and consulting practitioners must assess the patient as eligible for access to voluntary assisted dying. I refer the member to clauses 23 and 34. Second, the second assessment cannot take place until after the patient has been assessed as eligible to access voluntary assisted dying by the coordinating practitioner and referrals made to the consulting practitioner. I refer the member to clause 29. Third, a patient cannot be assessed as eligible for access to voluntary assisted dying by a coordinating or consulting practitioner unless that practitioner is satisfied that the patient meets
Mrs L.M. HARVEY: I draw the Attorney General back to what he said previously. Clause 40 states—

If the consulting practitioner assesses the patient as ineligible for access to voluntary assisted dying, the coordinating practitioner for the patient may refer the patient to another medical practitioner for a further consulting assessment.

The patient is assessed against the criteria in clause 15, which we have already passed. One of the reasons that a patient may be ruled ineligible is because it is deemed that the person is not acting voluntarily or is being coerced. If a coordinating practitioner sends a patient to a consulting practitioner, and the consulting practitioner says he thinks the patient is being coerced and is ineligible, the coordinating practitioner can then refer the patient to another consulting practitioner to get a different view; and, if they also deem that the patient is ineligible because they are being coerced, the coordinating practitioner can then send the patient to another consulting practitioner, who may well say they think the patient is being coerced. How many times can that happen in this process?

The DEPUTY SPEAKER: I think we have already answered that question.

Dr D.J. Honey: No, we haven’t.

The DEPUTY SPEAKER: My apologies. I thought it had been asked and answered. Attorney, would you like to tackle that one?

Mr J.R. QUIGLEY: Certainly. We have to focus on not the doctor, but the patient’s right. We have to focus on the dying person’s right. If the dying person wants to go to more than three doctors, that is the choice of the dying person. We are not talking about a healthy person; we are talking about someone who is approaching death. If they want to go to three, four or five doctors, I do not think it should be within this Parliament’s prerogative to say to a dying person that they are not allowed to go to more than one doctor. I do not think that is fair. With all due respect, and I do not wish anything upon her, but should the Leader of the Opposition feel unwell, she can go to as many doctors as she likes to have her unwellness diagnosed. Why should a dying person be in any worse position than her good self?

Mrs L.M. HARVEY: If I were unwell and went to a doctor, the scenario might be somewhat different. I might be going there for a treatment option that does not involve asking that doctor to assist me to die. If I go to a coordinating practitioner and they send me to several consulting practitioners who say that they disagree with the coordinating practitioner and that the patient is being coerced, surely this legislation compels a responsibility for the coordinating practitioner to do something to protect the patient, who has been found by a consultant practitioner to be being coerced. Surely, if they thought that undue pressure was being applied to a patient who is seeking to end their life via voluntary assisted dying, there is a responsibility for the coordinating practitioner to respond to that and not refer the patient on until the pressure of the coercion has been addressed. I seek the Attorney General’s advice about how that might be dealt with.

Mr J.R. QUIGLEY: That will be dealt with by three of the 102 safeguards. First of all, the terminally ill patient has to make a request and then be assessed. As soon as that person is assessed, that information will go to the board. Then the consulting practitioner’s diagnosis—we have already dealt with that in the previous amendment—will have to go to the board. We will get to the board’s duties later, but if assessments come raining in across the desk that Johnny has gone to this practitioner or that practitioner and it is changing all the time, the very purpose of the board is to look at what is going on in that case. The patient could seek a second opinion or perhaps a third opinion, but if there are more than that, the registrar at the board should decide to look at it. That will be its job. That is our second safeguard. The third is that the patient—bearing in mind that this whole legislation is about confering rights upon those who are dying and horribly suffering in agony or those who are mentally suffering. The patient is assessed against the criteria in clause 15, which we have already passed. One of the reasons that a patient may be ruled ineligible is because it is deemed that the person is not acting voluntarily or is being coerced. If a coordinating practitioner sends a patient to a consulting practitioner, and the consulting practitioner says he thinks the patient is being coerced and is ineligible, the coordinating practitioner can then refer the patient to another consulting practitioner to get a different view; and, if they also deem that the patient is ineligible because they are being coerced, the coordinating practitioner can then send the patient to another consulting practitioner, who may well say they think the patient is being coerced. How many times can that happen in this process?

The DEPUTY SPEAKER: Member, just before you start, I want you not to repeat the same question again.

Mrs L.M. HARVEY: No, I will definitely not.
The DEPUTY SPEAKER: Good, because we have had three goes at it, so let us move on.

Mrs L.M. HARVEY: I seek further clarification on this process, and perhaps the Attorney General’s advisers can tell me whether these safeguards are further along in the bill where the responsibilities of the board are examined. We have a coordinating practitioner who assesses a patient who is eligible to access voluntary assisted dying. They find a consultant practitioner.

Mr J.R. Quigley: Who assesses them and says that they are eligible.

Mrs L.M. HARVEY: The practitioner says they are eligible and sends the report to the board. The coordinating practitioner then refers the patient to a consultant practitioner, the consultant practitioner assesses the patient is ineligible because they believe the patient is being coerced, and that report then goes to the board. This clause says that they have been rejected for access to voluntary assisted dying, but the coordinating practitioner can send them to another consultant practitioner. Once the patient has gone to the consultant practitioner and the report is with the board, the coordinating practitioner can then send them to another consultant practitioner who may assess them as ineligible because they are being coerced, and that report goes to the board. I know the Attorney General is coming at this from the perspective that the patient wants to find a consultant practitioner who agrees with them, but if the patient is being coerced, are they exercising their right to voluntary assisted dying freely or are they being coerced? That is what we need a safeguard for. I need some reassurance from the Attorney General on this legislation that once the consultant practitioner files the report with the board saying they have ruled the patient ineligible because they think they are being coerced, whether the board then needs to take some action with the coordinating practitioner and the patient to resolve the cloud of potential coercion before the patient goes to another consultant practitioner who may or may not think they are being coerced. In that case, if this process takes nine days, depending on how quickly the board acts, the patient could have accessed voluntary assisted dying, and potentially nobody would have investigated whether the individual was being coerced into accessing it. Does the Attorney General understand?

Mr J.R. Quigley: I do understand. I know I am a traffic lawyer who got lucky, but I can understand that point!

Mrs L.M. HARVEY: I meant no disrespect to the Attorney General’s intelligence. I wanted to understand that I had articulated my point.

Mr J.R. Quigley: I did not take any. I was just saying that I do understand. I am a traffic lawyer who got lucky, but I do understand that!

The DEPUTY SPEAKER: Attorney, did you want to respond to that? My understanding is that the member for Darling Range was going to —

Mrs A.K. Hayden: No.

The DEPUTY SPEAKER: Okay, no.

Mr J.R. QUIGLEY: The member seeks reassurance and I give her reassurance, because it goes off to the consulting practitioner. As I said before, it is the duty of the board. If different opinions are coming onto the registrar’s desk—there will not be thousands of these a year; they will be limited in number—and if, in relation to one file, things come in raising the issue of coercion, the registrar will step in and say, “What the heck’s going on here?” That is why we have these safeguards.

Mrs L.M. HARVEY: Do they step in after the first one?

Mr J.R. QUIGLEY: That is why we will have contemporaneous, not ex post facto, reporting to the board, so the board will be able to see in real time what is happening with the doctors. The member for Cottesloe may not agree with the legislation, but I am sure he would agree that 102 safeguards are better than 58.

Mr P.A. KATSAMBANIS: In the Attorney General’s first response to the Leader of the Opposition, he indicated that the opportunity for a patient to seek a further consulting assessment was part of the general rights that a patient has to seek second, third and subsequent opinions on all types of medical treatment. I want to examine that statement by reference to the words of clause 40, which states —

If the consulting practitioner assesses the patient as ineligible for access to voluntary assisted dying, the coordinating practitioner for the patient may refer the patient to another medical practitioner for a further consulting assessment.

As I read that, the patient has no right to request a further consulting assessment. The patient has no right to undertake a further consulting assessment. The right in this clause is conferred solely on the coordinating practitioner, who may or may not choose to exercise that right. In that respect, that is not a right conferred on the patient. That is not a right for the patient to seek a second, third or subsequent opinion; it is an option available to the coordinating practitioner. That is the plain and simple reading of this clause. Given that is the case, on what basis would the coordinating practitioner determine not to refer the patient to another medical practitioner for

Extracted from finalised Hansard
a further consulting assessment; and, if the coordinating practitioner did so determine not to refer the patient for a further consulting assessment, what steps would the coordinating practitioner have to undertake to inform the board, and under what clause would those steps be taken?

Mr J.R. QUIGLEY: Thank you. I agree with all of the above.

Mr P.A. KATSAMBANIS: So the Attorney General was wrong.

Mr J.R. QUIGLEY: No, I was not; I was right!

Mr P.A. KATSAMBANIS: No, you were totally wrong.

Mr J.R. QUIGLEY: I will prove it.

Several members interjected.

The SPEAKER: Members!

Mr J.R. QUIGLEY: I said it is conferring a right. This bill confers —

Several members interjected.

The SPEAKER: Members! That is a good idea. Go ahead, Attorney General.

Mr J.R. QUIGLEY: Calm the farm. The bill itself confers that right. I say that it confers a right upon the dying patient. The bill itself confers that right and gives that patient the power. Clause 40 states —

If the consulting practitioner assesses the patient as ineligible for access … the coordinating practitioner … may refer the patient to another medical practitioner …

Under the Interpretation Act 1984, “may” is to be interpreted as permissive and not compulsory, so the discretion lies with the coordinating practitioner. Under this legislation, the patient has the right to terminate the whole process and say, “I’ve gone to a dud doctor. I terminate the process.” This is about patients’ rights. At any time in this whole process, right up until the time of consuming the substance, the patient has the right to terminate the process. Once having terminated the process—this is not like the Court of Appeal or the High Court, where people get one crack—the patient is conferred the right to go to another doctor and make an application. He can make an application to a second doctor and the second doctor has to do an assessment and that assessment has to go to the board, and the board would say, “Woo hoo, we’ve got conflicting assessments here. We’d better have a look at this.” There might be only one or two of these a week. We do not expect everyone to go charging off. A lot of people—perhaps myself; I have looked down the barrel—would rather take a different option. But I am not here to put my beliefs into law. I am here to legislate, and the government is here to legislate, for the majority of Western Australians, and that is the 88 per cent of Western Australians who want this bill. If the patient does not like what the doctor is doing and how the doctor is treating him, he can do exactly what the member can do—terminate the relationship and start a new relationship. What is wrong with that?

Mr P.A. KATSAMBANIS: I want to follow up on this. It was great rhetoric, but I did not get an answer to my question. If the consulting practitioner chooses not to refer the patient for a further consulting assessment, do they have to do anything else? Do they have to inform the board; and, if so, in what way and in what form will they do it? Or is it simply a case that the matter will just expunge itself because the board has received an initial affirmative from the coordinating practitioner and then a negative from the consulting practitioner and then they just sit there and as the coordinating practitioner has taken a decision not to refer the patient for a further consulting assessment, it just ends there and the patient can then do exactly what the Attorney General said and go back to the start and seek a new coordinating practitioner? Is there any obligation on the coordinating practitioner to communicate any further with the board when the decision is made by the coordinating practitioner not to refer for another consulting assessment?

Mr J.R. QUIGLEY: It does not end just there, because when the consulting practitioner assesses the patient as being ineligible and goes back to the doctor, he would say, “I’m now ready to go to stage 3. Give me the written form that I sign” and the doctor would say, “I can’t do that because you’ve got a negative assessment from the consulting practitioner.” That is another Labor safeguard. It is another of the 102 safeguards. They would go back to the coordinating practitioner and say, “I’ve been to your mate. I’m ready for the next step; where’s the form?” and the coordinating practitioner would say, “No, I can’t give you a form because the consulting practitioner said no.”

Mr J.E. McGrath: But then the patient would say, “What do I do now?” and he would get some advice. What advice would he get? Would the coordinating practitioner say, “We can send you to someone else”?

Mr J.R. QUIGLEY: If it is all right with you, Madam Deputy Speaker —

Mr P.A. KATSAMBANIS: I’m asking about the coordinating practitioner. I want an answer. I’ve asked it twice. I think I deserve it.

The DEPUTY SPEAKER: Members, can we just let the Attorney General answer.
Mr J.R. QUIGLEY: I have given the member the answer.

Mr P.A. Katsambanis: No; I’ve had no answer—none.

Mr J.E. McGrATH: All I am saying is that in this process there would have to be contact between the person seeking approval and the coordinating practitioner. The coordinating practitioner would make contact and would call the person to come in. They would say, “You’re in a bit of trouble here because although I support what you want to do” —

Mr J.R. Quigley: Not “I support what you want to do”—can I just get the language right—“I assess you as being eligible under 15(1)(c) for the criteria.”

Mr J.E. McGrATH: All right. He would say, “I’ve assessed you, but your problem is that the consulting practitioner who we sent you to disagrees.” The person would then say, “That’s not much good for me. What can I do now?” I would have thought that at that stage the coordinating practitioner would say, “Do you want to go further? Shall we find another practitioner for you to go through the process again or do you want to forget it?” That is how I think it will work. I guess the question here is: how many times can this happen? The Attorney General has said there can be a second, third and fourth opinion. Every time one of those opinions is sought, an assessment will be made and that would have to go to the board.

Mr J.R. Quigley: Correct.

Mr J.E. McGrATH: There would be a trail of what has happened.

Mr J.R. Quigley: Correct.

Mr J.E. McGrATH: Somewhere in the board’s assessment, it would have to acknowledge that something has gone wrong—“This guy’s been given a negative assessment three or four times.” That is what we are asking about when people talk about doctor shopping: Is the Attorney General happy with how this is going to work? Can he assure the chamber that the process will make sure that a person who just shops around until they find someone who gives them that right cannot do that because that would be wrong?

Mr J.R. Quigley: I agree with everything the member for South Perth has said. He is able to go to 10 doctors if he wants. He can doctor shop. We know that people doctor shop. They doctor shop for things like codeine and different drugs to manufacture hillbilly heroin or whatever they call it. They doctor shop.

Mrs L.M. Harvey: So you’re saying they can doctor shop to access voluntary assisted dying?

Mr J.R. Quigley: No; that is what happens normally. In normal situations, people doctor shop and there is no oversight of that doctor shopping. But in this case, if a doctor says no, that “no” will go to a statutory authority. If they go doctor shopping and get a second no—on coercion—what do members think the registrar will do? The registrar has a statutory duty to do something. It is different from the normal situation, in which the member can doctor shop freely as many times as he likes. Under this bill there will be an oversight body—one of Labor’s 102 safeguards—that inhibits doctor shopping because the registrar will step in and investigate. As I said, no-one is anticipating thousands of these a year. This will be handled. Victoria is starting to get some vision on this at the moment. Projecting out from the numbers Victoria has at the moment, it is anticipating approximately 150 a year. Western Australia has half the population; we might get less than 100 a year, or less than two a week. That means the registrar will be getting two of these a week. If one of those files has four rejections because of doctor shopping, what does the member think the registrar is going to do?

A member interjected.

Mr J.R. Quigley: The chair of the board. What will the chair of the board do if he is looking at a file—today, no; tomorrow, different doctor, no; the third day, doctor shopping, no? We do a similar thing in pharmacy, because when people buy drugs now that contain codeine and its derivatives, it is entered on a computer, and when someone goes down the road pharmacy shopping, it pops up. This is a more sophisticated level of that type, because it involves the chair of the board.

The DEPUTY SPEAKER: Members, I am not taking any more questions on this. I think we have done this to death. If we have a fresh question on clause 40, I am down with that. Go ahead, member for Carine. He was already on his feet; sorry, member for Dawesville.

Mr A. KRSTICEVIC: Right at the very start of the debate here, the member for Girrawheen raised the issue of the independence of the practitioners and the fact that it is not mentioned anywhere in the bill. The Attorney General then got up and agreed with the member for Girrawheen, saying that it was not mentioned anywhere in the bill that the practitioners need to be independent. We have confirmation from both sources that there does not have to be independence there. The Attorney General then said that there are three processes that each doctor goes through to make that decision, and those processes themselves are what determines the independence of these doctors. Of course, we have also heard that these practitioners could be in the same practice, and in the same consulting rooms, using the same database and referencing the same materials, and the second practitioner could just as easily, then,
access not just the same materials as the first practitioner, but also the decisions made by the first practitioner. I am a bit concerned about the fact that the bill does not actually have any independence in it. The minister has indicated the processes that we need to go through, but in all three processes they can refer to exactly the same information, and the second practitioner can actually refer to the notes of the first practitioner. I just want clarification around that point, because I do not see any independence in that.

Mr J.R. Quigley: As I pointed out, there are three areas in the bill that necessarily involve independent assessment. When the member refers to accessing the same information, he is quite right. A brain tumour is a brain tumour by any other name. Who said that? Was it Evelyn Waugh? A rose is a rose by any other name. A brain tumour is a brain tumour by any name it is called. The doctors will be accessing the same information. They will be looking at the same X-rays, CT scans, blood count—the same information—in the two independent assessments.

Mr A. Krsticevic: Just today I was reading online about a young lady who was assessed as having cancer, and seven months after she was assessed as having cancer, the doctors found out that they had made a mistake and she did not have cancer. They did not make the assessment properly; they were not looking at the symptoms properly. We need to look at all the symptoms, causes and issues concerning a particular diagnosis, because there are plenty of examples when practitioners got it wrong because they did not look at the information properly. The minister is saying that because the doctors are all looking at the same information, they will come to the same assessment, but if that is the case, they are not really looking at the symptoms properly because there are plenty of misdiagnoses going on, including of cancer. We know of many circumstances when people have gone through lots of pain and suffering to undertake treatment and operations and are subsequently found not to have had cancer. They have been forced to go through that whole process, and it is devastating. If two doctors are referring to the same database and the same criteria—not just the scans, but all the symptoms—and they look at them independently, one doctor might say it is a migraine and another might say it is a brain tumour. There are examples of that.

Mr J.N. Carey interjected.

The Speaker: Member for Perth!

Mr A. Krsticevic: They are online now, and the member can look at examples. I will show the member. Several members interjected.

The Speaker: I am on my feet. Members, please, through the Chair.

Mr A. Krsticevic: It is very important to make sure that these assessments are independent and that they look at all the information, not just the scans, and determine something in there, because the scans might not be accurate, for whatever reason. There is an actual example now, online, of a woman in Australia who has suffered this exact circumstance. It took seven months for the doctors to determine that she was not actually suffering from cancer, and the operation she had was not appropriate. I want to make sure that there is that independent assessment, and the doctors are not just automatically taking the central information that is available to everybody without looking at it properly.

Mr J.R. Quigley: She did not have brain cancer, for a start.

The Speaker: I am sorry; I will just introduce you.

Mr J.R. Quigley: Thank you. We have known each other for 18 or 19 years, but I am pleased to meet you! I say that with all due respect, Mr Speaker.

Let me use the example of a brain scan—so let us not talk airy-fairy. The member has decided not to tell us what this woman’s condition was that could not be determined. I know some conditions that women have cannot be determined by scans. For example, endometriosis, in which cells grow outside the uterus, cannot be diagnosed through a scan; it has to be diagnosed through an endoscopy. These days brain cancer can be diagnosed through a scan. The member says, “They have to have a better look at it.” In the olden days, they had to cut off the top of a person’s head, lift off the lid, have a dip in there, put it on a tray, have a dip in there and see whether what they were touching was a brain cancer. That is what they used to do. My friend, a very incredible, brilliant surgeon died of brain cancer. It raised with me the possibility of viral infection. However, that is what they used to do. Now they can do it with a scan. When the member said, “examining the same data”, let us not use the word “data” loosely; it is examining the same results from diagnostic testing.

Dr D.J. Honey: I have only two very simple questions to finish any inquiries I have in relation to this clause. The Attorney General may have said this and I —

Mr J.R. Quigley interjected.

Dr D.J. Honey: Sorry; I was not sure whether the Attorney General was having a conversation. The Attorney General may have answered this question and I may have missed it. If the coordinating practitioner goes to a consulting practitioner and gets a negative assessment—that is, the consulting practitioner says that this person is not eligible —
Mr J.R. Quigley: Can I interject?

Dr D.J. Honey: Yes, I am happy for the Attorney General to interject.

Mr J.R. Quigley: The coordinating practitioner does not go to the consulting practitioner, the patient does.

Dr D.J. Honey: It was my understanding that the coordinating practitioner would appoint the consulting practitioner.

Mr J.R. Quigley: Correct; they may refer.

Dr D.J. Honey: Yes—may refer. I appreciate that and thank the Attorney General for that distinction.

The patient goes to the consulting practitioner and the consulting practitioner says that the patient is not eligible. Then the coordinating practitioner says, “I don’t accept that.”

Mr J.R. Quigley interjected.

Dr D.J. Honey: I am happy for the Attorney General to clarify this because I want to have it clear in my mind.

Then the coordinating practitioner directs the patient to another consulting practitioner who is an expert in the same field. They come forward and say that the patient does meet the criteria. How does the coordinating practitioner decide which opinion they should choose?

Mr J.R. Quigley: We have to once again focus on the patient’s rights. One of the criteria is that the patient is enduring —

Several opposition members interjected.

The Speaker: Member, go outside if you want to have a meeting. Your members cannot hear what the minister has to say.

Mr J.R. Quigley: We have to focus on the patient’s rights. The coordinating practitioner is not a judge of their rights. It is an assessment of criteria. The coordinating practitioner assesses the criteria as having been met, and sends the patient off to a consulting practitioner. The consulting practitioner says, “No, you don’t meet the eligibility criteria.” Where I was going to interject, member, is that when—focus on this—the consulting practitioner has said no, they have to immediately send that assessment off to the board. That is the next step. It goes back to the coordinating practitioner who then says, “The consulting practitioner disagrees with me. You don’t meet the criteria. I am sending you off to another consulting practitioner for a second opinion, if that’s what you want.” The patient is not put in a black maria—they do not use that word these days, do they? The member has heard of it, of course. It was the English prison van that used to take prisoners from the courts—the black maria. The member for Cottesloe is old enough to have heard the term. They do not put the patient in the black maria and take them to a consulting practitioner. The patient is asked if they want a second opinion. If the patient wants a second opinion, the coordinating doctor at that point says, “This assessment is so strong, I’m not going to send you off for a second opinion”, not “I must send you off for a second opinion”, and that is the end of the process. The patient says, “I’m outta here.” The patient then has the rights that the member has to go to another general practitioner and apply for another assessment. As soon as that is done, contemporaneously it goes to the board and the chairman says, “Hello, hello. What’s going on here? Last week I had an assessment from a coordinating practitioner who says that he’s okay—he’s assessed. I’ve had another report from a consulting practitioner that says he’s not eligible, and then suddenly on my desk arrives a fresh application from a completely new GP who says he’s just assessed the patient.” It is the responsibility of the chairman of the board to question what is going on. We are providing that as a safeguard to protect this doctor-shopping concept. The coordinating practitioner will say, “It’s all over because I’m not sending you on. It is such a clear-cut case that you’ve got the flu and not lung cancer, so I’m not sending you on.” The obstinate patient says, “I still think it. I want to go and get a second opinion.” They can do that, and they can end it. We must focus on the rights of the —

An opposition member interjected.

Mr J.R. Quigley: Was the member looking at my haircut?

The Speaker: Come on, member; no.

Mr J.R. Quigley: We have to focus on the rights conferred by the legislation on the ailing patient. That is the focus of this Parliament and the focus of this bill.

Dr D.J. Honey: I think I understand that part, but it is my understanding—I would be grateful if the Attorney General can educate me further on this—that the coordinating practitioner can recommend that the patient go to a second consulting practitioner. In that case, the second consulting practitioner comes back with an opinion that is different, in that the second consulting practitioner believes that the patient is qualified to access voluntary assisted dying. How does the coordinating practitioner choose? There is one opinion that says they are not eligible and another that says they are. How do they choose? That was my question, and I want to explore the safeguard that the Attorney General has mentioned, but I ask him to explain that to me. How do they choose between those two opinions—or do they choose?
Mr J.R. Quigley: They do not have to choose. The coordinating practitioner has assessed them as eligible and sent the form off to the board. The consulting practitioner has said they are ineligible and sent that off to the board. The coordinating practitioner, after receiving that information, says, “I can’t give you the written consent form because you don’t qualify”, and may send them off for a second opinion. The second opinion is that the person is eligible. Once that happens, the person is eligible; it is not up to the doctor to choose. The patient has rights under this bill, and once the patient has met all the criteria of the bill, we can go to the next step, which is another one of Labor’s 102 safeguards—requesting the written form.

Dr D.J. Honey: The Attorney General can see the concern we might have with that and the concern about whether doctor shopping might arise. If there is an especially sympathetic coordinating practitioner—

Mr J.R. Quigley: We hope so.

Dr D.J. Honey: I hope they are all sympathetic, but in this case, sympathetic to the case. Obviously they have got to the point at which they believe the patient qualifies. In that situation they can simply keep on going—as the Attorney General has described, and I appreciate the clarity of his description—until they find an opinion that agrees with their opinion, and they can progress. I believe that is clear, but I will be happy for the Attorney General to clarify. That then goes to the protection the Attorney General believes is offered by the board. The board can have oversight of this process at each stage. At each assessment, a report goes to the board, so the board is seeing the process; it is not invisible and there is nothing going on in the background. Where does the power for the board derive? I hope the Attorney General can go to this point. The only power I can see is under clause 118, under which the board has all the powers it needs to perform its functions. Without that, all the other clauses are just functional clauses. How does the board have any power to intervene in this process?

Mr J.R. Quigley: With respect, I do not choose to answer that question at this time because that question will, I expect, be mined deeply when we get to clause 117(c), which covers the powers of the board.

Mrs A.K. Hayden: We have actually discussed this at some length and I would like to move an amendment to the clause. The Attorney General will be able to speak to the amendment and we can keep going afterwards. We have outlined the situation in which the consulting practitioner knocks back a patient because they are ineligible but the coordinating practitioner can continue to try to find a consulting practitioner until they find someone who is able to accept the application. The Attorney General said that that is not a problem—

The Speaker: Member, are you going to move an amendment and then talk to it?

Mrs A.K. Hayden: Sorry, absolutely, Mr Speaker. I move—

Page 26, line 6—To delete “assessment.” and substitute—

assessment no more than three times.

I move that amendment because we cannot have doctor shopping continue exhaustively until they finally find a doctor or consulting practitioner who is prepared to tick off what four, five or 10 other practitioners have not ticked off. The Attorney General indicated that the eligibility involves having an illness that will cause death within six months. However, that is not the sole eligibility requirement. It also requires a person to be over the age of 18, to be an Australian citizen or permanent resident and to have been living in the country for at least 12 months. However, more important, and the biggest concern we all keep raising, is the possibility of coercion and, as we heard from the member for Armadale with his amendment, anyone with a disability. As he said so eloquently, his daughter is at Ames to Please. We do not want anyone caught up in this. If someone has not backed that eligibility, the ability for someone to shop around until a practitioner is found who is prepared to tick the box is simply not good enough. It is not a safeguard. That extra safeguard needs to be included because, in my opinion, if three consulting practitioners say that it does not meet the eligibility requirement, there has to be a point at which people stop shopping until someone is finally found who is happy to tick the box. This is not about any normal referral system or access to treatment; it is about someone having access to end their life. It needs to be taken far more seriously than it is being taken at the moment.

Mr J.N. Carey: It is being taken seriously.

The Speaker: Member for Perth, it was you that time.

Mrs A.K. Hayden: This clause needs to be taken far more seriously than it has been taken.

As I said, it is not about someone’s illness being assessed as causing them death within six months; it is far more than that. It is also about whether the patient is capable of decision-making. Attorney General, we asked the Minister for Health—I note that it is quarter past four in the morning, so my memory may not recall exactly—what will happen to the reports that are sent to the board for oversight and he said they were for data collection. He did not say they would indicate, “Hey, we need to stop shopping around until we find a box.” He said it was about data collection. When we asked what the board would do with it, he said that the government has not worked that out yet; it will be determined after the legislation has been passed. That is my recollection.

Extracted from finalised Hansard
Several members interjected.

The SPEAKER: Members, please!

Mrs A.K. HAYDEN: Do you know what, at quarter past four in the morning, that is an issue and we are debating legislation that will enable someone to take their life.

Mr M. Hughes: Oh!

Mrs A.K. HAYDEN: Do not “Oh” me, member for Kalamunda. Does he think it is serious that someone could be coerced —

The SPEAKER: Member, I am on my feet. I am not a shortie. Through the Chair, please. No interjections, thank you.

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

Mrs A.K. HAYDEN: The issue is that only one person needs to be coerced; only one person needs to slip through the gaps.

Mr M. Hughes interjected.

Mrs A.K. HAYDEN: If the member for Kalamunda says anymore, I think he might pass out.

The SPEAKER: Member, through the Chair, please.

Mrs A.K. HAYDEN: If one person slips through the gaps, that will make this legislation disgusting. That is what we are talking about here. My issue is the information that I recall—at quarter past four in the morning. If I do not recall it correctly, it is because we should not be debating it right now; we should be doing it in the normal business hours. With all of that, with the oversight of the board, we are not sure exactly what its duties will be. I believe we were told that it will be done after the passing of this legislation. I move that we put that extra safeguard in there so it cannot be referred more than three times.

Dr D.J. HONEY: Attorney General, I am not going to belabour this point. I think we have covered this in some detail. I want to reinforce the concern that this seems to be a one-way street. If a coordinating practitioner believes absolutely that a patient should access the voluntary assisted dying process, they do have the capacity to keep going. In the absence of knowing how the board can intercede in this process—the Attorney General has said that we will consider that later, and that is fine in the normal course of events—what we are trying to do here is to have some reasonable control. I appreciate that a patient may have more than one condition. They may have two conditions, so it may be that one condition is not going to enable the patient to meet the criteria, but the second condition would and it may be appropriate that that is referred to a second person. But I think that, in this case, having three referrals allows for reasonable exploration by the coordinating practitioner of a patient’s issues. Let us say we have an urbane Dr Nitschke who is a passionate advocate for this and feels very, very strongly that this has to go ahead for this patient and that they can just keep going. As I said, it seems to be a one-way street until we know the capacity of the board to intercede in this, and we have not heard that; we have heard only the assertion that it would be possible. Until we know that, we have to be certain there is some control over the number of times that a coordinating practitioner can keep going to obtain an opinion that suits their own opinion.

Mr J.R. QUIGLEY: I will be brief in my reply. First, with the greatest respect, member for Darling Range, I would like to correct you that they are accessing a substance that is going to kill them. This is not right. What is going to kill them is the disease that they have. Under clause 15(c), it has to be a terminal disease that on the balance of probabilities is going to kill them within six months. Therefore, they are not accessing a substance to kill them; they are being killed by a growth within their body. That is the first point, so it is wrong to say that. Second, as to the functions and powers of the board, you say, “We don’t know what they are.” That is the pity that just evidences that in all the time in the three or four weeks that this bill has been before the Parliament, you have not read it.

Mr P.A. KATSAMBANIS: I will be brief. I think that the member for Darling Range has articulated the position about this amendment very well. This is a matter of ensuring the integrity of the entire regime that is being proposed, and this amendment would add some integrity to that process. In particular, it would add an additional safeguard to vulnerable people. I think that an opportunity to get a second assessment on three separate occasions is more than sufficient to ensure that there is not a rogue diagnosis or a misdiagnosis. To not provide some form of limit would open up the regime to abuse and, as the member for Darling Range rightly said, one instance is one too many. Therefore, I am happy to put on record that I support this amendment.

Mr J.R. QUIGLEY: This will be the last that I say on this amendment. Members of the opposition who now want to speak on it can speak on it, but the government will not further reply. The member talks about integrity. If the government were to accept this amendment, the member for Darling Range would still vote against the bill. She voted against the bill at the second reading stage. If the government accepted this amendment, she would still vote against the bill containing her amendment. That is a lack of integrity, and the government does not wish to further debate.
Amendment put and a division taken with the following result —

Ayes (14)
Mrs L.M. Harvey  Mr A. Krsticevic  Ms L. Mettam  Ms M.M. Quirk
Dr D.J. Honey  Mr S.K. L’Estrange  Dr M.D. Nahan  Mrs A.K. Hayden (Teller)
Mr P.A. Katsambanis  Mr R.S. Love  Mr D.C. Nalder
Mr Z.R.F. Kirkup  Mr W.R. Marmion  Mr K. O’Donnell

Noes (36)
Ms L.L. Baker  Mr M. Hughes  Mr M.P. Murray  Ms J.J. Shaw
Dr A.D. Buti  Mr D.J. Kelly  Mrs L.M. O’Malley  Mrs J.M.C. Stojkovski
Mr J.N. Carey  Mr F.M. Logan  Mr P. Papalia  Mr C.J. Tallentire
Mrs R.M.J. Clarke  Mr M. McGowan  Mr S.J. Price  Mr D.A. Templeman
Mr R.H. Cook  Mr J.E. McGrath  Mr D.T. Punch  Mr P.C. Tanley
Mr M.J. Folkard  Ms S.F. McGrath  Mr J.R. Quigley  Mr R.R. Whitby
Ms J.M. Freeman  Mr D.R. Michael  Mr D.T. Redman  Ms S.E. Winton
Ms E.L. Hamilton  Mr S.A. Millman  Ms C.M. Rowe  Mr B.S. Wyatt
Mr T.J. Healy  Mr Y. Mubarakai  Ms R. Saffioti  Ms A. Sanderson (Teller)

Amendment thus negatived.

Mr D.T. REDMAN: I have a question for the Attorney General on clause 40. This clause is there for a circumstance in which —

Several members interjected.

The SPEAKER: Members!

Mr D.T. REDMAN: — the second consulting practitioner assesses the patient as not eligible against the criteria.

Mr J.R. QUIGLEY: I just missed that, because the Speaker was calling at members.

Mr D.T. REDMAN: I just re-highlighted that the reason we have this clause is to make provision for the coordinating practitioner to choose to seek the services of another consulting practitioner to make an assessment. One of the reasons that the first consulting practitioner might not have deemed the patient eligible is that they do not have decision-making capacity, which is one of the criteria. Knowing that, will the coordinating practitioner have a responsibility to say, “No, the process stops here”, rather than going on to perhaps ask another consulting practitioner? I guess I am making this point: is the coordinating practitioner’s assessment of the decision-making capacity of the patient locked in? They will have sent the note off to the board and the board will know that they have got past this point and will look at the next consulting practitioner. The patient did not pass the eligibility requirements, and the reason may well have been that their decision-making capacity had deteriorated in that time. Then the coordinating practitioner would have responsibility for choosing to seek the services of another consulting practitioner, knowing that the decision-making capacity has deteriorated. Would they not have a responsibility to shut the process down there and not let it go any further?

Mr J.R. QUIGLEY: Of course. I refer to the Interpretation Act 1984, section 56, which states that “may” is permissive, not compulsory. At that stage, the coordinating practitioner will not be locked in at all. They may choose not to send them on to a second consulting practitioner, which means that the person will be ineligible because they did not get an opinion from a consulting practitioner, so they cannot go on to the next stage, to written declarations. They do not get to written declarations because they did not get a positive result from the consulting practitioner.

Mr D.T. Redman: But the process is not shut down. They can still seek another opinion, is what you’re suggesting.

Mr J.R. QUIGLEY: I would have to ask the member to define the pronoun.

Mr D.T. Redman: The first —

Mr J.R. QUIGLEY: I want a definition of “they”, as in “they can still seek a second opinion”. Who are we talking about with the pronoun “they”?

Mr D.T. Redman: The coordinating practitioner because they are in charge of the decision.

Mr J.R. QUIGLEY: Right. The coordinating practitioner “may” send them off to a second consulting practitioner, or the coordinating practitioner might have such a strong opinion back from the consulting practitioner and say, “You’ve deteriorated; I can’t be satisfied”, and the process ends. “May” is permissive. He does not have to send them off. I referred to the black maria earlier—they cannot be made to go to a second one. The coordinating practitioner might get back and say, “That’s so conclusive, I’m not going to send you off to anybody else.”

Clause put and passed.
Clause 41: Patient assessed as eligible may make written declaration —

Mrs L.M. HARVEY: Clause 41 relates to an important step in the process in which the patient needs to make a written declaration. I refer the minister back to clause 26(1)(g), which states —

the request and assessment process, including the requirement for a written declaration signed in the presence of 2 witnesses;

I will just repeat —

… including the requirement for a written declaration signed in the presence of 2 witnesses;

Clause 41, “Patient assessed as eligible may make written declaration”, states —

(1) A patient may make a written declaration requesting access to voluntary assisted dying if the patient has been assessed as eligible for access to voluntary assisted dying …

Given that clause 26 has this written declaration as a requirement, I think there might be a drafting error in clause 41 in that “may” in those first two lines should in fact be “must”. The explanatory memorandum states this about clause 41 —

This clause provides that if a patient is assessed as eligible for access to voluntary assisted dying by both their coordinating and consulting practitioners, they may progress their request by making a written declaration requesting access to voluntary assisted dying.

I am flagging with the minister that I think this needs to be amended; those words need to be changed. It is a requirement that the patient completes a written declaration. This wording states that the patient “may” make a written declaration and it is somewhat ambiguous. It is inconsistent with what is in the explanatory memorandum and it is inconsistent with what is articulated in clause 26. In addition, when we look at the definitions, we see that “may” is a much weaker word than “must”. “Must” is an obligation; a requirement — someone is compelled to do something. An ironic example of “may” is that “you may admit that it is possible that you are wrong”. Perhaps the minister may accept that “may” is possibly the wrong word in this context.

Mr R.H. COOK: Thank you for not saying I “must”, because I “may” accept that the wording here is incorrect! I cannot say it as articulately as the Attorney General, but I made the observation to the member for Girrawheen the other day that “may” in this sense provides an authority, an opportunity to do something. The patient is not compelled to have the written declaration if they choose not to proceed with the voluntary assisted dying process. That is why it states “may” at that point. I refer the member to clause 41(1), which states that a patient may make a written declaration if the patient wishes to pursue voluntary assisted dying. If they exercise the voluntary right that is given to them by “may”, the declaration “must” have the two witnesses and that is where the distinction comes from.

Mrs L.M. HARVEY: I accept that explanation. Thank you for clarifying that for me.

Minister, I am quite concerned about the time that we have been sitting. I have certainly been awake for 23 hours. All my members have had to be in the chamber for the entire duration of the debate, while the minister’s members have had the luxury of having some sort of rotation. It would be sensible if we could agree to wind up this consideration in detail deliberation and look to reaching an agreement. I cannot speak for the minister’s members, but my members and I could agree to pass this legislation over the next sitting week of Parliament, by 19 September. I understand that that would be consistent with when the Legislative Council expects to receive the legislation. I would like the minister to consider that because I am concerned about the welfare of my members.

Mr R.H. COOK: We are all in the hands of our leaders. I am always encouraged when I see the Leader of the House and the manager of opposition business speaking behind the Chair. I will defer to the Leader of the House.

Mr D.A. TEMPLEMAN: There have been some discussions with the manager of opposition business and the Nationals WA. The intention is to conclude clause 50 today and I will then adjourn the house.

Mr W.J. JOHNSTON: The minister is absolutely right about why it needs to be “may” and not “must”, because we cannot make the patient make the election.

Clause 41(1)(b) refers to “the” consulting practitioner for the patient, but, of course, there might have been more than one because as we know from clause 40 — we had extensive debate on clause 40 and I am not redoing it — there may have been two or more people referred to as a consulting practitioner. Therefore, I wonder whether it should be “a” consulting practitioner rather than “the” practitioner.

Regarding the witnessing process, is there any expectation about how the doctor will know about the witnessing; for example, will the doctor have to see the witnessing of the document? That does not appear to me to be in the bill. What is the process for the doctor to satisfy himself that the declaration has been made properly?

Extracted from finalised Hansard
Mr R.H. COOK: To answer the first part of the member’s question with regard to the consulting practitioner, if a consulting practitioner either excuses themselves from the process, or forms a negative view, once they have made that negative view, they cease to be the consulting practitioner. Therefore, at all stages, there is only ever one consulting practitioner. For the purposes of this part of the bill, there would be only one consulting practitioner, who would, in the words of the clause, assess the patient as eligible to access voluntary assisted dying.

To answer the second part of the member’s question, the written declaration would be made in the same way as any other written declaration. There is no specific framework in relation to the coordinating practitioner for how that will be formed. I draw the member’s attention to clause 44, which makes the point that the written declaration is taken to the coordinating practitioner, who has a role with regard to what then happens with the written declaration.

Clause put and passed.

Clause 42: Witness to signing of written declaration —

Dr M.D. NAHAN: The purpose of the witness is simply to acknowledge the signing of the document. There is no relationship; there is no assessment. It is just as a notary—to note the signing of the document—but with the caveats in subclause (2)(a) to (c) that they cannot be beneficiaries.

Mr R.H. COOK: Yes.

Mr P.A. KATSAMBANIS: Ordinarily, I do not have a great problem with people witnessing documents. However, the risk here is that one or more of the witnesses may well be a party who may derive a benefit that is not covered by these provisions. Clause 42(2) states, in part, that a person is an ineligible witness if the person —

(a) knows or believes that the person —
   (i) is a beneficiary under a will of the patient making the declaration; or
   (ii) may otherwise benefit financially or in any other material way from the death of the patient making the declaration; or

(b) is a family member of the patient making the declaration; or

That is sensible. Where I think this protection is possibly not as strong as it could be is in relation to blended families. I make that point specifically because “family member” is defined in this legislation; it is not left open to other legislation. However, stepchildren in particular are not defined to be family members for the purposes of this legislation. In a blended family, a stepchild of a patient may not be a beneficiary under the will, and upon death of the patient may not stand to benefit financially or in any other material way. However, in the way that wills operate, if a step-parent passes away before an actual parent of that stepchild, that can ensure a flow of funds from the deceased step-parent, to the step-parent’s partner, and, in the future, uncrystallised—there may not even be a will at that stage—a benefit may confer. That is not covered in clause 42(2)(a)(ii), because it would not be a benefit at that stage, and there would be no expectation of a benefit at that stage. That is the sort of area that, again, I have described in the past as pernicious influence. It is subtle, and it is pernicious. I raise this issue.

I know that the minister really has not been accepting amendments, so I have not drafted an amendment, but I think that if the definition of “family member” were slightly broader, it would cover issues such as this, because there are risks. We are dealing with vulnerable people and, at the end of the day, we are dealing with the type of influence that could end up conferring a financial benefit on someone that might be a motivating factor. Again, I raise this in good faith. The minister knows my position on the bill. I do not support the principles of the bill, but if we are to pass such legislation in this Parliament, I want to be party to making it as safe as possible and with as much protection as possible. If we extended that definition a bit more broadly or dealt with it in another way, it would provide significantly stronger protection in the one per cent or even one in a thousand cases of people who may not have witnesses who are acting fully independently or in the best interests of the patient.

Mr R.H. COOK: I appreciate the member raising this. I think it is an important issue. In the scenario that the member raised, I think the family member, or stepchild, however it should be characterised, be captured under clause 42(2)(a)(ii) because they would benefit “financially or in any other material way”. From my perspective, I do not think that person would be eligible to be a witness.

Mr P.A. KATSAMBANIS: That is the point. I do not want to labour this, but on the death of the patient, there would be no benefit flowing to the stepchild. The benefit would only flow completely indirectly because if the step-parent died first, a benefit from the step-parent’s estate—it could be all or part of the estate, depending on the step-parent’s family arrangement—would not pass to the stepchild. It would pass to the parent of that stepchild—the actual parent. No benefit would accrue and there would be no expectation of benefit at that stage until the death
of the parent. But it would play on some people’s minds that if the parent went before the step-parent, the stepchild would not benefit from the step-parent’s estate at all in the ordinary course of events. That is where I think the risk is. I raise the issue of stepchildren specifically. I think that is where the risk is. I cannot see how clause 42(2)(a)(ii) could be interpreted to cover that in the way it is currently drafted, because there is no expectation or benefit that will flow from one event to the other. It is just the series of subsequent flows that may, in the future, add a benefit. I think it is too obtuse to be captured by clause 42(2)(a)(ii).

Mr R.H. COOK: I think the pertinent issue here is the language the member used. He said “in any material way on the death of the patient”. In the provision the language is “in any material way from the death of the patient”. It is not a benefit that has to accrue on the death of the patient. It is a benefit that has to accrue from the death of the patient. It does not have to be realised the instant that the patient dies. From that point of view, to be an eligible witness they have to have anticipated that and made sure they are clearly eligible. I would say that in relation to this clause a stepchild would not be eligible.

Mr P.A. KATSAMBANIS: Let us get that on the record. In the scenario that I have described, the minister has indicated that the stepchild would not be eligible to be a witness under this clause. I do not want to verbal him, so he can confirm that.

Mr R.H. COOK: Yes, member, that is the intent.

Dr D.J. HONEY: I do not want to dwell on this point but I understand that one of the reasons that the minister is not entertaining amendments is that he does not want to hold up progress of the third reading so this process is finished in a timely manner to meet the government’s agenda. That is obviously the minister’s decision.

The SPEAKER: Member, can you get on to the question, please?

Dr D.J. HONEY: I am, Speaker. I wonder whether there are models, and maybe the Attorney General has already looked at them. Someone may not have a direct pecuniary interest, but they are a friend of someone who does and they could be acting in a capacity to support their friend, which would lead to some undue influence. I am sure there must be some models used for a similar potential scenario in the future. That is my only comment on that clause.

Dr M.D. NAHAN: Why are notaries not just used—public notaries?

Mr R.H. Cook interjected.

Dr M.D. NAHAN: Notaries, people who —

Several members interjected.

Dr M.D. NAHAN: No.

Dr D.J. Honey: Justices of the peace?

Dr M.D. NAHAN: Yes, justices of the peace.

Mr P.A. Katsambanis: It is so hard to get two of them the same room at the same time.

Mr R.H. COOK: I thank both the member of Cottesloe and the member for Riverton. Can the member for Cottesloe quickly remind me of his concern?

Dr D.J. Honey: It is only that maybe someone does not have a pecuniary interest, but they are a friend; they are sympathetic to a person who has a pecuniary interest.

Mr R.H. COOK: The member for Cottesloe made reference to the Attorney General. The Department of Justice and the State Solicitor advised us on the wording for what is needed to ensure that safeguard. Turning to the member for Riverton’s question, the Ministerial Expert Panel on Voluntary Assisted Dying made strong recommendations to us that it should not necessarily be a JP or some process like that. Obviously, the person affected is very close to the end of their lives, and from that perspective it was a matter of creating extra safeguards to make sure that everyone was satisfied with the process. To get a JP or, as the member for Hillarys observed, to get two JPs in a timely manner would make it difficult.

Ms M.M. QUIRK: I move —

Page 28, after line 2 — To insert —

(d) is an owner of, or is responsible for the day-to-day management and operation of any health facility as defined in section 160(1) at which the patient is being treated or resides; or

(e) is directly involved in providing health services or professional care services to the patient making the declaration.

Extracted from finalised Hansard
That just extends the number of constraints on who can witness documents. Members will all be familiar with the kinds of allegations that have come out of the Royal Commission into Aged Care Quality and Safety and the undue influence and duress that proprietors of such establishments can mete out to residents. This wording mirrors what is in Victoria and it seems to me a prudent step to also include it in our bill.

Mr R.H. COOK: I appreciate what the member is trying to achieve. I have half an ear open, so apologies if the member said this, but I assume that she was picking up that matter from the Victorian legislation.

Ms M.M. QUIRK: Yes.

Mr R.H. COOK: Obviously, we looked at the Victorian legislation when considering the drafting for these clauses. We believe that the intent of the Victorian legislation is picked up in our clause 42(2)(a)(ii). That was placed into the Victorian legislation because the legislators did not want the witness to benefit in any material way. In that case, they did not want the facility owner to benefit in any material way from the death of the patient. That is why we believe we have captured that intent in that clause.

Ms M.M. QUIRK: It seems to me there needs to be an explicit prohibition so that it is absolutely cut and dried. It would be difficult for someone to reconstruct what has happened and find witnesses. It seems to me, if there is a strict prohibition so that these people are precluded, it makes it much clearer. The portion of the bill that the minister points me to, “may otherwise benefit financially or in any other material way from the death of the patient”, is simply too broad and non-specific.

Mr R.H. COOK: I do not think it is. I think we do effectively capture the intent of that Victorian clause, and, in effect, it makes the Victorian clause redundant, from that perspective. I might add, by our wording, we also pick up any other issues that might arise by way of that patient’s institutional care.

Division

Amendment put and a division taken, the Acting Speaker (Ms J.M. Freeman) casting her vote with the noes, with the following result —

Ayes (14)

Mrs L.M. Harvey Mr Z.R.F. Kirkup Mr W.R. Marmion Ms M.M. Quirk
Dr D.J. Honey Mr A. Krsticevic Mr S.J. Price Mr D.A. Templeman
Mr W.J. Johnston Mr S.K. L'Estrange Dr M.D. Nahan Mr D.C. Nalder
Mr P.A. Katsambanis Mr R.S. Love

Noes (35)

Ms L.L. Baker Mr D.J. Kelly Mrs L.M. O'Malley Mrs J.M.C. Stojkovski
Dr A.D. Buti Mr F.M. Logan Mr P. Papalia Mr C.J. Tallentire
Mr J.N. Carey Mr M. McGowan Mr S.J. Price Mr D.A. Templeman
Mrs R.M.J. Clarke Mr J.E. McGrath Mr D.T. Punch Mr P.C. Tinley
Mr R.H. Cook Ms S.F. McGurk Mr J.R. Quigley Mr R.R. Whitby
Ms J.M. Freeman Mr D.R. Michael Mr D.T. Redman Ms S.E. Winton
Ms E.L. Hamilton Mr S.A. Millman Ms C.M. Rowe Mr B.S. Wyatt
Mr T.J. Healy Mr Y. Mubarakai Ms R. Saffioti Ms A. Sanderson (Teller)
Mr M. Hughes Mr K. O'Donnell Ms J.J. Shaw

Amendment thus negatived.

Mrs L.M. HARVEY: I have a query about the eligibility of people to be a witness to a written declaration, as I want to understand how some of these practices are constructed. I understand that a consulting or coordinating practitioner is ineligible to be a witness. However, would an employee of a consulting practitioner or a coordinating practitioner be eligible to be a witness? Obviously, these can be small businesses, with a receptionist and maybe a nurse employed within the practice. I just want to understand whether there could be a financial relationship between the coordinating practitioner and/or the consulting practitioner and an employee who could then be a witness to a declaration.

Mr R.H. COOK: As long as they do not benefit in any material way from the death of the patient making the declaration, technically, they could play that role.

Clause put and passed.

Clause 43 put and passed.

Clause 44: Coordinating practitioner to record written declaration —

Mrs L.M. HARVEY: The coordinating practitioner has to record the written declaration. Obviously, this will form part of the patient’s records. For how long will a copy of the written declaration have to be held by the practitioner?

Mr R.H. COOK: I am not familiar with the requirements under the Health Practitioner Regulation National Law, although there would obviously be very strict rules about that.

Mrs L.M. Harvey: That is 10 years for GPs.
Mr R.H. COOK: Yes. I am advised it would also be subject to the State Records Act.

Mr P.A. KATSAMBANIS: I have a question that relates to this whole division, but I will ask it now. Correct me if I am wrong, but the written declaration will be in an approved form and given to the coordinating practitioner for the patient. That form will be approved by the CEO, I take it; is that right? Will that be in a suite of forms that will be publicly available? It sounds to me a bit like the guidelines for enduring powers of attorney, standard medical assistance forms and the like. Is it likely to be publicly available or is it likely to be on the portal that we have discussed in relation to how coordinating practitioners can deal with the board?

Mr R.H. COOK: It would be something that would obviously be decided by the CEO in the implementation phase. Nothing occurs to me about whether it would be a problem if it was or was not publicly available. I am advised that in Victoria, it is not; it is part of the suite of documents available on the portal. But, obviously, we will come to a view about that as we go into implementation.

Mr P.A. KATSAMBANIS: Will the approved form that the witness must certify come with some form of guideline document, which can be handed to the witness? It is a bit like signing a will. When I was a practitioner, if a will needed to be taken away to be signed, my goodness, not only did I have a standard form to go with it, I also would get a pencil and very lightly write “witness to mark here” et cetera on every page. Although this will not be an approved form, I expect, and I hope, that the CEO will produce some form of guideline document, a one-pager, that can be handed to the witness.

Mr R.H. COOK: That is right.

Clause put and passed.

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

Mrs L.M. HARVEY: This clause provides that the coordinating practitioner must notify the board of a written declaration within two business days after receiving a written declaration. I seek clarification. Does the board need to receive the original signed copy or can it receive a signed copy that has been scanned and emailed or a certified true copy of an original?

Mr R.H. COOK: No. I am advised that it will be sufficient for it to scanned and electronically sent.

Clause put and passed.

Clause 46 put and passed.

Clause 47: When final request can be made —

Dr D.J. HONEY: This is a simple question. I am interested in the logic behind the clause. If the minister can explain it, I will not go on at length on this clause. What is the logic behind clause 47(3), which is that the final request can be made within the designated period of nine days? Why is that necessary, if it can be brought forward if a patient is going to die inside that nine-day period?

Mr R.H. COOK: The nine-day period may be waived in exceptional circumstances. Both the coordinating practitioner and the consulting practitioner must be of the view that the patient’s death is likely to occur or that the patient is likely to lose decision-making capacity in relation to voluntary assisted dying before the end of the nine-day period. It is essential to allow the nine-day period to be waived in these exceptional circumstances as it would be unreasonable to require a patient to wait for 10 days if they are to die or lose capacity within that time frame. This was supported by the ministerial expert panel. Even if the nine-day period is waived, the final request may only occur the day after the consulting assessment is completed. Furthermore, all steps in the voluntary assisted dying process must be completed, albeit at a quicker rate.

Mr P.A. KATSAMBANIS: Clause 47(3)(b) contains an “and”, so there is paragraph (a) and then it states —

(b) the opinion of the coordinating practitioner is consistent with the opinion of the consulting practitioner for the patient.

That requires both practitioners to agree that the expedited process is necessary. I am not going to get into the specifics of clause 47(2)(a) because I understand why it would be in there in the case of losing capacity. I am not convinced that it is needed because the patient is likely to die in the meantime, but irrespective of that, I will not debate it. However, is this concept of the coordinating practitioner and the consulting practitioner agreeing to this something that they each assess when they make their initial assessment, or is this something that they then assess after all the steps have been completed? I think it is important, particularly for these practitioners, to know when they do this.

Mr R.H. COOK: It is both, member—it could be either/or. It could be early in the process, and it could be at the end of the process. By way of information and of interest, this clause reflects the intent of the only amendment that was ever made to the Oregon act since it was initially struck, because it was considered to be a humanitarian aspect of the bill.

Extracted from finalised Hansard
Mr P.A. KATSAMBANIS: I note that there is potential here for further assessment and consultation by both the coordinating practitioner and the consulting practitioner. In the initial assessments, there are quite lengthy statutory requirements on what they do. There are no particular statutory requirements here that would be required to be undertaken if a further assessment takes place. It might not have to do, but it may, as the minister himself indicated. Are we to deduce from that that normal clinical practice and normal procedures of medical practitioners, including keeping records and recording those sorts of things in their normal practice of dealing with the patient, would apply here, and no other formal statutory requirements would apply, or would they also have to apply the statutory framework for their initial assessment to that subsequent assessment, if it is necessary?

Mr R.H. COOK: I could not put it better myself. It would be part of the clinical process. The member can understand that the coordinating practitioner might ring up and say that patient X or Y is deteriorating quite quickly, and seek an opinion: “What you think; what’s your opinion? I reckon they’re going to pass away in the next few days” or whatever, and they would form a view that way. Like any aspect of their clinical work, it would have to be recorded in the patient’s record and the record of the consultation. Under clause 49(2)(f), they would also have to report to the board.

Mr W.J. JOHNSTON: I understand the need for this. If the bill is going to pass, I understand why this is being provided. I just want to clarify, alongside the question asked by the member for Hillarys, whether any processes are provided by this legislation that would be truncated from its normal time lines, other than the nine days, by the operation of this clause. Is any other thing going to be truncated as well?

Mr R.H. COOK: No, other than the speed with which they take place. They will still have to go through all the steps in the voluntary assisted dying process, and the administration has to take place at least a day before the final review.

Mrs L.M. HARVEY: I seek one final clarification from the minister. There are obviously some circumstances—I speak specifically about when cancer may be invading the nervous system, for example, the celiac plexus and those sorts of things—when the pain can become difficult to manage with some immediacy. Is there any opportunity to truncate the process in that scenario?

Mr R.H. COOK: The only capacity they have to truncate the process is if they expect the patient to die or lose decision-making capacity inside the nine days. I think those are the only circumstances anticipated, unless the pain medication dose at that time becomes so high that they lose capacity simply through the effect of the pain medication.

Mrs L.M. Harvey: That was going to be my next question, so thank you.

Clause put and passed.

Clauses 48 to 50 put and passed.

Mr D.A. TEMPLEMAN: In moving to adjourn debate, I would like to acknowledge the parliamentary staff and the advisers who have been here and the efforts of all members in this marathon.

[Applause.]

Debate adjourned, on motion by Mr D.A. Templeman (Leader of the House).

Legislative Assembly

Tuesday, 17 September 2019

[page 6784]

VOLUNTARY ASSISTED DYING BILL 2019

Consideration in Detail

Resumed from 5 September.

Debate was adjourned after clause 50 had been agreed to.

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

Mr R.H. COOK: Madam Deputy Speaker, with your indulgence, and if members would entertain me just for a moment, a number of questions were asked by members the week before last and I undertook to provide responses in relation to some that I could not answer then. There was one question from the member for Dawesville, which, to paraphrase, was: will the details of schedule 4 and 8 drugs be able to be obtained through a freedom of information application? I am informed that any person may make a request to access documents under the Freedom of Information Act; however, the making of a request does not mean that they will be given access to the documents. Access may be denied if the documents contain exempt matter. Clause 5(1)(e) of schedule 1 of the FOI act exempts disclosure in circumstances in which it would endanger the life or physical safety of any person.

Extracted from finalised Hansard
The member for Riverton asked for insight into previous budgets in relation to palliative care. The member said —

The minister said that $206 million has been allocated over the forward estimates … Can the minister provide by way of supplementary information what was spent on palliative care in the previous … years … Expenditure on palliative care over the past four years—that is, 2015–16 to 2018–19—totals $157.1 million. That has been broken down. In 2015–16, expenditure on palliative care was $32.2 million; in 2016–17, it was $38.7 million; in 2017–18, it was $41.4 million; and in 2018–19, it was $44.1 million. I note that that last figure is subject to finalisation. These figures do not include palliative care that is delivered in hospital settings as that activity is reported separately as part of actively-based funding for subacute services—that is, hospital-based services. Palliative care is provided in a number of different service settings—in homes, clinics, hospices, residential care facilities and hospitals. It is not currently possible to provide consolidated Western Australian data on the number of people who accessed palliative care in those years due to a range of palliative care providers being engaged in service provision both contracted through the Department of Health and undertaken directly by health service providers. The development of consolidated data is addressed as a priority by the Department of Health.

Dr M.D. Nahan: Minister, is the management of the last four years the same as the forward estimates?
Mr R.H. COOK: Yes, I understand that is the case. I have seen similar qualifications in that context.

Dr M.D. Nahan: Would you table that data?

The DEPUTY SPEAKER: Member for Riverton. We need Hansard to know who you are.

Dr M.D. NAHAN: Would you table that data?
Mr R.H. Cook: I would be very happy to.

Dr M.D. NAHAN: You read most of it out.

Mr R.H. COOK: Further, the member for Hillarys asked a question about student medical practitioners. I might talk to this later when the member for Hillarys is back in the chamber.

The member for Girrawheen asked what training curriculum is in place for Victorian doctors. I have some information on the details of the Victorian curriculum, which I seek to table.

[See paper 2720.]

Mr R.H. COOK: Finally, the member for Girrawheen asked where is the word “independent” used in relation to the two doctors. I am advised that there is no express reference in the bill to the first and second assessments by the coordinating consulting practitioners being independent; however, it is implicit. This is due to three reasons. Firstly, the coordinating consulting practitioners must separately assess whether the patient is eligible for access to voluntary assisted dying—clauses 23 and 34. Secondly, the second assessment cannot take place until the patient has been assessed as being eligible for access to voluntary assisted dying by the coordinating practitioner and a referral is made to a consulting practitioner—clause 29. Thirdly, a patient cannot be assessed as eligible for voluntary assisted dying unless both practitioners are separately satisfied that the patient meets all the eligibility criteria and understands the information required to be given to them—clause 27 and 39.

To clarify for the member for Dawesville, the following clauses under schedule 1 of the Freedom of Information Act may be relevant to VAD-related matters, including clause 5 regarding matters prejudicial to law and enforcement, public safety, and property security; clause 6, which deals with matters revealing the deliberative processes of government; and clause 8, regarding confidential communications.

The DEPUTY SPEAKER: We are on clause 51. The question is that clause 51 —

Mr R.H. COOK: Sorry.

The DEPUTY SPEAKER: There is more?

Mr R.H. COOK: No. Deputy Speaker, I undertook to table that response for the member for Riverton. I am happy to do so now.

Mr Z.R.F. Kirkup: Are you tabling all of them?

Mr R.H. COOK: That makes sense! I should have done that at the beginning and not read them all out. I will table them all.

[See paper 2721.]

The DEPUTY SPEAKER: We are on clause 51. I will try again.

Mr D.C. NALDER: I understand the intent of clause 51; I have read the explanatory memorandum. The clause states —

The validity of the request and assessment process is not affected by any minor or technical error …

I understand the intent, but I am nervous about how the courts will interpret this in the future. When will an error be major? I accept that there will be a problem if the form does not have a signature, but that is not clearly specified.

Extracted from finalised Hansard
here. I want to make sure that this clause is tight enough and that it would not be open to interpretation by the courts in the future to determine what would be a minor or major technical error on the form, which includes, as it states in proposed section 50(1)(a), the first assessment report form, all consulting assessment report forms, and the written declaration. I am not clear about what would be considered a minor technical error or a major technical error, and what would constitute a failure and what would be acceptable. I note that the explanatory memorandum explains that it could be a mistaken date or a spelling mistake, those sorts of things. I get that, but I am worried about how this will be interpreted in the future and want to ensure that it is covered appropriately.

Mr R.H. COOK: The member is quite right. This clause is an administrative necessity. It clarifies that a technical mistake on a form such as a spelling error in a name or an accidental incorrect date on a witness’s signature will not have the effect of invalidating a patient’s entire request and assessment process. I am advised that essentially this will be up to and including those sorts of errors that do not have an operational or technical element or substantive element in relation to the detail of the form.

Dr M.D. NAHAN: I refer to the data the minister provided. When he provided it, he stated that it does not include expenditures in hospitals. Is that right? Does that include public hospitals as well as private hospitals? Does the minister have some feeling about the magnitude of palliative care —

The DEPUTY SPEAKER: I am sorry, member for Riverton. I do not think this applies to clause 51.

Dr M.D. NAHAN: I am asking for his due diligence and his understanding on this issue just to clarify it.

The DEPUTY SPEAKER: But, member, we are on clause 51.

Dr M.D. NAHAN: I understand that.

The DEPUTY SPEAKER: You cannot go back to that clause at this point. I recommend that there will be some other way to find out that information, but not this way.

Dr M.D. NAHAN: I will find some other way.

Ms M.M. QUIRK: The form proposed in this clause is exactly the same form as that provided for in the Victorian legislation. Of course, words like “technical error” have their ordinary meaning, but I am somewhat confronted about the extent to which something will be considered to be a technical mistake given that there are no forms in the schedule to this bill, which would help us understand the information that would be required. We could then explore a bit more the kinds of information that would not invalidate a request as opposed to those that would. Form 5, the “Final Review Form”, is set out on pages 118–122 of the Victorian legislation. The minister said, for example, that the date on which a witness signs a document is not material, but presumably dates on which medical practitioners insert information will be material; is that correct?

Mr R.H. COOK: We have to remember that this whole process is overseen by the Voluntary Assisted Dying Board, so I guess this stuff does not happen in historical assessment. It is essentially about understanding that the actions required to take place in the voluntary assisted dying process do take place. Obviously, if it goes to an element of whether an assessment took place and whether it was confidently carried out, that would clearly be substantive. This clause is just about making sure that administrative errors do not of themselves frustrate the process or trip up a practitioner or, indeed, more importantly, a patient due to what is essentially a technical oversight.

Ms M.M. QUIRK: I will not labour this point, but I want to emphasise the question of how we are to know when something goes from being minor to material in nature. Can the minister give us some idea, other than a spelling error or an incorrect date, of something that would not invalidate the entire assessment process? For example, doctors’ writing is notoriously bad, so if we could not ascertain one of the words written by the doctor making the assessment, would that be material? I am trying to understand the required level of compliance.

Mr R.H. COOK: As the member is aware, there are a range of processes that the patient has to undertake in conjunction with the coordinating and consulting practitioner to be able to access the voluntary assisted dying process. The coordinating and consulting practitioners have to contemporaneously inform the Voluntary Assisted Dying Board of that process as they march through the steps. If the Voluntary Assisted Dying Board could not ascertain that the assessment has taken place properly or the name of the coordinating or consulting practitioner, it would be of material relevance. I think the member used the phrase “ordinary meaning” in her first question about this clause, and that is probably the correct assessment to understand it. It is about making sure that someone is not frustrated simply from a very technical and minor oversight.

Ms M.M. QUIRK: The last thing I want to clarify is that the minister said that the practitioners must contemporaneously submit the record of their decision to the board. Does the minister mean contemporaneously with them having made the decision, not with each other?

Mr R.H. COOK: That is right. It is a completely separate process. I used the word “contemporaneously” in the context of the Victorian legislation, under which those forms are not required to be lodged for seven days. In ours, it is within two days.

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

Mr Z.R.F. KIRKUP: I am just trying to understand how a patient would decide not to continue once they have gone through the request and assessment process. Are they obligated to inform the coordinating or consulting practitioners at all?  

Mr R.H. COOK: The patient would be making their decision known by telling the practitioners or omitting to contact them again to continue the process. This clause is obviously very important, because we want to make sure that it provides for a patient who seeks access to voluntary assisted dying to decide at any time not to proceed with the process. It is an entirely voluntary process and there is no compulsion to continue once someone has started.  

Mr Z.R.F. KIRKUP: I appreciate the importance of the clause. My obvious concern is about when someone chooses not to go through with the process. In every other step along the way, the VAD board or the practitioner have been informed through some sort of data collection measure. I am trying to understand how we might ascertain why a decision was taken by a patient not to go ahead but then to decide to continue a number of days or weeks later if there is no obligation for them to inform the practitioner. We have dealt with a number of clauses so far that have ensured that there is enduring will and that an enduring decision takes place if some time passes. The clause is very important. I am just curious to understand why nothing else has been added to it to ensure that the patient informs the coordinating practitioner.  

Mr R.H. COOK: As the member knows, this process can only proceed if the patient continues to make requests. Essentially the process stops if the patient ceases to make other requests. Ordinarily, we would expect the patient to make that declaration themselves because they would be in regular contact with their practitioners, but, almost by definition alone, if they fail to contact their coordinating or consulting practitioner, they are essentially communicating a decision. It might stall the process and they might come back to it, but it will not continue until the patient re-energises it, for want of a better description.  

Mr Z.R.F. KIRKUP: I appreciate that, minister. My concern is that right through this process we want to make sure that as part of eligibility the person has an enduring will—an enduring decision to continue. It is probably worth us just being aware of the issue, because after going through the assessment process and to the final request, someone could, rightly so, choose not to continue, which is obviously very important. I do not take away from the importance of this clause. Perhaps as part of some of the literature furnished to the patient there should be information encouraging or obliging them to inform their practitioner somehow, because as part of the eligibility, we want to establish that there is an enduring decision. If the patient chooses not to go ahead, and they wait a month, it might not necessarily mean that they have decided. There might be two different cases, for example. There might be an individual who wants to go through with the process, but after the final request they simply pause for a month before making an administrative decision. There might then be a replication of that situation, with the person deciding not to go ahead, but then going ahead. There is no way of assessing the situation to ensure whether there is enduring will, which is an eligibility requirement. I think that is something we should constantly be aware of. Perhaps the information furnished to the patient at the start of the process should encourage them, if not oblige them, to inform their practitioner.  

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

Dr M.D. NAHAN: My advice is that in examples overseas, particularly in Oregon, where there is this type of legislation, a sizeable portion of people never take the medicine. When that was queried, it was not clear how many had done that or why. One of the purposes of this VAD process is that it will be monitored through the collection of data. That seems to me important. I am not questioning the need for the patient not to be put off from making a final decision, but it would be very important for data collection and the soundness of this process to have a body collecting that data at the end, after the patient has made a final decision, whatever it may be, to take the medicine—or poison—or otherwise. The minister has gone to great lengths all the way to this point to provide for the collection of data, so it seems to me to be a weakness not to know of the decision. I think it would be very interesting if, as I am told occurs in Oregon, a sizeable percentage of the people who finally get the poison simply do not take it, so the question is: why?  

Mr R.H. COOK: I certainly will not question the member’s information from overseas, knowing the circumstances he brings to the process. However, I am informed that the Voluntary Assisted Dying Board will be informed of every step along the way, whether on the return of the voluntary assisted dying substance or the oversight of the death certificate for it. That data would be collected ordinarily as part of that process. Ultimately, the obligation is on the system to report to the Voluntary Assisted Dying Board rather than the patient themselves having an obligation to do that—that is, those participating around the patient. From that perspective, that information will be collected almost by default, albeit, the member is making the case that it will be collected because there is a gap in the information. It is obviously the role of the Voluntary Assisted Dying Board to collect that information.  

Dr M.D. NAHAN: I do not see why it would be difficult. I do not think the patient should communicate with the board, but all the away along the process it is the coordinating practitioner’s role to inform the board of decisions.
We have gone through that. It seems to me to be relevant that if the patient passes away without taking the poison, the poison will go back, which I understand, but it would be relevant to inform the board that the patient decided of her or his free will not to take the poison —

Mr J.E. McGrath: The substance.

Dr M.D. NAHAN: — the substance; it is poison—for research and understanding the implementation of this voluntary assisted dying process. It could be done, as the minister said, by default by returning the material, so obviously it would not have been taken, or maybe taken only partially. This is for research purposes. I cannot see why it will not be done.

The DEPUTY SPEAKER: There is no question that I can hear, there.

Dr M.D. NAHAN: Why not have the coordinating practitioner report to the board why he or she is returning the substance; that is, the patient decided in the end not to take it?

The DEPUTY SPEAKER: Do you want to answer that, minister?

Mr R.H. COOK: The coordinating practitioner, and particularly the administering practitioner, have an obligation to report whether the voluntary assisted dying substance was taken. In addition, if the patient opts for self-administration, the contact person they nominate in that process has a positive obligation to report that as well.

Mrs A.K. HAYDEN: Following on from that line of questioning, because I think it is the crux of what everyone is worried about, clause 4 provides for “the request and assessment process” that has to be undertaken. It is to show that the voluntary and enduring nature of the patient is assessed. Why does the assessment stop there? I do not think the minister has answered why it stops there. Why does the assessment not continue? Surely the most important part of this step is whether someone decides not to continue. Why is that not included as part of the assessment? If a patient chooses to self-administer and takes the substance home, within what time frame will they return it and how do we make sure it is returned? More important, the reason a person changes their mind is vital feedback for anyone who is overseeing the legislation. I do not understand why the assessment stops at that point and does not continue.

Mr R.H. COOK: We will come to the role of the contact person later in the bill so I will refrain from digging into that part.

It is important that if someone wants to continue with voluntary assisted dying, they must make a positive decision, which has to be enduring and their capacity to make that decision has to be assessed. If the person feels they no longer wish to proceed, the obligation is not on that person to communicate that. There may be obligations on the coordinating practitioner or the consulting practitioner or, indeed, the administering practitioner—there certainly will be on the contact person concerning self-administration. But from that perspective, the obligation is on someone to continue with the process, not for them to signal they no longer wish to participate in the process. We have to remember that these people are at the end of their life and they will be making a range of decisions. I do not think we should put an extra burden on the patient. Obviously, there are burdens on the consulting practitioner and particularly the coordinating practitioner, but not on the person. This is not so much a mechanism by which someone can withdraw from the process; it is simply to say that a person has the right at any stage not to participate in the process.

Mrs A.K. HAYDEN: Thank you, minister. I appreciate the minister’s explanation. Can I get an understanding that if it is further on in the bill, it will be assessed and reported on if someone pulls out and that data will be collected and it will be reported on by the practitioner?

The DEPUTY SPEAKER: I think the minister has answered that already.

Mr R.H. COOK: Yes, member.

The DEPUTY SPEAKER: Member for Dawesville, do you have a different question?

Mr Z.R.F. KIRKUP: I do, otherwise I would not be standing up, Deputy Speaker.

The DEPUTY SPEAKER: That is unusual but go ahead. Thank you for the observation.

Mr S.K. L’Esteange interjected.

The DEPUTY SPEAKER: I am sorry; I did not hear that. Let us continue.

Mr Z.R.F. KIRKUP: That is fine; I appreciate that. I want to clarify two things. I take issue with two statements the minister made. Perhaps our respective views on the bill are slightly different. The minister suggested as part of his response to the member for Riverton, who I appreciate was talking about the administration decision, that at this point of the bill, we are not at the administration decision yet; we are prior to that point. The minister said that the board is informed the whole way through, but that is not true regarding this clause. The board is not informed the whole way through if the patient chooses not to go ahead at this time. That is one concern. There is no obligation on the patient to inform their practitioner, thus the board is not updated. A slight air gap exists, I suppose, whereby the board is informed the whole way through from the first request assessment and the second request assessment.
et cetera. Then there is an air gap between the provisions of this clause, in that the patient has gone through the request and assessment and the board is reinforced and re-engaged at the decision-making stage and at the time the substance has been administered, and if the patient chooses not to continue. We spoke very early on concerning the consultation process about the importance of collecting data. This could be a decision point when a patient chooses not to go ahead and is making an administration decision. The patient has been assessed as allowed to access the substance but at this point they choose not to go ahead. It is surely important that the reason for that is given. We would not necessarily know because the obligation has not kicked in whereby the practitioner has to inform the board. If the person passes away before accessing the substance, we would not know because there is no obligation to report on that. They will simply be lost in the system. There is no obligation for the patient to inform the practitioner if they make a conscious decision not to go ahead with it.

I take issue with one of the points that was made—that the board is informed the whole way through. I query whether the minister believes the air gap that I have identified exists, and if that is the case, is he concerned about that lack of integrity to follow the process the whole way through?

Mr R.H. COOK: I am informed that if the patient’s death takes place at any stage during the process, regardless of the extent to which they have gone through the entire cycle of voluntary assisted dying, the certifying practitioner is obliged to submit the death certificate to the board, so there is complete oversight. I understand the point the member is making, but I think perhaps this clause will not give him administrative reassurance because it is not designed to do so; it is designed to unequivocally set out the rights of the patient to make sure that it reflects the fact that it is entirely voluntary.

Mr Z.R.F. KIRKUP: I appreciate the minister’s response, particularly on the coordinating practitioner’s obligation to inform the board or provide the death certificate. How might that work if the patient has communicated with the coordinating practitioner only via audiovisual link?

Mr R.H. COOK: The coordinating practitioner does not need to be the certifying practitioner for the death certificate. The obligation is on the certifying practitioner to inform the Voluntary Assisted Dying Board about the death certificate.

Mr Z.R.F. Kirkup: So, the certifying practitioner being?

Mr R.H. COOK: When someone dies, a medical practitioner has to certify the death.

Mr Z.R.F. KIRKUP: How might the certifying practitioner know that that person has gone ahead with the VAD process?

Mr R.H. COOK: At this stage, the patient would have family members, a contact person or an administering practitioner who would already have been engaged in the process. The patient will not be making this decision in isolation so that everyone sits around wondering what went wrong; it will be in the context of the ongoing care that that patient is under. For instance, the patient might be sitting in a wheatbelt town, surrounded by family and supervised by the general practitioner, but the general practitioner may not be the administering or consulting practitioner; they might just simply be a member of the medical community in that town. So even though there has been audiovisual contact between the patient and the coordinating and consulting practitioner, a general practitioner is obviously competent for the certification process.

Dr M.D. NAHAN: To follow on from the member for Darling Range, my understanding—maybe the member for South Perth can back me up on this—is that, particularly in the Oregon experience, a sizeable proportion of the people who have the substance do not take it. That is actually a very important part of this, because when people first get a diagnosis of a death sentence, they go into, as we call it, existential stress. Access to the substance can give them a backstop to feel more comfortable about waiting for a period before making a decision. All I am interested in is whether, down the track, we will collect this data and the assessors and researchers into this process will have access to the decisions of people who have acquired the substance but have decided not to use it. If it is not used, it might provide them some backstop just to know that they have it if, in fact, they were to decide in the end to do it.

Mr R.H. COOK: Yes, that information would be collected, and we will obviously go through that in detail when we talk about the voluntary assisted dying substance and its management.

Mr Z.R.F. KIRKUP: I appreciate the information the minister gave in his previous response, which was that at this point in the process, the person might have a contact person or an administering practitioner nominated. I do not want to verbal the minister, but if that is what he actually said, there is actually no obligation on the patient at that point of the process to appoint either one of those at all, so I am not entirely certain that that would be the case. I am simply identifying what I think is an air gap, and I appreciate that it might be dealt with as part of the information that is furnished to the patient. The minister made the point that the certifying practitioner will provide the death certificate to the Voluntary Assisted Dying Board because they might have a contact person or an administering practitioner identified, but there is no obligation on the patient to have done either of those steps at this point in the process, as best as I can read the legislation.

Extracted from finalised Hansard
Mr R.H. COOK: Obviously, there is an obligation on the coordinating practitioner. In the event that the patient dies, the coordinating practitioner will be obliged to contact the Voluntary Assisted Dying Board. There will also ultimately be a death certificate in that process, so there will not be that information gap.

I stress again that clause 52 does not relate to an administrative process; it essentially sets out the rights of the patient and communicates that the entire process must be driven by the patient. The patient is not obliged, even after the completion of the request and assessment process, to take any further action in relation to access to voluntary assisted dying. It is a clarifying clause that really underpins the principle that this is an entirely voluntary process for the clinician, the practitioners and the patient.

Mr Z.R.F. KIRKUP: I appreciate that, minister. I apologise for my frustration at this point. I do not disagree with the importance of the clause and the rights that it confers on the patient to not proceed with this. My point is that if the patient dies along the way, before making an administrative or contact person decision, or any part like that, we will be stuck at the point at which the patient has been assessed and they will not know whether that patient has died, especially if they have been with a coordinating practitioner in an audiovisual sense. The practitioner will not know whether that patient has died, so there is no way —

Ms A. Sanderson: They have a relationship.

Mr Z.R.F. KIRKUP: But there is no obligation on the patient to inform them; that is exactly the point, member for Morley. There is no obligation —

Ms A. Sanderson: They’ve died.

Mr Z.R.F. KIRKUP: I understand that; they have died, or something has occurred. We just do not know, if the patient does not choose to proceed, and there is no obligation on the patient to tell —

Ms A. Sanderson: You’re stabbing in the dark at crazy hypotheticals, member, and they have a relationship.

Mr Z.R.F. KIRKUP: Okay, I appreciate that they might have a relationship. I am just making the point that I think there is an identified air gap and I think there is a concern.

Clause put and passed.

Clause 53: Eligibility to act as administering practitioner —

Dr D.J. HONEY: I refer to clause 53(1)(a)(ii) with regard to the nurse practitioner. How do we know that there will not be coercion in this process? I have mentioned before that hospitals are extremely hierarchical. Typically, the specialists are not questioned by anyone, and doctors in hospitals have considerable seniority over nurses. Nurses may feel too intimidated to challenge a doctor. How do we make sure that a nurse is not coerced into being involved in this process when they really do not wish to be involved in it, but they do not feel able to reject the doctor requesting them to help with administration?

Mr R.H. COOK: I am not going to enter into a discussion about the workplace culture of a hospital. I remind the member of clause 10(1), which states —

A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Western Australia).

Clause 10(2) states —

Subsection (1) applies whether or not the contravention constitutes an offence under this Act.

It will essentially be malpractice for a nurse practitioner to participate in this process by way of coercion. The legislation sets out very clearly the obligations of the administering practitioner. From that perspective, I understand what the member is saying in the context of the theory that medical practice sometimes gets to a dark place. Nowadays, particularly in relation to nurse practitioners, it is a highly professional qualification and, ultimately, falls under the rigour of national and local laws.

Dr D.J. HONEY: I am not implying any lack of professionalism by nurses. My concern is specifically around coercion on a nurse practitioner from a more senior person in a hospital, not out of some dark purpose, but simply because they believe this process should go ahead and they need an assisting practitioner. I am particularly thinking about small country practices. For example, Kojonup Hospital may have a handful of nurses, and only one medical practitioner who has agreed to participate in the process, and a nurse could feel compelled to be involved in it. It was really a question around that: is there any check and balance against coercion? It is a bit like sexual harassment in a workplace. There are very strict laws around sexual harassment, but we know that sexual harassment occurs very broadly in workplaces despite the numerous laws, rules and regulations, and severe penalties for that. The concern is about what processes will be in place to make sure there is not coercion, but I am not sure that the minister can give me any more of an answer than he has already given me.

Extracted from finalised Hansard
Dr M.D. NAHAN: What about in rural areas such as the Kimberley if a patient decides to go through the process and self-administer the substance or have it administered at home? Is the minister confident that he will be able to get one of the eligible administering practitioners to every facility in our large state?

Mr R.H. COOK: The member has summed up very succinctly the challenge of providing health care in Western Australia. It is a challenge; there is no doubt about that. One of the suggestions or recommendations from the ministerial expert panel was that nurse practitioners be able to participate in the voluntary assisted dying process for that very reason. We have lots of nurse practitioners in Western Australia, so the aspiration is that that will make it more available to people in remote communities. It will simply be a challenge that the WA Country Health Service and others will have to overcome, and they do that every other day. Ultimately, it is a challenge.

Mr R.H. COOK: Obviously, if the administering practitioner is to carry out a role in voluntary assisted dying, they will have to be there. It underpins the challenges in country health. It is just one of those things that the WA Country Health Service deals with every day.

Dr M.D. NAHAN: This is a new and very important one—somebody is being assisted in dying. We heard a couple of weeks ago that a number of wheatbelt centres had no doctors. This is a challenge for us. This is not a criticism of this government; every government has faced the same situation in trying to get medical practitioners to various areas. This is an additional special requirement. All I am seeking is a commitment from the government that what needs to be done will be done irrespective of the cost.

Mr R.H. COOK: Again, it is a challenge. We have 248 nurse practitioners in WA, 43 of whom are practising in WA country health regions, so the member can see why it is important to have them potentially involved in the process. The member is right; in some places, doctors are like hen’s teeth. Like everything else we do in country WA, this is just something that we are going to have to endure.

Ms M.M. QUIRK: Can the minister remind us what qualifications and training a nurse practitioner has generally? Then I want to explore the specific training for specific nurse practitioners.

Mr R.H. COOK: A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. They must be a registered nurse first and then complete an approved post-graduate master’s degree. In Australia, the registered nurse must have 5 000 hours of advanced clinical experience before they are eligible to be endorsed as a nurse practitioner by the Nursing and Midwifery Board of Australia. A medical practitioner or nurse practitioner must have successfully completed the approved training for voluntary assisted dying before they can be an administering practitioner.

Ms M.M. QUIRK: Under clause 53(2), the requirements for nurse practitioners to be administering practitioners will be approved by the CEO. Can the minister let us know what requirements are contemplated to be necessary for that approval to be forthcoming?

Mr R.H. COOK: During the implementation period, the Department of Health will develop a means by which interested medical and nurse practitioners may pre-register to check whether they meet the necessary eligibility criteria to act as a coordinating, consulting or administering practitioner and to receive the approved training. The CEO will approve the training for the various roles in relation to obligations under the voluntary assisted dying legislation. Ultimately, a nurse practitioner would be required to have had some experience in the area in which the patient is located and would obviously need to have the necessary clinical experience to fulfil the role of administering practitioner.

[Quorum formed.]

Ms M.M. QUIRK: I am not sure whether the minister or one of his colleagues explained the other night that there had been discussions with the Royal Australian College of General Practitioners about training modules and components. Presumably, independent discussions are going on about nurse practitioners. With whom are those discussions being conducted, and does the minister expect that the training will be on a par with that given to medical practitioners?
Mr R.H. COOK: The Australian College of Nurse Practitioners was consulted about nurse practitioners playing a role in this process, as was the Royal Australian College of General Practitioners. Obviously, they will be consulted again about the training modules. In relation to general practitioners, the college has offered to oversee and accredit the course to make sure that it contributes to overall professional standing.

Ms M.M. QUIRK: The minister raised the issue about the nurse practitioners having some expertise in the areas that they would be expected to deal with in the capacity of administering practitioner. Am I to understand, for example, that a nurse practitioner who principally undertook midwifery would not be appropriate, or would they be considered appropriate if they have had the necessary training?

Mr R.H. COOK: The nurse practitioner would need to register with the chief executive officer to take part in the training and, obviously, the assessment of that nurse practitioner’s experience would be relevant to whether they are registered. For instance, some nurse practitioners take a management stream in their careers. They are obviously highly qualified clinicians, but ultimately they have decided to specialise in leadership and management. Clearly, they would not have the day-to-day clinical knowledge that would be expected of someone who is still practising on the wards. It is an acknowledgement that nurse practitioners and, indeed, doctors come from a range of different backgrounds, specialisations and experience in their careers, and this is about making sure that the chief executive officer has oversight of this important role.

Ms M.M. QUIRK: I think the minister has pointed out that this is not the path that Victoria has gone down, because it does not have the same issues with remote and regional areas as Western Australia. There is a subtle ethical difference between nurse practitioners and physicians that I do not think this provision has necessarily picked up, and I am not confident that the CEO will even address it. I am not by any means diminishing the skill of nurse practitioners, but there is not the same history involving an ethical framework. As I understand, there have only recently been discussions about an ethical code for nurse practitioners, and nurse practitioners very much see their role as advocates for the patient. There could be some conflicts about their perceived obligations to advocate for the patient, as opposed to maybe having the independence to balance the ethical complexities in a fraught area such as this. I raise that as an issue that concerns me. At least, at the end of the day—the minister has been saying this throughout consideration in detail—there is a well-established ethical framework for medical practitioners. Although I recognise that nurse practitioners operate professionally, there is not that same consensus about ethical obligations and to whom they are owed.

Mr R.H. COOK: I appreciate the member’s observations. The development of the nurse practitioner qualification has been a huge benefit to the health community. They are highly qualified and highly experienced, and many in the medical fraternity often make the observation that they would trust a nurse practitioner over a GP any day. Notwithstanding that, the member made the observation about the differences between Victoria and Western Australia. As it happens, the nurse practitioner field has been particularly well developed in Western Australia, as opposed to Victoria. Victoria may have gone down this route, but I think you can count the number of nurse practitioners in Victoria on the fingers of one hand. It is a particularly well developed health practitioner field in Western Australia, and, as the member observed, we also have a very large area in which to operate.

Mr Z.R.F. KIRKUP: I am keen to understand whether an administering practitioner could have a commercial arrangement or relationship with a coordinating or consulting practitioner.

Mr R.H. COOK: It is technically possible, but the assessment still has to be independent.

Mr Z.R.F. KIRKUP: I imagine there might be some issues in relation to ethical guidelines, but could the administering practitioner be a related family member, or something like that, to the patient? I imagine it would be like other practitioners, but this is a bit different from normal practitioners.

Mr R.H. COOK: I think that would be captured under the malpractice arrangements. I do not think that would be possible, but it is important to be vigilant with these things.

Mr Z.R.F. KIRKUP: My next question is in relation to subclause (2) about the publishing of the information that is required. There is a lot of reliance on the website of the department to be providing various bits of information that are required. I imagine that this is all going to be found in the same place or in a relatively consolidated manner and very easy to find.

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: I note that nurse practitioners will already be in communities, and I want the minister’s assurance that, as part of their training, they will receive some cultural training on this issue. They no doubt know the communities in which they live, but obviously there are special issues surrounding death for Aboriginal communities, for example, that I think should be included in that training.

Mr R.H. COOK: I can most certainly make that commitment. It was a key recommendation from the ministerial expert panel. I do not have it directly in front of me—I can just see a photocopy from a distance—but I think it is even part of the Victorian training module. But the member is absolutely right; it is a very important consideration.

Clause put and passed.

Extracted from finalised Hansard
**Clause 54: Application of Division**

**Mrs A.K. HAYDEN**: Clause 54(a) states that this division applies if —

the request and assessment process has been completed in respect of a patient; and

The coordinating practitioner will have two days within which to lodge the completed final review. Once the final review has been completed, the patient will be given access to the administration of the voluntary assisted dying substance. Is there a chance that the patient will have access to the substance prior to the Voluntary Assisted Dying Board being notified?

**Mr R.H. COOK**: Upon reaching that stage, the patient must make an administration decision. Obviously at that stage, it has been confirmed that the patient has decision-making capacity, and that their request is enduring. The patient would then need to make an administration decision, and that would involve the appointment of an administering practitioner, or a contact person. Therefore, it is highly unlikely that in that intervening period, the Voluntary Assisted Dying Board would not have been told. I guess it is technically possible. Under this legislation, there is a capacity to reduce the nine-day period in the event that the coordinating and consulting practitioners were of the view that the patient would die within those nine days. It is technically possible, but ultimately it would be extremely rare.

**Mrs A.K. HAYDEN**: We have gone to the final assessment, and the board is not aware of it. Does the minister not believe we should make sure that the board is aware and is notified before the substance is administered? The board is overseeing everything and ticking off on the lot. We need to remember, as the minister has said, that the people who have gone down this path just want to end it as quickly as possible. They may be able to get the substance as soon as the following day, and the board is not notified. We have done all this work to ensure that the board is part of the process, but we are keeping the board out of it at the end. I know that the minister is not open to amendments, but maybe we should add that the substance cannot be administered until the board has been notified.

**Mr R.H. COOK**: I understand the point the member is making. The relationship ultimately is between the coordinating practitioner and the patient. Clause 54(b) states —

the final review form in respect of the patient certifies that the coordinating practitioner for the patient is satisfied of each of the following —

It then outlines each of the final stages. That will ultimately be the final review process for the coordinating practitioner. The patient will have to go through a process by which they will get the voluntary assisted dying substance. As we have already discussed, that will primarily be through a hub-and-spoke model, closely controlled by the chief executive officer. I understand the point the member is making. We have deliberately created a process whereby the relationship will be between the coordinating practitioner and the patient, oversighted by the Voluntary Assisted Dying Board. The Voluntary Assisted Dying Board in that context is not a police officer; it is an oversight panel. I understand the point the member is making, but, from that perspective, we do not believe it is necessary in the context of this stage of the process.

**Mrs A.K. HAYDEN**: Clause 54(b) states —

the final review form in respect of the patient certifies that the coordinating practitioner for the patient is satisfied of each of the following —

It then lists subparagraphs (i), (ii) and (iii). Does that mean that the approved substance could be administered by a medical practitioner or nurse practitioner who has not been part of the prior assessment?

**Mr R.H. COOK**: The way it will work is that this will be the final review stage by the coordinating practitioner. At that point, the coordinating practitioner will have gone through the assessment process and will be convinced that the patient’s decision-making capacity endures, and that their decision to access voluntary assisted dying endures. It will then go through to the administration phase. Under the administration phase, it will be up to the patient to make the decision. That is covered in clause 55, and we will have a closer look at that when we get to that clause.

**Ms M.M. QUIRK**: I raise this issue now because the minister has raised it. The minister made the assertion that the Voluntary Assisted Dying Board is an oversight board. It is an information-collecting board, and a board that ensures that the process has been complied with, but that oversight may well occur after the patient is dead.

**Mr R.H. COOK**: The roles and functions of the board are well and truly set out in clause 117, so I will beg the member’s patience in digging deeply into that. The function of the board will be to monitor the process. It is certainly more contemporaneous than the Victorian model, but it is not at the bedside, for want of a better description. Perhaps we can deal with that in more detail when we get to clause 117.

**Mr S.K. L’ESTRANGE**: I draw the minister’s attention to clause 54(b)(ii), in case I missed this at some point during the debate when we were last in session. It states —

that the patient in requesting access to voluntary assisted dying is acting voluntarily and without coercion; How will that be assessed?

*Extracted from finalised Hansard*
Mr R.H. COOK: The member is right; we did traverse this territory fairly extensively earlier. Obviously it is the role of the coordinating practitioner, armed with both their medical experience and their mandatory training in the voluntary assisted dying process, to make that call. Part of the training process will be to examine and be able to detect issues around coercion and things of that nature. If either the coordinating practitioner or the consulting practitioner is in any way in two minds and not absolutely convinced, they must seek further advice.

Mr S.K. L’ESTRANGE: What I am about to ask is in no way a reflection on our medical practitioners. I just want to pose this question so that it is on the record and we are all aware of it. If a medical practitioner was incredibly supportive of voluntary assisted dying as a medical option for a patient, and if, by virtue of another clause in this bill, they were able to introduce into the conversation between themselves and the patient the option of voluntary assisted dying, how would that be assessed or tested to determine whether opening up that conversation was in and of itself a form of subtle coercion?

Mr R.H. COOK: This is the matter of bedside conversation, and this is what our medical workforce is there to do—discuss people’s options at the end of life. This is the reason that we place so much trust in our medical workforce.

Mr S.K. L’ESTRANGE: I certainly get what the minister was implying—that there is a bedside-manner aspect to this. I suppose that I am looking at this from the perspective of somebody who might have been diagnosed with a terminal illness six months out, as per the legislation, in which case they might be sitting in a chair in a doctor’s office. I think we had an example about this from the member for Armadale the last time we sat. The patient might be relatively clear of thought and able to think for themselves, but they might be influenced by the authority or expertise of a doctor. In that sense, although they are not deeply in pain and suffering at this point in time, they are six months out from that fate. How do we know whether, at that point, the advice they will be getting is not a form of coercion?

Mr R.H. COOK: At this point, the patient will have had two assessments, one by the coordinating practitioner and one by the consulting practitioner, who each have to come to a separate assessment of the patient’s decision-making capacity, that they are not being coerced, that they are acting entirely voluntarily and that their decision is enduring. It is in that context. That is a hallmark of the assessment process. I understand the context in which the member for Armadale raised that particular issue, but, ultimately, the patient will have undergone a rigorous process to test their will in relation to this. The patient will have made a written declaration by this point as well, which will have been witnessed by two witnesses who do not stand to benefit financially in any way from the patient’s death. We can see that a range of people will have been involved in the process, each of whom will obviously have formed a view on potential coercion.

Mr S.K. L’ESTRANGE: Thanks for that, minister. As I said, my line of questioning was not actually to do with anybody getting a financial gain or anything like that; it was purely about getting medical advice. I wanted to make sure that was fully understood by the minister. Thank you.

Ms M.M. QUIRK: I refer to capacity, which comes under clause 54(b)(i). I think we have already established and are in fierce agreement that capacity can wax and wane throughout the process. How long is there between the administration decision and the actual administration? I ask that because there could be some issue in the interim, between the final review form and the certification and the actual delivery and administration of the drug.

Mr R.H. COOK: There is no specific time frame, but the member is right; decision-making capacity has to be enduring. The administering practitioner will have a similar role in terms of that capacity. One of the great limitations of this legislation is that it will not assist people who do not have that enduring capacity. Some people have criticised the bill for that, but I think the member for Girrawheen and I would share a concern that that has to be there.

Ms M.M. QUIRK: I think we are agreeing on this, minister. Really, until the time of administration, the administering practitioner will have an ongoing professional obligation to make an assessment about capacity, even though there is no formal requirement to do so in the bill.

Mr R.H. COOK: There is no specific time frame. Obviously, the patient’s decision must be enduring. I guess that in some respects, we do not want coercion to go the other way either—that is, to talk the patient out of it. As we have observed, the patient’s decision-making capacity will have to be present throughout the process. Indeed, even the administration decision will have to be clear and unambiguous. From that perspective, I think we have provided the right framework to make sure that the patient has that capacity throughout the process.

Ms M.M. QUIRK: This probably relates more to clause 55, but the minister did just mention number 38 in the hit list of protections; that is, the medication administration method decision must be clear and unambiguous. Are those words in the bill itself?

Mr R.H. COOK: Yes. I am sure we will come to that shortly.

Clause put and passed.
Clause 55: Administration decision —

Ms M.M. QUIRK: Effectively, in Western Australia, a patient will be able to choose between a self-administration decision and practitioner administration decision, but it is the coordinating practitioner who will advise the patient when a practitioner administration decision can be made. My view is that clause 55(2) places too much power in the hands of the practitioner and takes power away from the patient. I would like the minister's views on that.

Mr R.H. COOK: As clause 55(2) states —

A practitioner administration decision can only be made if the coordinating practitioner for the patient advises the patient that self-administration of a voluntary assisted substance is inappropriate …

I understand the member’s perspective, but I respectfully believe that too much power is not placed with the coordinating practitioner.

Ms M.M. QUIRK: We can differentiate between this requirement and the requirement in Victoria, where physician administration of the drug is possible only when a patient physically cannot do it themselves. One could argue that the provision is much broader in Western Australia. I want to know why that is.

Mr R.H. COOK: We had clear advice from the expert panel on this. It was thought that the Victorian provision was far too restrictive. I am advised that consistent with good medical practice, the coordinating practitioner will provide the patient with advice that the patient is able to consider in order to make an informed decision about the method of administration. That the patient’s decision is well-informed is fundamental to the proposed model for voluntary assisted dying in WA. Practitioner administration may occur only upon advice from the coordinating practitioner that self-administration is not appropriate, having regard to one or more of the following reasons: the person’s ability to self-administer the substance; the patient’s concerns regarding self-administration; and the administration method suitable for the person. A person may still access practitioner-administered voluntary assisted dying when they are physically capable of self-administering a voluntary assisted dying substance. This is because a person’s ability to access practitioner administration should not be dependent on their physical ability alone, but rather a number of factors that both the practitioner and a patient consider salient when deciding the administration method. For example, a physically capable person may still have an inability to self-administer due to concerns about incorrectly administering the substance or having an allergic reaction to the medication. This position is different from Victoria, where only physically incapable people may access practitioner administration. To quote that legislation —

… the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance; …

That is from section 46 of that act. However, the ministerial expert panel was clear that such a limitation should not apply in Western Australia.

Ms M.M. QUIRK: Why?

Mr R.H. COOK: I think I have just made that clear; it is because it was considered too restrictive. Ultimately, the ministerial expert panel wanted patients to be able to access voluntary assisted dying and that their capacity to self-administer, whether physical or otherwise, should not be an impediment to access the voluntary assisted dying process.

Mr P.A. KATSAMBANIS: There are different regimes in different places and some of them have had time to embed themselves. There has been a parliamentary inquiry and an expert panel inquiry into this legislation, so can the minister indicate to the chamber what percentage of people he expects will choose self-administration as opposed to practitioner administration?

Mr R.H. COOK: No, I cannot. Welcome to the debate.

Mr P.A. Katsambanis: I have been here a long time.

Mr R.H. COOK: Earlier, I tabled a response to one of the member’s questions. I just wanted to make sure that he got it.

Mr P.A. Katsambanis: I got that.

Mr R.H. COOK: I can inform the member that, for instance, 95 per cent of patients in Canada have chosen a practitioner-administered voluntary assisted dying substance. That might potentially give the member an indication. I am not sure.

I just want to say that I was not being critical; I just wanted to put it on the record.

Mr P.A. KATSAMBANIS: No; sure. There are a million things going on in this place at the moment, for all of us. I do not want to put words in the mouth of the minister, but in the choice between self-administration and practitioner administration, the Canadian regime seems to be closer to the regime that is being proposed here than the
regimes in other jurisdictions—for instance, Oregon and Victoria. Based on that figure of 95 per cent practitioner administration decisions in Canada, would the minister accept that it is more likely than not that practitioner administration will become the administration of choice in Western Australia?

Mr R.H. COOK: I do not think we are in a position to be able to make that call. I am perusing some notes in front of me to see whether they will assist me—not. Ultimately, Western Australia will have to plough its own path on this. We are in a not in a position to provide further advice on what we think the division might be between self-administration or practitioner administration.

Mr S.K. L’ESTRANGE: I am trying to work through clause 55. Clause 55(2)(c) states —

the method for administering the substance that is suitable …

But that is all based around subclause (2), which states —

(2) A practitioner administration decision can only be made if the coordinating practitioner … advises
the patient that self-administration … is inappropriate …

I am wondering why paragraph (c) is there?

Mr R.H. COOK: Some patients may not be able to swallow a voluntary assisted dying substance and some might be able to swallow but would not be able to ingest or digest the substance. Some medical limitations in the process may inform the nature of the administration.

Mr S.K. L’ESTRANGE: Is the answer that the minister just gave not covered by subclauses (2)(a) or (2)(b)?

Mr R.H. COOK: No. The ability of a patient to self-administer the substance may refer to their physical capacity to undertake the task. The patient’s concerns about self-administering the substance also go to the point about the patient’s views or attitudes to the process. The third is the medical limitations that are associated with that.

Ms M.M. QUIRK: As the minister rightly pointed out, the criteria in Victoria is narrower. I am a bit concerned that a medical practitioner will be somewhat assertive and insist on practitioner administration. The minister would accept that there is always an unequal power relationship between doctors and patients, even for those who are assertive and educated, and that people tend to bow to the advice of their doctor. I wonder whether for that reason it might be appropriate to require a witness to be present when an administration decision is made. It seems to me that that would be a way to alleviate some concerns.

Mr R.H. COOK: I am informed that this is considered to be a medical decision. A range of issues will impact on the decision. From that perspective, it is not a question of oversight and having a witness vouch for the integrity of the decision. A patient has to make the decision with the advice of and in conjunction with their practitioner. From that perspective, it is not appropriate that it needs to be witnessed because by its very nature it is a medical decision and, therefore, the patient must make their decision in conjunction with and based on the advice of the coordinating practitioner.

Ms M.M. QUIRK: Can the minister confirm—I am not a full bottle on this by any means—that in Oregon the majority of, if not all, cases are by self-administration?

Mr R.H. COOK: I understand that that is correct.

Mrs A.K. HAYDEN: The minister said that he would answer a question I asked during debate on clause 45 under this clause. That question was whether a decision could be made during the final review that a practitioner who was not part of a patient’s personal process could administer the substance.

Mr R.H. COOK: Thanks for reminding me to come back to this point. The coordinating practitioner can delegate the task of an administering practitioner, but the administering practitioner, regardless of whether they are the coordinating or administrating practitioner, must still be convinced of those three elements—that is, the decision-making capacity in relation to voluntary assisted dying; the patient’s request to access dying is voluntary and without coercion; and that the patient’s request to access voluntary assisted dying is enduring. As we discussed earlier under clause 53, the administering practitioner must also have met the requirements approved by the CEO and have undertaken the mandatory training.

Mrs A.K. HAYDEN: Does the administering practitioner have to go through the same elements that the minister just referred to?

Mr R.H. COOK: That is correct.

Dr M.D. NAHAN: In essence, this is a third check. There is the coordinating practitioner, the consulting practitioner and the administering practitioner. All three must decide that the patient is free and capable of making such a decision and that there is no coercion—that is, they are of sound mind and there is no coercion. There will be three vetting checks by medical experts along the line to quantify that.

Mr R.H. COOK: That is the case. Obviously, if the coordinating practitioner is also the administering practitioner, there are not three people involved in the process, but the member is quite correct that there is that three-stage process.
Dr M.D. NAHAN: The coordinating practitioner is generally administering; how can that be in very isolated areas?

Mr R.H. COOK: That is correct. In an isolated situation the member can understand that the coordinating practitioner is unlikely to be the administering practitioner, so it is an extra check and balance. That should provide members with more assurance because extra eyes and minds are applied to the process.

Dr M.D. NAHAN: One of the objectives of the process is for it to be expedited because the person is generally on the pathway to death. I understand if the coordinating practitioner is the administering practitioner, but if they are not and if they are new to the patient, which could be the case in isolated areas in particular, how are they going to make decisions about the consciousness of the person and, particularly, the issue of coercion? Their main role is basically to oversee the administration of the substance; that is what their basic role is. The patient has already been vetted twice, but if they are new to the process, how can they possibly be really careful, particularly about coercion, when it is not the patient, but the people around the patient who are the major concern?

Mr R.H. COOK: At this stage, of course, the patient has undertaken two assessments, it has been made sure that their decision-making capacity is enduring and they have made a written declaration witnessed by two people. The administering practitioner would be talking to the patient about their decision and would have regard to the decisions of the coordinating and consulting practitioner. It would obviously be an element of the training process for the administering practitioner to be able to make sure that they are satisfied with those three elements.

Dr M.D. NAHAN: What happens if after the patient has gone through this lengthy two-stage process of the coordinating practitioner making the decision that they are eligible, the administering practitioner, who is an expert, has been trained and gone through the process, makes a decision that something is up and they are not going to do it? Where do we go from there?

Mr R.H. COOK: In the first instance they would go back to the coordinating practitioner and express a view that they do not think the patient is eligible. Indeed, they would also make reference to the Voluntary Assisted Dying Board, because at that point they are essentially stopping the process.

Dr M.D. NAHAN: That is interesting. It would be extremely frustrating to the patient for them to have gone through this process and then all of a sudden for the person whose real role it is to facilitate a decision that has already been made to decide not to go through with things. This is actually a third check in this process that I do not think the minister has emphasised enough. In Oregon a lot of the deaths take place at home or at a place of the person’s choosing, which is a good idea. When the substance is administered, the family and relatives will be around the patient, and the administering practitioner might get a view that the coordinating practitioner never had—they might; we do not know. If the administering practitioner says that they are not confident and they cannot sign off on a lack of coercion, and the matter goes back to the coordinating practitioner, do things start all over again or does the coordinating practitioner get another administering practitioner who is more aligned to the coordinating practitioner’s views? Are we stuck in a do-loop going around with very sick people?

Mr Z.R.F. Kirkup: What is a do-loop?

Dr M.D. NAHAN: That is before the member’s time. It is a computing term. It is being stuck in a circle going around and around that cannot be got out of.

Mr R.H. Cook: A vicious circle.

Dr M.D. NAHAN: Yes, a vicious circle.

Mr R.H. COOK: The member could appreciate that if the administering practitioner is of the view that the patient has lost capacity, the process stops and has to go back to the coordinating practitioner. As we have discussed in earlier clauses, the patient ultimately has the capacity to go to the State Administrative Tribunal and say that they do have decision-making capacity. The situation would require an administering practitioner to be of the view that the patient does have the capacity. It is an element and another restriction, or safeguard if you like, to the process, and I think it is an important one.

Dr D.J. HONEY: I know this is covered later, but I might as well deal with that here. I refer to clause 55(2)(c), which states —

the method for administering the substance that is suitable for the patient.

Could the minister outline what those methods are? Just to pre-empt the answer little bit, do they include injection, intravenous drip or assisted ingestion? What methods are anticipated for the administration of the substance?

Mr R.H. COOK: Obviously, the method depends on the patient’s circumstances, as I mentioned in my response to the member for Churchlands. It will depend upon the patient’s physical capacity to absorb or take the drugs. The member mentioned a number of ways that could happen and yes, they would be included. Kerry Robertson, the woman who accessed voluntary assisted dying in Victoria, took the substance orally, but other patients may need to have it administered by injection or IV drip. I am advised that the likely methods of death may include self-administration, which would be oral medication in liquid or tablet form administered by the patients.
They themselves, or practitioner administration, which would be the administration of the substance by the administering practitioner—for example the coordinating practitioner, another medical practitioner or nurse practitioner—in the form of a liquid or tablet, or via injection, oral tube, nasal tube, intravenous line or stomach peg. I am not saying that is an exhaustive list, but it gives an idea.

**Dr D.J. HONEY:** I am not trying to be cute here, but if someone opted for oral self-administration, they changed their mind and the practitioner decided that the only alternative was a lethal injection, I assume it would require a different substance, or form of it, and there would be some delay in the process until that substance was accessed.

**Mr R.H. COOK:** I am conscious that I am a layperson answering a question from someone who I think has a PhD in chemical engineering, so I am going to be very careful what I say. I assume that it would be a different substance, depending on the nature or method of application.

**Mr Z.R.F. KIRKUP:** I have a number of issues I would like the minister to look at concerning the administration decision. As part of the administration decision and the conversation the patient would be having with their coordinating practitioner, and they decide on self-administration, there is no requirement for them to nominate a location where they might take the substance. Am I reading the bill correctly?

**Mr R.H. COOK:** Yes, member, that is my understanding. We come to self-administration in clause 57.

**Mr Z.R.F. KIRKUP:** I appreciate that. Clause 55(1) provides for the consultation they will have with their coordinating practitioner. Is that consultation about what decision they want to make and there are no other circumstances around that? Will the practitioner have a conversation with the patient at that time to discuss the options they have and what it will look like if it falls through?

**Mr R.H. COOK:** This clause deals with the administration decision which, as the member can see, has a very specific legal application in relation to the voluntary assisted dying process. The member can understand that at this time a range of conversations are going on between the patient and the coordinating practitioner about their pain and a range of circumstances. Clause 55 deals with the nature of the decision around self-administration or practitioner administration.

**Mr Z.R.F. KIRKUP:** I appreciate that, minister. One of the concerns that was raised with me as part of the town hall contact I had in my district was that a lot more people in my district indicated their preference for an administration practitioner. The onus here obviously is reversed; it is self-administration unless one of those three concerns are raised there, individual concern or the like. Is there any reason the default option is not provided together with the administration decision with the practitioner as part of this legislation?

**Mr R.H. Cook:** Is the member suggesting that they do not have to have the same checks and balances in the event it is self-administered?

**Mr Z.R.F. KIRKUP:** A lot of concerns raised with me in my district was that the default position be practitioner administered rather than self-administration. People who raised this issue with me felt they do not necessarily like having the conversation, “I have some concerns about the self-administration so here is the practitioner.” A lot of people would feel safer knowing that the legislation reflected practitioner-administered decision by default, and wondered why that was not the case.

**Mr R.H. COOK:** I do not agree with the characterisation of it as a default mechanism one way or the other. I believe this is, essentially, a decision the patient would make after many discussions with the coordinating practitioner. Obviously, clause 55(2)(a), (b) and (c), are all elements that will inform that decision. Ultimately, this is a decision they will come to with and on the advice of the coordinating practitioner for the patient. I do not think we default one way or the other. We are saying there are two pathways and they need to take one or the other.

**Mr Z.R.F. KIRKUP:** I appreciate that. A lot of the concerns raised with me, and it was my view, were that in light of subclause (2), patients have to meet a certain number of requirements to reach the practitioner rather than having to work back from it being taken as a given that the practitioner administers it. The patient has to prove that they can self-administer. I appreciate that it is not in the legislation; it was a concern raised a number of times in my district by people who felt that the practitioner should have that role. I appreciate that the minister has already answered that to provide some clarity.

Clause 55(3) states that an administration decision “must be clear and unambiguous”. I appreciate the requirement there also for the audiovisual. I am keen to understand more about that if administration is ultimately proven not to be allowed to occur because they cannot make a clear and unambiguous decision in person. Does the minister see any other option? I assume the minister is quite confident that the audiovisual element will remain the same.

**Mr R.H. COOK:** I am confident about the audiovisual. The member will also see in subclause (4) that the patent may make an administration decision verbally or in another way, for example, by gesture, so it contemplates the circumstances in which the patient has lost the capacity to speak and is very frail. Obviously, there will be a range of communication protocols in place for that. My advice is that the patient’s administration decision must be clear.
and unambiguously made by the patient either in person or by means of audiovisual technology either verbally, by gestures or by other means of communication available to the patient. This is to prevent discrimination against people on the basis that they cannot speak. As long as their request is clear and unambiguous, this will suffice. Examples of alternative means of communication include sign language, and the use of a communication board or an iPad communication aid. Such strategies are often established with the person by a speech pathologist.

Ms M.M. QUIRK: I think the minister has answered the question. I wanted to know what the words “in another way” meant. Obviously, that is broader than gestures. I think the minister referred to the use of an iPad. Would that be the kind of use he contemplates coming under the definition of “in another way”?

Mr R.H. COOK: Yes, member. I hope that description satisfies the member’s concerns about subclause (4). Obviously, it is important that just because a patient has a physical incapacity they are not disadvantaged in the process and cannot participate.

Mr S.K. L’ESTRANGE: To follow up on the member for Girrawheen’s point about using gestures or an iPad in the administration decision or “in another way”, can the minister clarify who will be in the room? Who will they be making the decision to?

Mr R.H. COOK: This goes to the question of the administration decision. Technically, it can be the coordinating practitioner and the patient. If it is via audiovisual, some assistance will be required with that. That is why it is important to have a line of sight, particularly in utilising gestures or some other form of communication.

Mr S.K. L’ESTRANGE: If we are talking gestures, it is hard to define what the gestures might be by people with different levels of incapacitation. We do not know, but, obviously, the medical practitioner present will have to interpret what they are seeing—if it is hand signals or whatever. Is there any safety mechanism in place to make sure a gesture is not misinterpreted? In these circumstances does there need to be more than one medical practitioner present so that the consensus view is that it is exactly what the patient wants?

Mr R.H. COOK: Does the member mean in person or specifically around the audiovisual?

Mr S.K. L’ESTRANGE: Either. Because, essentially, the medical practitioner will be trying to interpret the administration decision of the patient. Is that correct in this instance?

Mr R.H. COOK: Yes.

Mr S.K. L’ESTRANGE: Therefore, I am asking: how is a medical practitioner protected from not making a mistake in how they interpret those hand signals or whatever?

Mr R.H. COOK: This again comes down to the training for that. I stress that the requirement is that the request has to be clear and unambiguous. If it is a hand gesture or something like that—remember, this comes at the end of a long process—existing protocols will be in place regarding the way the patient communicates. If the patient has lost speech capacity or speech is challenged, a speech pathologist or some allied health professional would have been engaged. It again comes down to the issue that the way the patient communicates the decision has to be clear and unambiguous. We have left it like this for the reason that we anticipate that there will be situations in which a patient has to communicate other than by way of verbal communication.

Mr S.K. L’ESTRANGE: My take on why clause 55(4) exists is that it is for those people who cannot communicate as clearly as would normally be the case. All I am asking is: why would the minister not consider there being a witness present—a medical practitioner witness—so that there are at least two people with expertise to actually listen to or observe that request in whatever form it might be? As we have seen, clause 55(4) contains the words “or in another way”. “Or in another way” could mean any number of things, so all I am suggesting is that it might be a good safeguard to have a witness present who has a medical background to make sure that not just one person is interpreting, but two, at the very least.

Mr R.H. COOK: I appreciate the member’s concern. I guess ultimately it is a question of balance. This is about empowering the patient to be able to make a decision to positively access the process, so from that perspective we are confident that protocols are in place to allow that patient to be able to make the necessary decision. I draw the member’s attention to the fact that there still has to be a witness in the practitioner administration process, so obviously it is not a process that takes place away from other folk. In communicating the decision, clause 55(4) simply allows or anticipates that there will be those who need to communicate in a way other than verbally. It is not necessarily the case that the way in which that is communicated will be unambiguous, so if there is ambiguity, obviously other measures would have to be put in place. I take the member’s point that he wants a witness because he thinks there might be ambiguity. If there is ambiguity, other measures have to take place because the decision made has to be clear and the request has to be clear and unambiguous. If they cannot be clear and unambiguous, they clearly are not fulfilling that clause of the bill.

Mr S.K. L’ESTRANGE: Is what the minister just said—if it is determined to be ambiguous—captured in the bill? How is that captured in the bill?
Mr R.H. COOK: Clause 54(3) states —
An administration decision must be —
(a) clear and unambiguous; and
(b) made in person before the coordinating practitioner for the patient or, if that is not practicable, in accordance with section 156(2)(a).

That refers to the audiovisual provisions.

Ms M.M. QUIRK: I am reluctant to raise this, given the minister’s learned adviser, but there is always an issue about leading questions. I am a bit concerned about how things are phrased. I do not want to make the process more problematic for those requesting it, but if they are relying on gestures, surely they cannot say something that will not really elicit a meaningful response. For example, if the medical practitioner is raising the various substances that might be used and the different kinds of responses or reactions that may take place, I am not quite sure how that conversation would take place. I understand that people with motor neuron disease who do not have speech, for example, are in a particularly difficult position. I do not want to diminish their right to exercise their choice in these matters, but they might say, “If you would you like X substance administered by me, blink”, or, “If you want it done at home, no blink”. From that, do we infer that the patient would like the drugs administered by a physician? As part of the training, is there going to be some issue about how those questions are put so that any response that is in a gesture form will in fact be meaningful and will communicate the full nuances, if you like, of intention?

Mr R.H. COOK: Yes, in the context of the training, they would canvass issues around how they ask these questions in a sensitive matter. Ultimately, it is a binary question. At this stage, the patient has been assessed by two practitioners, made a written request, made the final review and communicated a range of things over a period of time, as I mentioned in reply to the question from the member for Churchlands. If people have some incapacity in being able to verbalise their particular perspective, obviously a speech pathologist would be involved. For the purposes of clause 55, the patient has to make a binary decision and it is either administered or self-administered. We could anticipate that it would be in the manner that the member described.

Ms M.M. QUIRK: Another issue comes up frequently in the context of the Aboriginal community. We are all familiar with situations in which people have been wrongfully charged and even convicted based on faulty police interviewing techniques. Again, I just want to raise that as an issue. I anticipate that that will be considered down the track at the implementation stage, but there is always the concern that those being questioned want to be agreeable; that is a cultural aspect that we need to be particularly mindful of.

Mr R.H. COOK: I completely agree, member.

Mr Z.R.F. KIRKUP: There are a number of references to gestures throughout the legislation, and I think reference was made to an iPad in relaying information. By the sound of it, I imagine that there is probably going to be some sort of application developed for that iPad. As the minister said, there will have to be a decision between two different administration decisions, for example. As part of this, when such a decision has to be made perhaps by gesture, is the department looking at making or developing any such application? I am keen to see what that looks like, because it might not be such a bad idea to have something like that.

Mr R.H. COOK: Not that I am aware of. We might anticipate that in the context of the legislation, but, more importantly, I think we would anticipate a whole range of applications utilising an iPad or some sort of device like that for communicating with people, whether it is on this issue or others.

Clause put and passed.

Clause 56: Revocation of administration decision —

Mrs A.K. HAYDEN: Clause 56 deals with the ability to revoke the decision, which we discussed at clause 54. Without going over that again, can the minister explain to me the process of returning the substance if the patient decides to go down the voluntary assisted dying path, opts for self-administration and then changes their mind?

Mr R.H. COOK: I will be very happy to do just that on division 4, which deals with prescribing, supplying and disposing of the voluntary assisted dying substance. It begins on page 45 of the bill.

Mrs A.K. HAYDEN: I do not want to move on from this clause only to have the minister tell me that I should have asked the question on this clause, so I am happy for him to direct me to another clause. If the substance is stored at home—again, this might be dealt with in division 4—is there a period within which it needs to be returned? Can the patient keep it and not record that they have changed their mind, because they want to delay it? If they want to delay the decision, do they need to revoke it? Is there a time period that changes it from a delay to a revocation of the decision?

Mr R.H. COOK: To a certain extent, I can respond to this by saying that delaying is not a revocation of the self-administering decision. Again, what will happen with the voluntary assisted dying substance is dealt with extensively in division 4. The clause essentially provides that the patient may at any time revoke an administration decision. The patient may inform the coordinating practitioner or the administering practitioner of the decision to revoke in a number of ways. Clearly, this is about stopping the process; it is not about delaying the process.

Extracted from finalised Hansard
Mrs A.K. HAYDEN: If I am the patient and I have decided to self-administer and euthanase myself, I can do this and then say, “I’m not doing it today.” Is there a time frame in which I have to administer it? Will the substance still be valid? Does the substance have an expiry date? I understand that the minister said that a delay is a delay and revoking is a different issue. I could take the substance home and administer it tonight, tomorrow or next month, but could I do it in six months or a year down the track?

Mr R.H. COOK: I can assure the member that, by definition alone, they would not delay it by a year. The short answer is no. The long answer is that we will deal with that in division 4. The revocation of the administration decision means that the patient may at any time revoke a self-administration decision by informing the coordinating practitioner for the patient that the patient has decided not to self-administer a voluntary assisted dying substance or revoke a practitioner administration decision by informing the administering practitioner for the patient that the patient has decided not to proceed with the administration of a voluntary assisted dying substance. This is about the revocation of the decision made under clause 55.

Mrs A.K. HAYDEN: The difference is that I have changed my mind and I have to hand it back. The minister will tell me what that process is when we get to division 4. But if I choose to delay it, that has nothing to do with revoking.

Mr R.H. Cook: Correct, yes.

Dr M.D. NAHAN: If a patient decides to self-administer it, they can revoke that decision, or they can change the decision to have it administered by an administering practitioner or they can say that they do not want it altogether. It is one of those options.

Mr R.H. Cook: Yes.

Dr M.D. NAHAN: I do not want to harp on this, but I think it is very important for us to have data on this. This is a very controversial process, as the minister well knows. Under clause 56(4), a lot of data on the revocation decision must be supplied to the board. That is great and I understand that. However, a patient may decide not to take the substance and they may not officially hand it back but keep it for a while and then pass away without using it. That is a very important piece of data that I do not think will be explicitly collected. I understand the revocation form; that is good. But from the discussions I have had with people, the substance has a potentially therapeutic aspect because it allows people to have, let us say, insurance if things get too painful. I think it is very important to have an explicit set of data that the board and other people acquire. One of the themes of this bill is for data to be collected at every step of the way, which is good, but this seems to be an omission. The member for Darling Range asked what would happen if they kept it for a year. There are many cases of people being diagnosed with a disease that will kill them in six months but they live for two years. We have heard it in this room. It could happen. We will deal with the treatment of the substance when we get to division 4. Again, there appears to be a gap in collecting data about people who have it in their possession and will use it if they need to, but decide not to.

Mr R.H. COOK: If a patient decides to self-administer, the contact person is required to return either the unused portion or the entire portion for disposal by an authorised disposer. In that context, the Voluntary Assisted Dying Board would have oversight of that process and would obviously be in a position to record that. The revocation of an administration decision will be provided in a revocation form to the Voluntary Assisted Dying Board, as the member observed. Ultimately, if a patient has gone through the process but not used the voluntary assisted dying substance, there would be a record of that from either the coordinating practitioner or the contact person, and that would be by way of either communication or the return of the substance.

Mr Z.R.F. KIRKUP: Under subclause (2), the patient may inform the coordinating practitioner or administering practitioner of the patient’s decision in writing, verbally or in another way—for example, by gestures. Why was “may” used, not “must”?

Mr R.H. COOK: It is because there are alternatives. They could do one or the other. Obviously, if they are going to revoke, they have to do what is outlined in either paragraph (a) or (b) of subclause (1), but that decision is theirs. It is about empowering them. We had this dialogue with the member for Girrawheen—in some instances, the CEO “must” and in other instances the CEO “may”. This is a “may” situation.

Mr Z.R.F. KIRKUP: I refer to subclause (3). The member for Darling Range spoke about the lack of a time frame for informing the coordinating practitioner of the revocation. There should be a requirement that that information is very quickly discussed, and that the practitioner is informed. Is there a reason why there is no particular time constraint on that?

Mr R.H. COOK: This empowers the patient to change the nature of the administration of the substance. The only constraint on that is that they make that decision before the substance is administered. Essentially, this is about the patient deciding not to take the medication or have the medication administered today or tomorrow. The day after that they might say, “Actually, I’ve decided to take it myself” or “I don’t want to take it myself; I want it to be practitioner administered.” In that sense, there is not a time frame or a specific limitation on when they make that decision.

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: Clause 56(3)(c) states —
within 2 business days after the revocation, complete the approved form … and give a copy of it to the Board.

Will the revocation form be published or provided anywhere else, because I do not believe that it is defined at this point in time? I obviously appreciate that it would not be defined in the legislation, but will it be published as normal? How will it be provided, and what does it look like in terms of how it is stipulated?

Mr R.H. COOK: As the member can see, subclause (4) provides detail about what is in the form. The form itself would be available on the website, for instance, for download. I can imagine that, at this point in the process, there is quite a lot of documentation sitting around the patient, and I would imagine it would be part of the pack that the patient would be issued with. Obviously this would be subject to implementation.

Mr Z.R.F. KIRKUP: My concern about the revocation form was the need for it to be easily accessible.

Mr R.H. Cook: “Give me that form; give me that form!”

Mr Z.R.F. KIRKUP: That is right. I raised with the Attorney General when he was at the table previously the issue of the lack of location on these forms—where those decisions were made. Given that the minister is here now, and we are able to go through it in a bit more detail, is there any reason why the location in which each decision was made has not been included? I imagine that that would be helpful, perhaps for review purposes or something like that. Is there any reason, in particular, that that has not been included? I appreciate the Attorney General’s limitations, but I asked him whether that would be helpful for any investigative or review purposes. His view was “not necessarily”, which is not to verbal him, but I am keen to understand why that would not be included. I think it would be helpful, perhaps, for us to be able to review the decision made at this location, and all that sort of stuff—just to track the process as part of that journey.

The ACTING SPEAKER (Mr R.S. Love): Members on my right—member for Wanneroo, member for Morley, and minister—keep it down, please.

Mr R.H. COOK: Just to clarify, the form is filled out by the coordinating practitioner, in answer to the member’s last question, but we have included in the form what we consider to be the bare minimum. I can imagine the chief executive officer or the Voluntary Assisted Dying Board would want to have other information in front of them, but this is the very bare minimum as required under the legislation.

Mr Z.R.F. KIRKUP: Effectively, it helps with the point that the member for Riverton made about data collection. My view is that we would want as much exhaustive data as possible, particularly about the location if it is a regional issue, but I appreciate that this is the bare minimum. My final question refers to subclause (5), which states —

The revocation of an administration decision does not prevent the patient from making another administration decision under section 55(1).

I assume that that has been included because effectively the revocation does not take away the patient’s enduring will. Is that correct?

Mr R.H. COOK: That is correct.

Mr Z.R.F. KIRKUP: Minister, I may as well just keep on.

Mr R.H. Cook: You said that was your final question.

Mr Z.R.F. KIRKUP: Yes, I did, but is there a reason there is no time constraint on that particular element, in revoking an administration decision, for some time to pass before the patient can go back and make another one? Is there any reason why more constraint was not applied to the patient making another decision? I imagine the patient would be asked whether they wanted to continue, and is just revoking that particular one—that sort of decision-making.

Mr R.H. COOK: Member I can confirm that this is about empowering the patient. We did not want to put any limitations or pressure on that decision-making process.

Ms M.M. QUIRK: It is probably evident to most people, but I am having a little trouble with clause 56(4)(c) in contemplating circumstances in which a revocation may occur. The coordinating practitioner does not fill in the form, but someone else does. Is that a situation in which, say, the patient might communicate with a nurse or something, and the form goes to the board having been completed by someone other than the coordinating practitioner?

Mr R.H. COOK: Yes, I guess it would take place in a clinical environment. It could be the administering practitioner as well for that matter. It is essentially there just for the purposes of completeness.

Ms M.M. QUIRK: I know we have been concerned about coercion in other contexts, but it seems to me that this could be a situation in which family members bully the patient, who, then, under some duress, tells the nurse, “No, I’ve made a decision but I no longer want to do this”, and we do not effectively have the supervision of the coordinating practitioner to clarify that position.

Extracted from finalised Hansard
Mr R.H. COOK: I am informed that under subclause 4(c), once the person has made the revocation decision, they then have to go and make another administration decision, so they would go back to then making a self-administration decision or a practitioner-administration decision. At all times, the coordinating practitioner would be involved in the process and, ultimately, as we referred to earlier, the administration decision must be clear and unambiguous.

Ms M.M. QUIRK: With reference to subclause (4)(c), I understand the minister’s last answer, but I would not mind if he would give me an example in which the circumstances contemplated in this subclause might occur.

Mr R.H. COOK: One example would be when a coordinating practitioner has delegated their role to an administrating practitioner, so the person by the bedside or close to the patient at that point in time may be the administrating practitioner, and the patient has formed a different view.

Clause put and passed.

Clause 57: Self-administration —

Dr D.J. HONEY: Subclause (2) refers to a voluntary assisted dying substance that is of a “sufficient dose” to cause death. Is there any guidance about what that amount will be? To short-circuit the discussion, will there be any limit on the amount? I have heard that in other jurisdictions, sometimes a double dose is prescribed in case the person who was self-administering the liquid regurgitated it and another dose was required to be administered. Could the minister explain what limit will be placed on the amount, and whether it would be possible to prescribe a double dose to ensure that the patient would ingest a sufficient quantity?

Mr R.H. COOK: I am advised that the choice of lethal medication will be a clinical decision made by the coordinating practitioner from an approved list of schedule 4 and 8 poisons only. That is covered under clause 7. The chief executive officer of Health will have the authority to approve schedule 4 or 8 poisons for inclusion on the approved list. It is intended, as part of the implementation of the bill, that a clinical panel be convened to determine the schedule 4 and 8 medication protocols suitable for voluntary assisted dying in Western Australia. The clinical panel will also inform the operational requirements for supplying, dispensing and ensuring the safe management of these medications. It is expected that this clinical panel will include appropriate representation from pharmacy, medical and nursing experts from a Department of Health and clinical perspective. I should say also that all persons who will perform a function under the bill will be subject to the Medicines and Poisons Act and the Misuse of Drugs Act. There are obviously very strict protocols for the prescription and management of those medications. The decision would be undertaken in full sight of the clinical training that goes with that, and ultimately there would be advice from the panel about the amount and things of that nature.

Dr D.J. HONEY: I hear that explanation, but that is in the future. Is it possible or likely under this clause that a double dose could be prescribed?

Mr R.H. COOK: There may be malpractice, I guess, in that context. Is the member saying that they would want to make sure there was enough of the medication, not that they would administer it twice?

Dr D.J. HONEY: My understanding is that in other jurisdictions, a double dose is sometimes prescribed, because people may have difficulty ingesting the substance the first time and regurgitate it, and they want to ensure that they receive an adequate dosage.

Mr R.H. COOK: I thank the member for the question. I now understand what the member is trying to ask. This goes to the important discussion that takes place between the coordinating practitioner and the patient about whether the patient will self-administer or the practitioner will administer. Clause 57(2) states —

The coordinating practitioner for the patient is authorised to prescribe a voluntary assisted dying substance for the patient that is of sufficient dose to cause death.

In that context, it is not about topping it up, so to speak. It is about a clinical decision. Part of that clinical decision is the way in which the drug will be administered. The member has raised—pretty impressively—a number of different ways in which that might occur.

Mr Z.R.F. KIRKUP: I refer to the requirement to “prepare” the prescribed substance. Can the minister explain why that has been included? I assume the substance could be a singular pill, or something like that; I do not know what it will look like. Will this preclude a patient from being able to consume a single pill? To me, “prepare” means all the types of processes that the member for Cottesloe has outlined. Why has preparation been enshrined in the bill? If in the future a single pill were to be developed, would a patient be precluded from simply taking that?

Mr R.H. COOK: I am advised that this is to enable the clinical panel to have available to it the full range of substances that might be brought to bear. The member is quite right. I guess that ultimately a pill would need to be prepared. However, I assure the member for Cottesloe that we could imagine a range of different ways in which the substance could be prepared, or combined with other substances, in order to take it in a manner that was appropriate for the particular patient.
Ms M.M. QUIRK: I want to raise a couple of issues. I intend to move an amendment, but, prior to that, I want to talk about subclause (4) and the words “authorised supplier”. That is defined earlier in the bill. As I understand it from clause 78, an authorised supplier is a person who is on a list authorised by the CEO. As the minister would say, we will get to that in due course. Subclause (4) provides that the authorised supplier is authorised to —

(a) possess the prescribed substance …
(b) prepare the prescribed substance; and
(c) supply the prescribed substance to the patient, the contact person for the patient or an agent of the patient.

Will authorisation be required for conveyance of the substance, or does that come within the definition of “supply” in paragraph (c)?

Mr R.H. COOK: Yes. The language is consistent with the language in the Medicines and Poisons Act.

Ms M.M. QUIRK: I know that we will get to this in clause 78, but does the minister contemplate that pharmacists in public hospitals will be on the list? Will private pharmacists be on the list? What will be the scope of people who will be authorised suppliers?

Mr R.H. COOK: I am advised that authorised suppliers will be limited to registered health practitioners authorised under the Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons. It is likely that authorised suppliers will include a public health service hospital or pharmacy with pharmacists and specialist practitioners who are authorised under the Medicines and Poisons Act 2014. These registered health professionals, including pharmacists, are already bound by professional obligations that require them to act within their scope of practice and area of expertise. As I mentioned earlier, we contemplate that we would probably have a hub-and-spoke system. It would certainly not be the case that the medicines would be available from the corner pharmacy. It would be a carefully delegated and authorised process, overseen by the chief executive officer.

Mrs A.K. HAYDEN: I asked about this earlier and the minister said we would deal with it later, so I am wondering whether it comes under this clause as well. It is in regard to preparing a prescription for the substance. With the preparation and handing over of the substance, will there be a use-by date, and is there a storage requirement for this substance?

Mr R.H. COOK: In relation to the dates, I am advised that that would obviously depend on the medication itself. Ultimately, that would come down to the advice provided by the authorised supplier to the contact person or agent of the patient. Storage of the medication is covered in subsequent clauses, so we will come to that fairly shortly.

Mrs A.K. HAYDEN: The use-by date obviously cannot be determined at the moment because we do not know what the substance will be. If there is a use-by date for the substance, what requirement will there be for the substance to be used prior to that expiration date or returned once it has expired?

Mr R.H. COOK: As I said before, it would depend on the medication. Obviously, there will be an obligation to return any unused portion of the medication. In the event that it expired for whatever reason, there would be a requirement to return it. We would not put a time line on the patient themselves. I am sure the chemist does not want to be in the position of saying, “Here’s a voluntary assisted dying substance. Make sure you use it inside a fortnight”, because that would obviously be a very unfortunate set of circumstances. We will need to carefully craft the circumstances and the conversation that will take place with the authorised supplier, but of course that will be subject to training.

Mrs A.K. HAYDEN: I thank the minister for that. I am not at all asking for that to occur, so I totally agree with the minister. My concern is more to the point that we do not know what the substance will be, so we are making it up as we go along at the moment. Let us just say that the substance has only a three-week lifespan for 100 per cent potency. I am concerned about a situation in which it expires and the potency level drops, or the substance is not as effective as it is meant to be. The minister’s answer, if I understood him correctly, is that nowhere in this bill does it say that if there is an expiry date on the substance, it needs to be handed back on that expiry date. The last thing we would want is for someone to do this and for the substance to not work because it has expired. That would be tragic.

Mr R.H. COOK: There is obviously a great deal of information that needs to be provided by the authorised supplier to the patient or their representative. That would clearly be part of it. I just draw the member’s attention to my earlier remarks about the clinical panel. Obviously, it would not have as one of the voluntary assisted dying substances a substance that was so unstable that it would have to be used within a very time-limited period, because that, of itself, would be counterproductive in terms of the process.

Mr S.K. L’ESTRANGE: I am still dealing with clause 57(5), which the minister started to talk about with the member for Darling Range. I am just looking at paragraph (b) that says —

possess the prescribed substance for the purpose of preparing and self-administering it; …

Has any contemplation been given to the maximum amount of time that that substance can be held by the person?

Extracted from finalised Hansard
Mr R.H. COOK: No.

Mr S.K. L’ESTRANGE: We can also look at subclause (5)(d), which states —

self-administer the prescribed substance.

I will just give an example of what could happen. A person goes and collects the substance or poison—whatever we want to call it—and takes it home. Let us say they live at home alone. Nobody then knows the time line within which this person is going to use the substance. If they use it straightaway and nobody knows this person, outside of the person who issued it, does that mean the body will be left in the home for some time? Is there any follow-up on that? If they are not going to use it at that point in time, is there any security around the substance itself? If there is no maximum time frame for the substance being kept in the home, there could be safety issues and issues with just looking after the person after they have deceased. What I am getting at is that I think time frames probably are an important practical aspect of this legislation, as well as a safety aspect.

Mr R.H. COOK: The self-administration will be at a time of the patient’s choosing. If they choose to self-administer, they will have to appoint a contact person under division 3, and that contact person will have a range of obligations in terms of the process. Under division 4, we will come to the management of the voluntary assisted dying substance in terms of responsibilities around storage and things of that nature. They are like any other schedule 8 poison or drug—the person has obligations for the storage of it. As I said, we can come to that. I am further advised that the legislation includes all the existing safeguards of the Medicines and Poisons Act—I think I have said that a number of times—for the safe and secure storage of the substance, and also provides for the closed-loop safe and appropriate prescription, supply, storage and disposal of any unused voluntary assisted dying substance. In addition to other statutory labelling requirements for prescription medicines, the authorised supplier will label the package or container with warnings about the purpose and dangers of administration of the voluntary assisted dying substance, and information about safe and appropriate storage of the substance. The member for South Perth made the observation that people probably keep more dangerous materials in their laundry than necessarily any of the voluntary assisted dying substances, but we can come to that in division 4. In relation to the member’s question around whether the person will be able to take it home and sit in a dark room by themselves, the answer is no; they have to appoint a contact person. The obligations and responsibilities of the contact person are covered under division 3. To go to the member’s initial question, there is no time line in relation to when a person has to exercise their right under the legislation.

Mr S.K. L’ESTRANGE: We will get to division 3—I thank the minister for directing me to that section. With regard to the time frame for the patient to administer, how does it work in other jurisdictions? Is this something that has been taken from somewhere else?

Mr R.H. Cook: Great question.

Mr S.K. L’ESTRANGE: Does the minister have any evidence of how it works? I note the minister’s point that poisons are held in households already—cleaning, gardening and rat poisons and whatever. I get that. Putting that to one side, this particular poison has a particular task and purpose, which can be achieved very efficiently. As the minister would know, those other ones can be quite clumsy, whether taken accidentally or on purpose. This is quite a direct-purpose poison. It will probably have instructions that go with it. I just park that as being separate to the other things held in the home.

Mr R.H. COOK: You are asking what is the practice elsewhere.

Mr S.K. L’ESTRANGE: Yes. How do other jurisdictions in Australia, such as Victoria, or elsewhere in the world approach this aspect?

Mr R.H. COOK: My attention is drawn to page 137 of the ministerial expert panel report. It provides a comparison between eight different jurisdictions and their medication management. None stipulate a time line for the process.

Mr S.K. L’Estrange: This is all self-administered?

Mr R.H. COOK: No. I think Oregon has it in only limited circumstances. I believe all of them have a capacity for self-administration; none stipulate a time line. Obviously, as people have observed, our legislation is largely modelled on the Victorian legislation; it does not have a time line either. Have a look at it.

Ms M.M. QUIRK: I foreshadowed that I would move an amendment to clause 57. The reason for this amendment is that there is a widely held misunderstanding about the oversight nature of the Voluntary Assisted Dying Board. In particular, some of the so-called safeguards that are listed state, firstly —

98. The Voluntary Assisted Dying Board is to monitor voluntary assisted dying in Western Australia under the Act

That is ex post facto and therefore needs to be explored in more detail. Secondly —

99. The Voluntary Assisted Dying Board has quality assurance and improvement functions

Extracted from finalised Hansard
That is certainly true after the event. Then the safeguards state —

100. The Voluntary Assisted Dying Board is to refer breaches or matters requiring review to the appropriate authority (e.g. Commissioner of Police, Coroner, Registrar Births Deaths & Marriages, Department CEOs, AHPRA, HaDSCO)

Those so-called safeguards effectively will come into operation after a patient has died. My amendment will clarify and make absolutely unambiguous the role of the board. Therefore, I move —

Page 36, lines 19 and 20 — To delete the lines and substitute —

(1) This section applies if —

(a) the patient has made a self-administration decision and has not revoked it; and

(b) the Board has given the coordinating practitioner for the patient a notice of no objection under section 117A for the self-administration decision.

I apologise at the outset. On Sunday, I settled this amendment with Parliamentary Counsel and had hoped that it would appear on the notice paper. However, I was told only today that Tuesday’s notice paper is finalised on Friday. Copies of my amendments have been distributed.

I must explain to members that I propose to introduce a new clause 117A. It will provide for a notice of no objection — in other words, in the course of an application, assessment and approval, forms would have to be sent to the Voluntary Assisted Dying Board. Consequently, the board would have to issue a notice of no objection under proposed new clause 117A. I make no apologies for this; that is a de facto permit. I know the amendment will be rejected by the government in part because the government says the regime under the Poisons Act is different from that which applies in this bill. Nevertheless, as I said, I am concerned that there is a misunderstanding about the role of the board. This amendment seeks to clarify that role.

Mrs A.K. HAYDEN: I rise to support the amendment put forward by the member for Girrawheen. By way of background, as we have been discussing today and previously, there is a gap here. The board is not involved to the extent that it could be—the notifications, the delay. Clause 117(a) states that the board will “monitor the operation of this Act”. To do that properly, the board will need to monitor every aspect of the legislation, not just the bits and pieces that the government chooses.

Clause 57 refers to “revoked” and a “substance”. We do not know what that substance is. We do not know whether it will have an expiry date. We do not know how it will be stored. We do not know how long it could be kept for. They can delay it. To me, there are too many gaps.

The board is not being informed in a prompt fashion to avoid any mistakes. What we are simply trying to do here is put in the required safeguards. We know the government has the numbers to pass this bill in the lower house. Our only job is to improve the bill and to put in any additional safeguards that we believe will protect people at the end of the day. I make no apologies for supporting the amendment. I stand here and say the board needs to be involved. The idea of the board is to monitor the operation of the act. Let us make sure it is able to monitor every aspect of this piece of legislation.

Mr R.H. COOK: I thank the members for their contributions. I understand what the member for Girrawheen is trying to do here. Essentially, she is right—it needs to be read in the context of her proposed new clause 117A. I understand what she is trying to do. It is about extra oversight. I appreciate the sentiment with which the amendment has been brought forward. However, I think it will add an extra burden on the patient when accessing voluntary assisted dying. In this context, the patient would have already gone through a rigorous process of assessment, written requests, and enduring decision-making capacity and interest in moving forward. This amendment would essentially make the board an additional coordinating practitioner. I think that the member for Girrawheen is right: it is a de facto permit system like that which exists in Victoria. I understand that the member for Darling Range has been pursuing this line of inquiry and, therefore, this amendment probably suits her purposes. However, I respectfully submit that it does not improve the legislation. I think that it would be an extra obstacle for the patient who by this stage would have already undergone a very rigorous process. This goes to the point about how people conceive the board’s role. As I have said on a number of occasions, the board is there to monitor the act; it is not there to police or stand by a patient’s bedside and provide an extra opinion. That is the role of the coordinating practitioner, with the assistance of the consulting practitioner. I appreciate the sentiment with which the amendment has been brought forward and respectfully disagree with the amendment.

Mr P.A. KATSAMBANIS: I state at the outset that I think this amendment improves the bill by improving the safeguards in the bill. Interestingly, the government and the minister have spent a lot of time talking about safeguards. However, when an amendment is introduced by the member for Girrawheen to produce such a safeguard, one that would provide real-time monitoring of this radical and revolutionary procedure in our legislation, the minister labels it an obstacle. It is not. I think the amendment is intended in good faith. Other regimes around the world

Extracted from finalised Hansard
have given their supervising boards the capacity to supervise the process rather than act as a postbox and collector of documents. That is the intention in this amendment. I think it is a good amendment. If we are to legislate for a regime such as this—I have stressed this in other contributions throughout this consideration in detail—we need to ensure the strongest possible protections are in place to protect not only the patient who wishes to access this, but also, at times of potential future litigation, the medical practitioners or nurse practitioners, and the general community. That is particularly the case in this clause, which we are seeking to amend now. I am talking about a whole series of amendments.

Sitting suspended from 6.00 to 7.00 pm

Mr P.A. KATSAMBANIS: As I was saying before I was interrupted by the break, we are dealing with the amendment to clause 57, but this is one of the clauses for which the proposed amendment really relates to new clause 117A. I do not intend to discuss the principles of what is being introduced by new clause 117A at every stage of the process, but I think this is a fitting stage to discuss them very briefly. I think they were well outlined by the member for Girrawheen, who moved the amendment, and also by the member for Darling Range in her contribution. This is about providing an extra safeguard. It is not an obstacle. It is a very important safeguard, because, as I said earlier, it helps the patient, it safeguards the practitioners and it also safeguards other people who might be involved in any debate or discussion after the event. It gives the board that has been created under the legislation a bit more of a supervisory capacity. The minister said the board is there to administer the legislation, but the board has no supervisory capacity in relation to all the paperwork that needs to be filled out for an act of assisted dying under this legislation. It is really a postbox to receive the documentation. It is more a matter of filing notices than anything else. The object of the proposed amendment is to give the board one final look at things before a patient moves to the final stage, and I think that is fair and reasonable. In some ways it is essentially what happens in other jurisdictions such as Oregon or Victoria. I think it would add one more significant safeguard and alleviate a lot of the concerns out there about the possibility of bad practice creeping in.

It was interesting that in one of the earlier discussions today the minister mentioned the word “malpractice”, and there is always a fear. I do not knock our medical profession in any way. I think our medical professionals are absolutely world class—totally committed professionals—but amongst all professions there are those one or two bad eggs, no more than that really, and we need to guard against those people. That is why we bring in prescriptive rules for all professions, whether it is the legal profession, the medical profession, the nursing profession or the accounting profession. Those rules are unnecessary for 99.9 per cent of practitioners who act ethically and morally, but we still bring them in. In this case, we are dealing with a patient who is being put to death one way or another, either at their own hand or by an assisted procedure; they are being put to death by medication. We are introducing this extra safeguard of an independent board to supervise the process and a final check-off.

It is interesting that the wording used in proposed new clause 117A is not that the board must issue a notice of objection; it is a notice of no objection. It is predicated on the basis that it is far more likely that the board will look at this stuff and, everything having been done right, will say, yes, it has been done right and we can move to the next step. It is almost couched in terms of it being highly unlikely that the board will intervene and say, “No, do not do it”, but we are dealing with that one in a thousand or one in a million. We are dealing with the externality. One fatal error in this regime is one too many. I know the government and the minister have indicated they do not want to accept amendments, but I urge them to consider this as one more important safeguard.

Dr M.D. NAHAN: I stand in support of this amendment for a couple of reasons. First, it will ensure that the board is informed prior to the taking of the substance. Most of the board’s actions, to the extent that it takes action, can only take place, if this is not done, after the death, which is too late. Importantly, the government has sold the legislation on the basis of 102 safeguards, and there are a number of safeguards we have gone through. However, many of those claimed safeguards are reports to the board, and the board really is not a safeguard unless it has powers to act as a safeguard before the action is taken. If the board is just an ex post facto assessor, decision-maker or reviewer if the process is drawn out, it does not have any teeth. The board has been promoted by the government as one of the major—I think the major—source of safeguards, and this amendment would allow it to be a safeguard with teeth. One of my concerns is that if the board is set up to react to expedite a request, and the legislation is designed to ensure quick action because the majority of people considering this will be on the pathway to death and speed can be a very important factor for them; in fact, the only amendment to the Oregon legislation to date has been to allow the process to be undertaken more quickly, and that amendment was brought on by the demands of the potential users of the process, so I worry about the board reacting quickly. As the member for Hillarys pointed out, if everything is going according to plan, the board will just tick and flick; it will say, “No issues here.” But there may be some cases in which information has not been adequately provided by the coordinating practitioner or all the other people who are supposed to report to the board, or the board may find some anomalies.

Clearly, we would want the board to act before the death, and this amendment would allow that to be done. I stand in support of it and I urge the government and the minister to consider it as something that will not undermine the legislation, but will strengthen it for both the community and potential users.
Amendment put and a division taken, the Deputy Speaker (Ms L.L. Baker) casting her vote with the noes, with the following result —

Ayes (11)

Dr D.J. Honey  Mr S.K. L'Estrange  Ms L. Mettam  Ms M.M. Quirk
Mr P.A. Katsambanis  Mr R.S. Love  Dr M.D. Nahan  Mrs A.K. Hayden (Teller)
Mr A. Krsticevic  Mr W.R. Marmion  Mr D.C. Nalder

Noes (38)

Ms L.L. Baker  Mr M. Hughes  Mrs L.M. O’Malley  Mrs J.M.C. Stojkovski
Dr A.D. Buti  Mr D.J. Kelly  Mr P. Papalia  Mr C.I. Tallentire
Mr J.N. Carey  Mr Z.R.F. Kirkup  Mr S.J. Price  Mr D.A. Templeman
Mrs R.M.J. Clarke  Mr F.M. Logan  Mr D.T. Punch  Mr P.C. Tinley
Mr R.H. Cook  Mr M. McGowan  Mr J.R. Quigley  Mr R.R. Whitby
Ms M.J. Davies  Ms S.F. McGurk  Mr D.T. Redman  Ms S.E. Winton
Mr M.J. Folkard  Mr D.R. Michael  Ms C.M. Rowe  Mr R.S. Wyatt
Ms J.M. Freeman  Mr S.A. Millman  Mr P.J. Rundle  Ms A. Sanderson (Teller)
Ms E.L. Hamilton  Mr Y. Mubarakai  Ms R. Saffioti
Mr T.J. Healy  Mr M.P. Murray  Ms J.J. Shaw

Amendment thus negatived.

Ms M.M. QUIRK: The minister, being a supporter of lots of physical activity, will of course be pleased that some of his colleagues got up a few extra steps in that division.

I had one last question on clause 57 about subclause (5)(a), which relates to an agent receiving the prescribed substance. What sanctions will be in place if the agent takes off with the prescribed substance and does not supply it to the patient?

Mr R.H. COOK: All persons who perform a function within the legislation are subject to the Medicines and Poisons Act 2014 and the Misuse of Drugs Act 1971. Obviously, penalties would be associated under those two acts.

Clause 57(7) states —

An agent of the patient is authorised to —

(a) receive the … substance from an authorised supplier;

If they act outside this legislation, they would not be so authorised, and so they would also be acting contrary to this legislation.

Mrs A.K. HAYDEN: I refer to clause 57 and self-administration. I am not sure whether this falls under subclause (5), which starts “The patient is authorised to”, but in the Netherlands, a doctor is required to be present during the time of self-administration until death occurs, to ensure that the poison is taken by the patient, administered correctly and that death occurs. If that does not happen, the doctor is present to administer more of the substance to ensure that the patient is successful in passing away. Why did the minister not consider putting such a provision into the bill?

Mr R.H. COOK: I am advised that this is ultimately a decision for the patient to make. If they want a practitioner with them, they can have one. In division 3 we describe the role of the contact person who has a role to participate under self-administration. Obviously, it is the responsibility of the medical practitioner to ensure that the voluntary assisted dying substance is adequately prescribed. We decided that it was not necessary for a self-administering patient to have a medical practitioner there. This is similar to the process that happens in Victoria. The member will remember the description of Kerry Robertson, who died at her home with her two daughters there, taking the voluntary assisted dying substance as prescribed, which produced the desired effect. Obviously, that comes down to the important decision made under clause 55, “Administration decision”. It is, I guess, a decision for the patient to make.

Mrs A.K. HAYDEN: I apologise if I missed it in clause 55, but with all due respect, everyone in this place has spoken about a peaceful, dignified death, yet when self-administration is about to take place, no-one is there as a backup to make sure that no unintended consequences occur. The person taking the substance might be unable to swallow or whatever in the way they will take the drug—we do not know that yet. If they are unable to administer it correctly, there is no backup to make sure they are going peacefully and there are no side effects. A doctor will not be there to make sure the patient’s dying wish is fulfilled, excuse the pun. I am really concerned for the family who may be there with them, witnessing the situation. It will not be a very pleasant sight if it does not work, and the person could be in pain. In all honesty, I do not understand why that is not in the bill as a safeguard.

Mr R.H. COOK: As we have mentioned in numerous places, this is about a patient-centred focus, if you like. From that perspective, I guess we are honouring the wishes of the patient who may wish to do this in the privacy of their own home not surrounded by medical practitioners. They will have come to the end of their life and gone through the voluntary assisted dying process and will be at the point at which they will self-administer. From that perspective,
it is for the patient to make the decision about the nature of that self-administration process, not for us to make that call. I think we have the balance right here. Again, we are informed both in design of the law and from the emerging experience in Victoria around the patient in that scenario. I take the point the member has made that a person could potentially find themselves in that situation, but, again, that is why clause 55 is important, which is the administration decision, to make sure the patient has all the information necessary to carry out the act.

The DEPUTY SPEAKER: Member for Darling Range, a different question.

Mrs A.K. HAYDEN: It is the final question on this. Let us say the substance does not work. What process would the patient undergo? They are at home and have taken it, but it did not work. What will be the process then?

Mr R.H. COOK: Obviously, they would make contact with the coordinating practitioner or their general practitioner. They would seek further assistance with the process. That decision would be for them to make. I am also informed that it is likely that the type of schedule for a poison that will be approved for the use in the voluntary assisted dying process will not have any other side effects for the patient. In the event that the medication does not result in the patient’s death, evidence indicates that the patient will awaken without otherwise being affected. That is the nature of the sedatives or things of that nature that ultimately will be used. These are issues for the clinical panel and the chief executive officer to consider in the context of the implementation.

Mrs A.K. HAYDEN: One last question, if I may. The minister is saying that it is likely there will be no side effects and we do not know what they will be, but there is the patient’s mental position and the family around them to consider. Is the minister telling me that once this legislation is passed, it is his intent that there will be guidelines around a list of what the family is to do if it is not successful?

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: I refer to the issue of “agent” in clause 57(5)(a) and (7). Who does the minister contemplate will be an agent? The agent is someone other than a contact person. The agent is not defined in the legislation. What quantity of drugs are we dealing with? I know that a range of prescribed substances could be given to the agent, but I am anxious to know what quantity or volume we are talking about to get some idea of possible criminal sanctions. If it will help the minister on that latter point, we can probably deal with the quantity issue at clause 71.

Mr R.H. COOK: Yes, I was going to refer to that, member. Thank you very much.

Obviously, in ordinary circumstances, we would anticipate that the contact person will be the agent—that is, the person who would have further obligations due to being officially nominated for the role they will play under division 3. As I said, I would ordinarily contemplate that the agent would be the contact person, but it does not necessarily have to be the contact person. It will be simply someone acting on behalf of the patient to take the voluntary assisted dying medication to the location of the patient.

Dr D.J. HONEY: That gives me a little cause for concern. Once poisons used to be quite freely available. As the member for Churchlands pointed out, I appreciate that we can look at other substances in houses, but I know of specific poisons that people could take to kill themselves. In my old world of cyanide when I was a lad, there used to be big bottles of sodium cyanide in laboratories. Now it is strictly controlled and we cannot access it without permits and the like. Even qualified scientists cannot access that without a special permit. All the other positions are well defined, and there is a lot of rigour around choosing those persons. I wanted to go a little further down this path. I am not going to do this exhaustively; I just want to get some idea about the qualifications for the agent. I picked up on something the minister said just then—that normally it would be the contact person. There are very strict qualifications for the contact person. Would it not be prudent to make them one and the same and say that the contact person is the agent? I appreciate the aim here is to be flexible, but my concern is that in this process, we have a person receiving a poison that is designed to kill someone, and that person could have no qualifications at all. I see this as a deficiency in the legislation, whereas a lot of effort has been made to ensure that people in other positions meet some basic criteria. I guess the nub of the question is: What are the qualifications for the agent? Would it not be more prudent to say that the agent is the contact person? I am not going to ask another question after that.

Mr R.H. COOK: Thank you, member. Picturing a patient who is at the end of their life, they would have had a very robust interaction with the health system and would be on a range of medications to manage a range of symptoms; therefore, in practicality, they would already have a pretty robust relationship with the health system. Ultimately, the name of the agent would be recorded by the supplier and potentially would be the husband or wife of the person involved, who may not be the contact officer, but might be someone who would ordinarily undertake these sorts of tasks. From that perspective, it could be the contact person, but not necessarily. I remind members that the Misuse of Drugs Act, which applies to schedule 8 poisons and some schedule 4 poisons, contains offences relating to the manufacture, sale, supply and possession of prohibited drugs, paraphernalia and so on. We have significantly robust regulations and laws for the protection and proper management of these sorts of medications. From that perspective, the member characterises it as creating too big an opportunity for the mismanagement of those medications. Part 7 of the bill deals with offences by the agent for unauthorised supply or possession. Ultimately, this clause deals with the proper carriage of the substance from the authorised supplier to the patient.

Clause put and passed.

Extracted from finalised Hansard
Clause 58: Practitioner administration

Mr Z.R.F. KIRKUP: Clause 58(2) refers to “sufficient dose to cause death”. I realise that we have not prescribed what that dose looks like, because there might be a range of different medications and things like that. This clause refers to “sufficient dose to cause death”. I note that in some other jurisdictions, significantly more than the sufficient dose is provided in order to bring about death. Is there any reason that this clause is specific as to the dosage? Obviously, I appreciate a quantity of the substance has to be provided to bring about someone’s death. I am curious about why that would not be provided as part of the usual prescription process and why it is defined here as “sufficient”?

Mr R.H. COOK: Obviously, the intent here is as described, but what is prescribed would depend on the patients themselves. The intent here is to outline that for this patient, with this condition, of this particular weight, and with their capacity to consume the voluntary assisted dying substance, the coordinating practitioner must prescribe a sufficient amount that will cause death for that particular patient in their particular circumstances. It is simply to be explicit about that. We do not want a little bit left over; we do not want there not to be enough. Essentially, we want the patient to take the substance and for that substance to have its effect.

Mr Z.R.F. KIRKUP: This will be via practitioner administration, so they will not take it.

Mr R.H. COOK: That is correct, yes.

Mr Z.R.F. KIRKUP: Under clause 58(4), the administering practitioner for the patient is authorised to receive the prescribed substance from an authorised supplier, and then there are a range of other aspects to that. Is my reading of the legislation correct—that the authorised administering practitioner will not have an agent; there will be no intermediary? Is there a responsibility on the administering practitioner to get it from the authorised supplier directly? Can they delegate that responsibility to somebody else? I could be wrong, but I could not see that in there.

Mr R.H. COOK: Member, the way an administering practitioner would take carriage of the medicine would be very different from the way a member of the public would. Obviously, it would be delivered to their rooms or the clinical environment in which they are operating, rather than the practitioner going to a chemist or a hospital, for instance, to get it. Maybe if they work in that hospital, it would be from that particular perspective. It is different from the self-administering regime.

Mr Z.R.F. KIRKUP: Just to clarify that a little bit more, if I can, let us say the administering practitioner is not in a hospital environment. Would they have to go and get that from the authorised supplier, who I imagine would be a pharmacist involved in the prescription and supply of that medication substance, like every other? Would they themselves have to go to the pharmacy to retrieve the substance or not?

Mr R.H. COOK: Yes.

Mr Z.R.F. KIRKUP: Can they not send someone as a delegate? I appreciate that in some other circumstances there might be an agent or a courier who delivers it. I cannot find it in the legislation, but I could be wrong. This is a good process to go through to clarify whether or not the administering practitioners have to go themselves directly to retrieve it. If they do not have to do that, is there any other part of the legislation that empowers a third party to be the courier?

Mr R.H. COOK: Yes, I think I understand. I am advised that it would be under the current arrangements under which a medical practitioner would get supplies of medications, so, again, it is very different from the punter in the street. It will be through the usual measures—a medical courier or whatever is authorised under the Medicines and Poisons Act for the carriage of those medicines.

Mr Z.R.F. KIRKUP: I appreciate that, minister, because, of course, in the normal circumstance, practitioners themselves are not usually in receipt of the medication. They write the script; they give it to the patient; the patient goes and retrieves it. The clinic itself does not necessarily have custody of any medication in a normal environment—not in all environments, I appreciate. Just to clarify, would it be like a flu injection process, or something like that, when the medication is delivered directly to the office of the clinic; is that right?

Mr R.H. COOK: Yes, that is right. I am sure we will come to the clause eventually, but my understanding is that the prescription itself will not go into the hands of the patient or the member of the public.

Mr Z.R.F. KIRKUP: I am going to clause 58(5), if I can, which states —

The administering practitioner for the patient is authorised, in the presence of a witness, to administer the prescribed substance to the patient …

Are there any requirements for the witness themselves? Are there any constraints on that witness? Could they be anybody—a family member or an employee of the practitioner? Is that defined later in the legislation?

Mr R.H. COOK: Clause 61 deals with the witness to the administration of a prescribed substance and we will come to that shortly.

Ms M.M. QUIRK: I have an amendment to this clause also. I am moving it for the similar reasons that applied to my amendment to the previous clause. I need to correct something that the minister said. He said that the insertion of the process that we recommend under proposed section 117A will make it more onerous for the patient. We would
contend that it is not more onerous because it is the coordinating practitioner who must apply for the no objection certificate. Yes, it means that there would be a delay of up to two days but, as I said beforehand, it assuages the concerns of many people who believe that under the bill as it is currently drafted, the board would not be acting as a real-time monitor. We will talk a bit about that when we get to those clauses in the bill.

It is for that reason that I move —

Page 37, lines 20 and 21 — to delete the lines and substitute —

(1) This section applies if —

(a) the patient has made a practitioner administration decision and has not revoked it; and

(b) the Board has given the coordinating practitioner for the patient a notice of no objection under section 117A for the practitioner administration decision.

Amendment put and negatived.

Ms M.M. QUIRK: Following on from what the member for Dawesville said, I can appreciate the witness being a family member; that makes eminent sense because most patients would like a family member present. This is down the track so we do not need to deal with it now, but I wonder whether the minister might consider at clause 61 that the proprietor of a nursing home should be an ineligible witness? We have talked about this before. In the case of a lonely patient who has no family around, there are very sound reasons for the witness to be independent.

Mr R.H. COOK: I am happy to deal with that under clause 61.

Clause put and passed.

Clause 59: Coordinating practitioner to notify Board of administration decision and prescription of substance —

Ms M.M. QUIRK: My question on clause 59 runs along the same theme that I have been pursuing today. It states —

Coordinating practitioner to notify Board of administration decision and prescription of substance

(1) Within 2 business days after prescribing a voluntary assisted dying substance for the patient, the coordinating practitioner for the patient must —

(a) complete the approved form …

Again, my concern is that this is seen as a safeguard but it does not necessarily have to be contemporaneous with when the substance was administered because it can be done two days later. Again, this clause emphasises that the board is nothing more than, if you like, a postbox for receiving and dealing with these various forms within the fullness of time.

Mr R.H. COOK: This has come up a few times throughout the debate. In practice, when the administering or consulting practitioners lodge these forms, they will be done electronically. It would essentially be done at the same time, but I understand what the member is saying about the two business days. It is certainly much more contemporaneous than the Victorian model, but it is simply an opportunity for the Voluntary Assisted Dying Board to oversee and monitor that the act is running according to plan and, from that perspective, this is another part of the process that is carried out by the Voluntary Assisted Dying Board.

Mr P.A. KATSAMBIANIS: My concern with clauses 57 to 60 is about the prescribed form that needs to be filled out and delivered to the board after the death of a patient. Clause 59(2) states —

The administration decision and prescription form must include the following …

It then includes a list of things, and what really surprises me is that nowhere either in that list or in the preceding clauses that we have dealt with is a provision outlining how the practitioner has to certify what happened to any of the remaining medication or whether all of the substance was used—I hesitate to use the word “medication”. Can the minister indicate how the board will oversee what happens with any substance that is left over? Regardless of whether there are provisions later on for that, one of the useful safeguards in these forms that are delivered to the board would be to have some form of certification that either the entirety of the substance was consumed in the process or, if not, a way of indicating what has happened to it and where it has been delivered to or deposited. We know that in the wrong hands this substance could have devastating and unintended consequences. I seek some clarification from the minister around that. Without that certification there is a gap. Although it is not listed in the clause, could the minister make an undertaking to see that it could be included in the prescribed form that the CEO will eventually create? That would at least create a little certainty around the possibility that any remaining substance may inadvertently or deliberately be misused.

Mr R.H. COOK: The member is quite right. It is dealt with in clauses 76 and 77, the latter of which refers to the practitioner disposal form.

Clause put and passed.

Clause 60 put and passed.
Clause 61: Witness to administration of prescribed substance —

Ms M.M. QUIRK: We previously talked about the witnesses to the administration of a prescribed substance. Clause 61(2) states —

... a person is an ineligible witness if the person —

(a) is a family member of the administering practitioner for the patient; or
(b) is employed, or engaged under a contract for services, by the administering practitioner for the patient.

Why is that considered necessary?

Mr R.H. COOK: As this is the final act in the voluntary assisted dying process, we thought that it was important that that person be independent, and the requirement for a witness during a practitioner administration is yet another safeguard in the voluntary assisted dying process. It reflects that the voluntary nature of the voluntary assisted dying process is fundamental to the WA model and that the decision to access death must be enduring.

Ms M.M. QUIRK: Again, we have this issue about independence. The intention is that there be some independence from the medical practitioner, but that is not explicit in that clause. Earlier, I asked why a proprietor of a nursing home where a patient might be would not also be an inappropriate witness.

Mr R.H. COOK: Sorry, ma’am. Could you clarify that you are saying that an administrator of a nursing home should not be eligible to be an independent witness?

Ms M.M. QUIRK: Yes. They might have some financial interest, or whatever.

Mr R.H. COOK: This is one of those clauses that are important for protecting everyone involved in the process. It is about protecting the patient to make sure that there is a witness to that process. It is also about protecting the administering practitioner. From that point of view, I think we have captured the level of independence required in this, and, obviously, it is important to have that level of independence. I do not appreciate the sensitivity that is necessarily excluding someone who is an administrator of an aged-care facility, or something of that nature; but I understand the point that the member is making. Ultimately, what we are doing, though, is simply trying to make sure that this person is at arm’s length to the person who is administering the voluntary assisted dying substance. From that perspective, that is the key outcome that we have achieved here.

Mr P.A. KATSAMBANIS: In relation to the witness that is required under clause 61, I have two very simple questions: Can the coordinating practitioner be a witness for the purposes of clause 61; and, if the coordinating practitioner cannot be a witness, where in the bill is that coordinating practitioner precluded from being a witness?

Mr R.H. COOK: No, it would not. Clause 62 deals with the transfer of the administering practitioner’s role. Under this clause, when the administering practitioner for the patient is no longer able, for any reason, to administer the prescribed substance to the patient, the role of the administering practitioner may be transferred to another person. By definition, if the coordinating practitioner is in the room with the administering practitioner, the coordinating practitioner is in a position to administer the voluntary assisted dying substance. Therefore, it could not, by definition, be there.

Mr P.A. KATSAMBANIS: That is not the question I asked, though. My question was very simple. There are two prohibitions on a witness in clause 61. The first prohibition is that they are a family member of the administering practitioner, which is pretty simple. The second prohibition is that they are employed or engaged under a contract for services by the administering practitioner for the patient. Those are the only two limiting factors. In reading this clause, it is very, very clear that if the coordinating practitioner was not the administering practitioner, even if the administering practitioner was a nurse practitioner under the employ of the coordinating practitioner, by the bare reading of clause 61, the coordinating practitioner would be a witness. My and the community’s fear around these sorts of procedures is that closed-loop that we have talked about. Yes, we accept that in the main the vast majority of people involved in this process will be honourable and ethical—absolutely. However, in closed-loop situations in which independence is called into question, it needs to be absolutely beyond doubt. We are dealing with administering a lethal substance that will take a person’s life, and I am not satisfied by the minister’s answer that clause 62, which deals with the transfer of an administering practitioner’s role, will in any way stop the coordinating practitioner from being an eligible witness to the administration of the lethal substance.

Several members interjected.

The DEPUTY SPEAKER: Excuse me, members! The minister is on his feet.

Mr R.H. COOK: Thank you, Deputy Speaker, and thank you, member. I disagree with the member’s interpretation. A coordinating practitioner can only transfer their role as the administering practitioner if they are unable to administer it. Therefore, if they are in the room with the patient, they, by definition, could administer the voluntary assisted dying substance.

Mr P.A. Katsambanis: Maybe they’re still unable. Maybe their arm is broken.

Mr R.H. COOK: Member, there may be a whole bunch of other scenarios. I just think the member’s interpretation of clause 62 is incorrect.

Extracted from finalised Hansard
Mr R.H. COOK: We did not think it was appropriate. This person is a witness to a medical practitioner view, subclause (3) deals appropriately with the obligations that we think are appropriate for a witness.

Ms M.M. QUIRK: Safeguard 44 states that a witness must also be present for the practitioner administration. From that perspective, it is a similar notion. Obviously, what we would expect from our medical practitioners is very different from what we would expect from a witness, who essentially could be an ordinary member of the public. From that perspective, we have a much higher level of burden on the medical practitioner than on the witness.

Mr R.H. COOK: Under section 65(2)(a)(i) of the Victorian act, the witness has to certify that —

the person’s request for access to voluntary assisted dying appeared to be enduring;

How does the witness ascertain that? Do they interrogate the patient? I wonder whether subclause (3)(a) is almost redundant. Certainly, subclause (3)(b) is reasonable.

Mr R.H. COOK: They would have to bear witness to essentially the patient continuing to seek voluntary assisted dying. Obviously, at that stage the patient has gone through an exhaustive process to reach that point. In the normal use of the word, the witness simply has to be satisfied that the patient’s wish to access voluntary assisted dying appears to be “enduring”. The witness plays an important role in supporting the administering practitioner, but from that perspective simply has to bear witness to that enduring request for access.

Ms M.M. QUIRK: I would like to pursue that point. If we look at clause 58, “Practitioner administration”, at subclause (5)(c) we see that the administering practitioner must be satisfied that —

the patient’s request for access to voluntary assisted dying is enduring.

We are now dealing with a clause that states “appeared to be enduring”. We know, for example, that the witness does not need training in assessing capacity or whatever. I wonder why the words “appeared to” have suddenly appeared in this clause, especially when we look at the equivalent provision in the Victorian legislation—I think I have the Western Australian legislation here—which has “appeared to be enduring” as opposed to “enduring”.

Mr R.H. COOK: Under section 65(2)(a)(i) of the Victorian act, the witness has to certify that —

the person at the time of making the administration request appeared to have decision-making capacity …

From that perspective, it is a similar notion. Obviously, what we would expect from our medical practitioners is very different from what we would expect from a witness, who essentially could be an ordinary member of the public. From that perspective, we have a much higher level of burden on the medical practitioner than on the witness.

Ms M.M. QUIRK: Safeguard 44 states that a witness must also be present for the practitioner administration. I thank the minister for referring me to section 65 of the Victorian legislation. Section 65(1)(b) states a witness must be “independent of the co-ordinating medical practitioner”. That is specifically stated in the Victorian legislation. It is not stated in this legislation, although it is in the explanatory memorandum. Section 65(2) states —

The witness who witnesses a person making an administration request and who witnesses the administration … must, in a co-ordinating medical practitioner administration form—

(a) certify in writing that—

(i) the person at the time of making the administration … appeared to have decision-making capacity …

(ii) the person in requesting access to voluntary assisted dying appeared to be acting voluntarily and without coercion; and

(iii) the person’s request to access voluntary assisted dying appeared to be enduring;

The Victorian legislation uses the same language, but it also refers to “coercion” and “decision-making capacity”, which are absent from this clause, and I ask why.

Mr R.H. COOK: We did not think it was appropriate. This person is a witness to a medical practitioner undertaking a procedure. We do not expect them to have the same expertise as the medical practitioner; therefore, we do not expect them to be able to provide the same level of authority in their observations. From that point of view, subclause (3) deals appropriately with the obligations that we think are appropriate for a witness.
Ms M.M. QUIRK: It is possible for a layperson to ask, “Do you remember what you had for lunch?” If the patient could not answer that question, the witness would then not have any confidence that necessary capacity was there or that the request was enduring. All I am saying is: yes, I appreciate that a layperson might not have the same level of training, but that is all the more reason to put in other subclauses that deal with coercion and capacity.

On the independence of witnesses, I give the minister this scenario. Say the proprietor of a nursing home had someone occupying a bed, for which there is much demand in Western Australia; I think we are 3 000 beds short. He had someone in the room who was on a pension, but he had the capacity to have someone in that room who would pay full odds for the room and was not entitled to any concessions. Something like that would mean that the proprietor of a nursing home may well have a financial interest and would not be an appropriate independent witness.

Mr Z.R.F. KIRKUP: I have listened to a number of my colleagues ask questions about the witness and I am slightly concerned about the relationship that coexists. I appreciate the minister has provided a response on that. If I were a witness, how might I go about establishing whether someone is being coerced? What role would I have as a witness to intervene in the process, if at all? What would my role look like? If I believe that beyond that point in time I must certify that the substance has been taken, am I legally obligated to intervene in any way to stop the process? Can I do that legally? Aside from providing certification, what is my role as a witness? I take the member for Girrawheen’s point: we are empowering an individual, who could be anybody. I understand that person needs to be accessible, but what role would they play if they have a concern about coercion? I am keen to understand that role, aside from the certification, which is what the clause appears to refer to from my reading of the legislation.

Mr R.H. COOK: Clause 61(3) states —

The witness to the administration of a prescribed substance to a patient must certify in the practitioner administration form for the patient that —

(a) the patient’s request for access to voluntary assisted dying appeared to be enduring; and

(b) the administering practitioner for the patient administered the prescribed substance to the patient in the presence of the witness.

The person has borne witness to the administration of the substance and they have remained convinced that the patient’s request for voluntary assisted dying appeared enduring. If they cannot certify it, the administering practitioner would be acting outside the scope of the legislation and, as the member will see later in the bill, there are some very harsh penalties for doing that.

Mr Z.R.F. KIRKUP: If the witness refuses to certify that because they believe that the patient has been coerced, for whatever reason, and they witnessed the administration by a practitioner that has ultimately brought about that person’s demise—they have effectively borne witness to an illegal act—would they be obligated to try to stop that act in any way, shape or form?

Mr R.H. COOK: A very serious act would have occurred. Like any other citizen, the witness would be required to contact the police, I would have thought. The Voluntary Assisted Dying Board would certainly engage in an investigation because an activity has been undertaken under the act that is contrary to the act. The member can imagine that there would be a range of remedies that the witness could undertake, such as speaking to the administering practitioner or coordinating practitioner, or, to the very extreme, referring it to the police.

Mr Z.R.F. KIRKUP: I imagine that if someone were about to perform a dangerous act on a person that would harm them in some way, I, as a citizen, would be obligated to stop that occurring or to do something. We would expect citizens to step in if they witness a situation like that. I realise that the legislation will stop there being any liability on the witness for not performing a lifesaving act—that is later in the legislation—but I worry that as the role of the witness is defined, the steps that they can take, aside from the lack of certification, have not been outlined. I appreciate the minister’s response and where we are at with that but I place my reservation on the record. There is the ability to witness someone’s death and believe that they have been coerced, but all they can do is not certify it or tell the police or the board. We would want somebody to step in before that occurs.

Mr M.J. Folkard: Dial triple zero!

Mr Z.R.F. KIRKUP: I appreciate that interjection. Maybe the witness will.

Ms M.M. Quirk interjected.

The ACTING SPEAKER (Mr S.J. Price): Members!

Mr Z.R.F. KIRKUP: I am trying to bring up that we are moments away from death, in all likelihood. I am trying to imagine a situation in which that would occur. To witness something like that would be very difficult. Not to labour the point, but I have some concerns about the role of the witness. I would appreciate some definition in the
legislation about the role the witness can play to try to stop the process, if at all. I appreciate that that is not in the bill. On the other side, it is interesting to consider a hostile witness who might not agree with the process. They may suggest that the patient was being coerced, and it is only themselves and the practitioner in the room.

**Ms A. SANDERSON:** Before the minister responds, I wonder if in his response he could provide any examples of whether this has possibly occurred in other jurisdictions in the 25-years’ worth of evidence that we have from those jurisdictions, and, given that we have to make decisions based on evidence and not wild hypothetical scenarios, whether there are any examples of a so-called hostile witness to a process impeding the process or whether someone has witnessed so-called harm being done to a terminally ill person.

**Mr R.H. COOK:** I was not going to respond to the member for Dawesville’s comments, but I am happy to provide that to the member.

Several members interjected.

The **ACTING SPEAKER:** Members!

**Mr R.H. COOK:** Around the table here, we have not heard of any action that may have taken place in that manner, but in any situation, if there are —

**Ms M.M. Quirk** interjected.

The **ACTING SPEAKER:** Member for Girrawheen!

**Mr R.H. COOK:** If there are unlawful acts, people respond to them in different ways. The legislation has penalties for acting outside the act, and that is appropriate. How a conviction of someone under this act may roll out will be the subject of court proceedings in the normal manner of events.

**Dr M.D. NAHAN:** I will not delay things, but the member for Girrawheen raised clause 61(3), and I would like the minister’s response. We have always been concerned about two issues in this process. One was the voluntary nature of the decision. Clause 61(3)(a) deals with that adequately and uses “appeared”. I accept that the witness will not be a real practitioner and will therefore have to go on appearance, but why did the government leave out the section that the Victorian legislation has on coercion? The government could use “appear” if it wished to use that word, and I think the Victorians used “appear”. The witness’s function is not just to witness the signing and the death, but also to make a final check that it is kosher. The two issues we are worried about is whether the person is conscious and wants the decision. The second is that there are no signs of overall coercion. It might be said that in 99 per cent of cases there will not be, and I accept that, but we are dealing with death. I am not clear why the government has left that out when it has included it everywhere else in the long process it has gone through. I cannot see why the government has left that out.

**Mr R.H. COOK:** Under clause 58, the administering practitioner’s role calls on their training and their authority under the act to make a declaration about coercion. The purpose of the witness is to bear witness to the final act. From my perspective, it is important that the patient’s request for access to voluntary assisted dying is enduring. The witness would not have the skills or the training to be able to certify in relation to coercion.

**Dr M.D. NAHAN:** So —

The **ACTING SPEAKER:** Member for Riverton, before you start, as you referred to, the member for Girrawheen had already asked the previous question you asked. If you continue asking the same question —

**Dr M.D. NAHAN:** I am not. This is an important issue. The minister is not pushing back.

The **ACTING SPEAKER:** No, but he is giving you the same response that you have already heard.

**Dr M.D. NAHAN:** I am just trying to find out what the role of the witness will be.

The **ACTING SPEAKER:** It has been answered.

**Dr M.D. NAHAN:** I accept what the minister just said, that, essentially, the administering practitioner will assess whether there is coercion. The question I have is: the administering practitioner, when trying to elicit that it is voluntary and the person has the wherewithal to make the decision, will have the training, but will the witness have that training also? Will they have to go through the same process that the administering practitioner will in terms of communication? There are a number of subclauses that state that the administering practitioner has to be able to elicit the response from the patient. This legislation asks a witness to make a decision that it appears to be enduring. If the patient cannot communicate other than in certain ways to the administering practitioner, how will the witness make a bona fide assessment?

**Mr R.H. COOK:** At the end of the day, it will probably be someone who is known to the patient, and they will simply undertake to ask the question. From that point of view, they will be able to form a view. I have answered this extensively to the member for Girrawheen. I have entertained questions from the member for Dawesville on this clause and several questions from the member for Riverton. I think we have covered this clause adequately.
Ms M.M. QUIRK: At the risk of repeating myself, what were the specific drafting instructions for this clause? Was there a specific drafting instruction to the effect that it should depart from the Victorian model?

Mr R.H. COOK: The member would understand that I will not be disclosing Parliamentary Counsel’s advice. The drafting instructions were best practice for Western Australia, being informed by the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying.

The ACTING SPEAKER: Member for Girrawheen, the minister has responded to your question, which you have already asked multiple times; slightly variegated each time. Can we just move on? If you are going to continue down this same line of questioning, the minister does not have to respond.

Ms M.M. QUIRK: I wish to place this question in Hansard: can the minister please disclose the government’s intention to exclude a reference to coercion and capacity?

Mr R.H. COOK: I think I have answered the member’s question.

Clause put and passed.

Clause 62: Transfer of administering practitioner’s role —

Mrs A.K. HAYDEN: Clause 62 relates to the transfer of the administering practitioner’s role. Can the minister explain to the house under what circumstances this may occur?

Mr R.H. COOK: Under this clause, when the administering practitioner for the patient is no longer able for any reason to administer the prescribed substance to a patient, the role of the administering practitioner may be transferred to another person. The ability to transfer the role ensures that a person is not disadvantaged due to unforeseen circumstances such as the original administering practitioner being no longer able to perform the role due to illness, injury or other reasons. The transfer may occur only when the patient has made an administration decision for practitioner administration and the coordinating practitioner has prescribed the voluntary assisted dying substance for the patient.

Mrs A.K. HAYDEN: I thank the minister for that. The minister said “other reasons”. Can he tell us what the other reasons may be?

Mr R.H. COOK: No, member.

Mrs A.K. HAYDEN: Does the practitioner to whom the role is passed have to go through anything to make sure that they have the same understanding as the original practitioner—that the decision was made under all the criteria that we have discussed? I do not want to labour over those criteria again.

Mr R.H. COOK: The person to whom the role of administering practitioner is transferred must meet the eligibility requirements set out under clause 53. Clause 5 defines “administering practitioner” in relation to a patient to mean the coordinating practitioner for the patient or a person—medical practitioner or nurse practitioner—to whom the role of administering practitioner is transferred under clause 62(2).

Mrs A.K. HAYDEN: Because the minister read that out quite fast, I ask him to confirm, so that I understand him correctly, that if the role of the administering practitioner is transferred to a different practitioner, the process will start again; that is, the practitioner needs to go through the same regulations and the checklist so they are 100 per cent certain that the patient has not been coerced or the like.

Mr R.H. COOK: Yes, in the administration role. They do not obviously perform the role of the coordinating or consulting practitioner, but in the administration role, yes, they would have to start afresh.

Mrs A.K. HAYDEN: Can this occur if the administering practitioner has decided that they have simply changed their mind and they do not want to proceed with this administration?

Mr R.H. COOK: It is the ability to transfer in the event that they are unable to fulfil the role of the administering practitioner.

Mrs A.K. HAYDEN: Just to clarify, the minister said “or any other reason” but could not indicate those other reasons. Could a reason be that they just changed their mind?

Mr R.H. COOK: They could have family obligations or they could be out of the country. There could be other reasons they cannot do it.

Mr P.A. KATSAMBARIS: When an administering practitioner is appointed, this clause foresees circumstances in which that practitioner would want to transfer the role. That makes some sense for the reasons that the member for Darling Range and the minister articulated. This clause requires that within two business days after the acceptance of the transfer, an administering practitioner transfer form needs to be both completed and given to the board. My initial question is: is it possible for the transfer to occur and the lethal substance administered prior to the board being informed of the transfer of administering practitioner responsibilities?

Mr R.H. COOK: Yes.
Mr P.A. KATSAMBANIS: Again, the minister can take this as a comment: I consider that to be another failure of the drafting of this bill. I think it is a significant concern that there are transfers of very onerous duties. Be that as it may, that is what the minister and the government wants.

In the transfer that occurs under clause 62, what provision is made so that the person accepting the transfer and becoming the new administering practitioner is bound by all the provisions that are contained in division 2 of part 4 of the act?

Mr R.H. COOK: They become the administering practitioner so they have to discharge all of their duties consistent with the act, not just at the point that they have received them. This is the same question that I answered from the member for Darling Range.

Mr P.A. KATSAMBANIS: Let us start working through the practicalities of this so we can understand the limitations and also the obligations. The administering practitioner has to fill out a practitioner administration form and send it to the board within two days of filling it out. That was set out in clause 60. If that form is not sent to the board before the transfer—within that two-day period, obviously, because there can be a transfer within the two-day period—who is obliged to fulfil the duties and obligations under clause 60? Is it the original practitioner or is it the substituted or transferred practitioner, or is the obligation on both of them?

Mr R.H. COOK: If they are to become the administering practitioner and the certification by the administering practitioner following the administration of the prescribed substance has already occurred, I am not sure what role the member would have them play because, by then, the process is complete. Is that what the member is suggesting?

Mr P.A. KATSAMBANIS: That was not my question at all. That was a previous question that the minister answered. I am saying that under clause 60, someone who has accepted to be the administering practitioner has to fill out a practitioner administration form. Under clause 62, there is the circumstance of transferring that responsibility. If the practitioner administration form, the original form, has not been lodged with the board at the time of transfer—they are allowed two days and the transfer could take place within those two days—whose responsibility is it to lodge that form under clause 60? Is it the original practitioner or the practitioner who has acquired the role under clause 62? Is the obligation on both of them? Do they each need to fill out a form?

Mr R.H. COOK: I think the member is confused. Under clause 62, an administering practitioner transfer form is lodged. We have the new administering practitioner, who would then undertake administration of the prescribed substance under clause 60, which would then require the practitioner administration form. There is no point in transferring the role of the administering practitioner if the voluntary assisted dying substance has already been administered. Just because it goes from clause 60 to clause 62 does not mean that things take place in that order. They simply capture different activities under the legislation. It is not in chronological order.

Mr P.A. KATSAMBANIS: I was attempting to refer to the form in clause 59, which is the administration decision and prescription form. The minister said that all this needs to be done afterwards rather than beforehand. Do all the obligations of the administering practitioner to inform the board occur after the administration of the substance and not before? Does the administering practitioner have any obligations to the board before the administration of the substance?

Mr R.H. COOK: Clause 59 points to the role of the coordinating practitioner, who is the only one who can prescribe the voluntary assisted dying substance. Under clause 59, the administration decision and prescription form would have been lodged by the coordinating practitioner. Only then will the coordinating practitioner be in a position to transfer the role of the administering practitioner to another medical practitioner, who would then be bound, obviously, by the administration decision. The prescription will be completed, and it will be the role of the medical practitioner who becomes the administering practitioner to fill out the administering practitioner form and complete the practitioner administration form.

Mr P.A. KATSAMBANIS: I think the answer to the last question I posed is effectively yes. There are no obligations on the administering practitioner to inform the board prior to the administration of the substance. This simply reinforces some of the previous debate—this is a comment, minister—that an entire administration process, including the possible transfer of the administration process, will happen completely outside of any information provided to a supposedly independent board—I assume it will be independent, more than supposedly. Again, it is just a safeguard that seems to be missing here. It is obviously a deliberate decision by the government. It weakens the protections available under the proposed legislation.

Mr Z.R.F. KIRKUP: My question relates to clause 62(5), which states—

If the original practitioner has possession of the prescribed substance when the role is transferred …

I am trying to understand the practicalities of how that will occur. I am trying to imagine a situation in which there has been a change in practitioner due to a patient’s location or whatever reason. The substance transfer, as I will call it, that occurs as part of subclause (5) suggests to me that the practitioners old and new will have to meet and

Extracted from finalised Hansard
effectively exchange the substance. Is that correct? Is there any capacity for the new practitioner to acquire the substance from somewhere else; and, if so, what will happen to the original substance? I imagine it will have to be disposed of. Under this legislation, will the practitioners effectively have to meet and swap the substance? I flag that I have another couple of questions about this.

Mr R.H. COOK: In the normal course of events, a medical practitioner would have means and ways in which the transfer of medicines takes place. It is covered under section 22(1) of the Medicines and Poisons Act 2014, which states —

A person who stores, handles, transports or disposes of a poison other than in accordance with regulations made under subsection (2) commits an offence.

Obviously, they would be required to undertake the transfer of the substance in a way that is consistent with the Medicines and Poisons Act.

Mr Z.R.F. KIRKUP: I appreciate that response, minister. That is not inconsistent with how the practitioner might receive the substance in the first instance. Obviously, a logistical chain already exists. If they cannot get that substance for whatever reason, is there any capacity for the new practitioner to access the substance, or a new substance? From my reading of the legislation, they cannot. They cannot go back to the start and prescribe a new vial or whatever it might be of the substance; they have to take the one that has been prescribed. I am trying to imagine a remote or regional setting in which a terminally ill person has a number of days to live. I know that the minister does not like to deal with wild hypothesis, but I am trying to understand the practicalities if someone moves and how this clause will come into effect. Is there any capacity for the new administering practitioner to access a new substance?

Mr R.H. COOK: Only the coordinating practitioner can write the prescription. That would have to be managed under the normal regime that we would expect under the Medicines and Poisons Act. There might be a circumstance in which they could ultimately, but under the Medicines and Poisons Act, the practitioner would have to account for that store of medicines at the time that they produce a new one. It would have to be consistent with the act.

Clause put and passed.

Clause 63 put and passed.

Clause 64: Patient to appoint contact person —

Mr S.K. L’ESTRANGE: Clause 64, “Patient to appoint contact person” states —

(1) The patient must appoint a person as the contact person for the patient.

The eligibility under subclause (2) states that they need to be 18 years of age, and subclause (3) states —

Without limiting who can be appointed as the contact person …

I want to focus on that bit, because it provides some examples of who can be appointed and it also leaves it open to anybody else. I acknowledge the seriousness of the role of the contact person, and I know we are not yet at clause 66, as the minister knows, clause 66 states —

(1) The contact person for the patient is authorised to —

(a) receive the prescribed substance …

(b) possess the prescribed substance … and

(c) supply the prescribed substance … and

(d) give the prescribed substance …

It is a pretty serious role. Was any consideration given to what a minimum standard, for want of a better word, should have been for the person who will hold the position of contact person?

Mr R.H. COOK: Essentially, this discussion would be between the patient and their carer, whether that would be the local doctor or their coordinating practitioner. The role of the contact person involves some clinical process, and they will have a role to play in the process, but at the same time it will also be a very intimate role, because this person will be intimately involved in the person’s end-of-life decision. Again, we are making this a person-focused exercise, and from that point of view understand that we do not want to limit it, as such, but we are anticipating that it might be the coordinating practitioner or another medical practitioner who has been involved in the process.

Mr S.K. L’ESTRANGE: I understand the personal focus, but there will be situations in which language barriers are involved. The person who the patient wants to be their contact person might not be a strong reader, for example. This person will be handling the prescribed substance and will be giving the prescribed substance. Through that, we would expect they may have to read instructions on how to give that prescribed substance. I would have thought that as a minimum there might be some sort of literacy standard for the contact person, irrespective of the relationship that that person has with the patient, given their role.
Mr R.H. COOK: Yes, member, and the contact person must accept the nomination for that role and they need to undertake that with the understanding that there are some obligations under this legislation, in particular to return any unused portions of the voluntary assisted dying substance. They will not necessarily be the person who will be holding the patient’s hand at the end of the process and they will not necessarily have to be a family member or someone like that, but it will have to be someone who is able to act competently under the provisions of the legislation.

Mr S.K. L’ESTRANGE: Should there be a provision in the legislation to make sure that that contact person, whoever it is, is competent to carry out their role?

Mr R.H. COOK: Not necessarily, member. Obviously, the contact person is something that would be discussed with their medical practitioner or coordinating practitioner, in this case in particular, and in that context they would talk about what is required for the role. The contact person has a role to play, but it is not one in which they will necessarily be making any sort of medical or other skill-based related decision; they simply have a role to play.

Mrs A.K. HAYDEN: Following on from that but going to a different step, in the explanatory memorandum under clause 64, the last paragraph states —

The intent of appointing a contact person is to ensure that once supplied, a voluntary assisted dying substance can be monitored and safely disposed of (if unused).

Under this legislation, is there any provision for training or information that will be required to be provided to that contact person to enable them to fulfil their role to monitor the assisted dying substance but also to dispose of it if it is not used? We will be giving this person quite a lot of responsibility, and I agree that they have agreed to be that person, so they are taking on this task, but is any training or information required under this bill that will be passed on to that contact person so that they can fulfil the requirements as outlined in the explanatory memorandum of the bill?

Mr R.H. COOK: I draw the member’s attention to division 9, clause 148, which explains what the board does when it receives an appointment form in relation to the contact person. In the implementation phase we would anticipate that a range of materials would be provided or developed to support the contact person carrying out their role. Clause 104 provides one of the key roles of the contact person, which is to give an unused or remaining substance to the authorised disposer. From that perspective, I think we have anticipated exactly what the member believes a contact person would need.

Mrs A.K. HAYDEN: It says under clause 148 that the board must send information within two days of receiving a copy of the contact person appointment form. Does the contact person appointment come before passing out the administrative drug? As we have established already, that could take place before the board is notified.

Mr R.H. COOK: The coordinating practitioner cannot even fill out the prescription without the contact person’s details being provided in that form.

Mrs A.K. HAYDEN: Just to clarify, the contact person will—the minister said, “More than likely”—receive a guideline or booklet or something for them to follow, that will be in regulations or whatever happens after the passing of this legislation. Will that definitely be included? The minister said, “More than likely”. Is it definitely included that they will be given that or not?

Mr R.H. COOK: Yes, member. Clause 148(b) contemplates that very thing.

Mr S.K. L’ESTRANGE: To follow on just from my previous line of questioning, I want to confirm that other than being 18 years of age, there is no other restriction on who can be appointed as a contact person as it currently stands. Is that correct?

Mr R.H. COOK: Yes.

Mr S.K. L’ESTRANGE: Would the minister see merit in having, at the very least, some restrictions placed on who could be selected? For example, if someone had a criminal history, possibly even relating to poisons, or any other criminal history that suggests they are not a decent citizen, would the minister think that, as a safeguard in this act, we could at least have some restrictions on who could be appointed as a contact person, given the nature of the duties of the contact person?

Mr R.H. COOK: Member, I am informed that, no, it is not necessary. There is no evidence overseas of a person who is a contact person undertaking a misuse of that role, or misuse of the substances involved. This is simply making sure that there is a single person who has responsibility for carrying out the acts in this part of the bill.

Dr M.D. NAHAN: Why do we have to have a contact person? Why can the patient not do it? In many circumstances, they will not be able to; I understand that. However, in some circumstances, the patient may want to do this himself or herself. My reading of the bill is that the patient must appoint a person as a contact person. Can they appoint themselves?

Mr R.H. COOK: Because the contact person has responsibilities after the voluntary assisted dying substance is consumed, or not, if they die naturally.

Extracted from finalised Hansard
The ACTING SPEAKER (Mr S.J. Price): Do you want to say more?

Mr R.H. COOK: No, the member for Riverton is nodding furiously, so I think I got my point across.

Mr Z.R.F. KIRKUP: I am going to assume that the minister’s answer to my question will be that this is patient-centric legislation, which we do not want to constrain too much. Why is it that under clause 64(6) we have not provided a time requirement for a patient who wants to revoke their contact person to inform the person of the revocation? In all other places throughout the legislation, there are a lot of time frame constraints of two business days. In this clause, there is no time constraint on the patient to inform the contact person that they have revoked their appointment, as best as I have read it. Why is that the case? I suspect the answer is probably at the start of my question.

Mr R.H. COOK: I am informed that the patient may revoke the appointment of a contact person. Following such a revocation, the patient must notify the person of the decision, whereupon the person ceases to be the contact person. We do not have the same regime of two days’ notice to the Voluntary Assisted Dying Board because that is an obligation of the medical practitioners who are involved, whether coordinating, consulting or administering. It is not an obligation of the patient. If a patient has revoked the appointment of a contact person, the patient must nominate another contact person in accordance with the act. This is to ensure that the voluntary assisted dying substance is monitored and disposed of as required by the act. The contact person also provides a clear contact point for the Voluntary Assisted Dying Board.

Mr Z.R.F. KIRKUP: I appreciate the minister’s response. Clause 64(6)(a) says that the patient must inform the person of the revocation. The patient obviously has to inform the coordinating practitioner, but the coordinating practitioner does not have to inform the person who was previously assigned to be the contact person. My question is: Why is there no time frame constraint? If I have appointed a contact person and I decide to revoke that, why is there no time frame applied to me on when I must inform them? I appreciate the role of the coordinating practitioner, but why is it that, as a patient, I am not required to inform the person within a set period of time that they have been revoked as my contact person?

Mr R.H. COOK: Member, again, this is around empowering the patient to make sure that things move forward in the way that they wish. Obviously, a new appointment has to be made, subject to section 64(1), and under that process, once that form has been completed and sent to the Voluntary Assisted Dying Board, the process will run on itself. The Voluntary Assisted Dying Board will then contact the new person. I suspect, in real life, the Voluntary Assisted Dying Board will say, “We now have two forms; we will go back to the coordinating practitioner and find out what is going on here.” But, obviously, one would revoke the other.

Ms M.M. QUIRK: We had some discussion about the difference between an agent and a contact person. Can the minister confirm that a contact person is under certain requirements to return drugs that have not been used, but there is no such requirement on an agent?

Mr R.H. COOK: Member, both the agent and the contact person have obligations under the Medicines and Poisons Act. Regardless of what role they play, they have obligations under that act in terms of the misuse of drugs and making sure that various aspects of that law are adhered to. The contact person, in addition to that role, also has obligations under this act. This sets out those obligations.

Ms M.M. QUIRK: We will get to this in due course, but I will just let the minister know that there are obligations under clause 104 that relate solely to a contact person and not to an agent. That seems to be problematical.

Mr R.H. COOK: No, it is not, member, but we will come to it.

Clause put and passed.

Clause 65: Contact person appointment form —

Mr Z.R.F. KIRKUP: I have a couple of questions on this clause. I will start with clause 65(1). Similar to other concerns about forms, if the full details of the contact person are not set out on the form, does that invalidate the form? We have the details there—the name, date of birth and contact details of the contact person. In all previous questions I have asked about forms, if we do not have the full address of someone, their full date of birth or whatever, it has not stopped that form from progressing. Is that still the case when it comes to the contact person?

Mr R.H. COOK: No, member, it does not invalidate it; however, as I mentioned before to the member for Darling Range, there are obligations that the Voluntary Assisted Dying Board has in relation to contacting the contact person, so the form obviously has to provide enough information for it to be able to contact the contact person.

Mr Z.R.F. KIRKUP: In clauses 65(1)(d) and (e), the contact person has to provide a statement consenting to their appointment—I appreciate that—and a statement that the contact person understands their role under the act and their requirements under section 104 to return any unused portion of the substance.

Mr R.H. COOK: Correct.
Mr Z.R.F. KIRKUP: How do they have to express that? Will the prescribed form include the question, “Do you understand your obligations”, tick, or whatever that might be, or do they have to physically write that out? Will the CEO issue that as part of the pack of forms, or will the contact person physically have to write out “I understand my obligations” et cetera?

Mr R.H. COOK: Obviously, there will be a declaration that they have to sign. Of course, this goes to the heart of what the member for Churchlands was saying. If this person understands what their obligations are and can carry them out, then, under clause 148, information will be provided that will continue to inform the person of their capacity to be a contact person.

Mr Z.R.F. KIRKUP: I will make a statement on subclause (1). My concern about the contact details is that all the information we have previously canvassed around contact details on forms allows for that partial information. At the moment, an email address would meet the legislative capacity for contact details. Obviously, the contact person plays a really important role, but there is no way to verify who the contact person is. For example, there is no identification requirement or a requirement for that person to be a citizen of the state. If a person provides an email address they could just be —

Ms M.M. Quirk: In this country they are called a resident. There is no such thing as a “citizen of the state”.

Mr Z.R.F. KIRKUP: They are a resident. Sorry, member for Girrawheen. I appreciate the member disabusing me of that notion. There is no requirement to ID the contact person or for them to be a resident. Additionally, the contact point could also be an email. I am flagging a concern that to provide an email address is not as rigorous, for example, as all the other requirements that a person has to go through. For example, a patient has to meet with their coordinating or consulting practitioner. I have some concerns about that, but I appreciate that it is unlikely to change at this point in time.

The ACTING SPEAKER (Ms J.M. Freeman): The question is —

Mr Z.R.F. KIRKUP: I am continuing, if I may, Madam Acting Speaker.

The ACTING SPEAKER: I thought you were wrapping it up.

Mr Z.R.F. KIRKUP: Subclause (2) states —

If the patient is unable to complete the contact person appointment form, another person can complete the form on behalf of the patient.

Could that person conceivably be the contact person; and, if so, does that represent a conflict of any sort?

Mr R.H. COOK: It could conceivably be the same person who takes on that role, but they would still have to be signed or declared by the patient.

Mr Z.R.F. KIRKUP: I appreciate that. Thank you, minister. Subclause (3) states —

The patient or the contact person for the patient must give the contact person appointment form to the coordinating practitioner for the patient.

Is there a particular reason for not having a time frame on that, such as two business days or something like that?

Mr R.H. COOK: The only reason, member, is that if the patient is not in a rush, then neither are we. From that point of view, they are in control of the process. Immediately after it is given to the coordinating practitioner, the coordinating practitioner has to get it to the Voluntary Assisted Dying Board inside two days. But again, this is up to the patient.

Mr Z.R.F. KIRKUP: My final question is on subclause (6). In picking up the point that the minister just made, I appreciate that a person cannot be moved through the process to prescribe until the contact person appointment form is provided. Does the minister envisage any capacity, as part of the implementation process, whereby the practitioner might be able to verify the contact person? The practitioner would probably want to make sure that the contact person listed is who they say they are. Does the minister imagine that in any part of the implementation process something like that might be done?

Mr R.H. COOK: Yes, as the member can see throughout the legislation, the coordinating practitioner has a pretty onerous and important role to play in guiding both the patient and other medical and health practitioners through the process. From that perspective, one would expect that they would want to make sure that the contact person is able to function under the act.

Mrs A.K. HAYDEN: The member for Dawesville asked most of my questions, so my remaining question will be quite brief. What happens if the patient cannot find a contact person?

Mr R.H. COOK: As we observed under the previous clause, the coordinating practitioner, the consulting practitioner or another registered health practitioner could play that role.

Clause put and passed.
Clause 66: Role of contact person —

Mr P.A. KATSBANIS: Clause 66 outlines the role of the contact person who is authorised to receive the prescribed substance, to possess it, to supply it to the patient and then to give whatever is left over to the authorised disposer as required under clause 104. They are onerous tasks obviously, but all relatively simple. Clause 66(2) states —

The contact person for the patient must inform the coordinating practitioner for the patient if the patient dies (whether as a result of self-administering the prescribed substance or from some other cause).

I have a few process questions around that. There is no actual obligation for the contact person to be present for the self-administration, as I understand it, so how would the contact person firstly inform themselves so that they can inform the coordinating practitioner? If we assume that that has occurred, then lots of forms need to be filled out. There is no indication of a required form that the contact person needs to fill out that would include things such as where the death took place, how the death took place, and whether it took place as a result of self-administration or some other cause. Why has that been left out? Why was there not one more form? I would have thought that given that this could broaden out to a range of people beyond just the practitioners involved—it could be a lay person in some circumstances or in many circumstances for that matter—some sort of authorised or prescribed form would be seen to be a positive thing. I know that the government has shied away from using prescribed forms, but it could be an approved form to make it simple for the contact person. There are two elements to that question. Firstly, how do they inform themselves? Secondly, why would they not be given a form to make it easier for them to provide the information to the coordinating practitioner?

Mr R.H. COOK: We are just trying to make it easier for the contact person. No, the contact person does not have to be there. The patient may want to undertake the process alone. Secondly, the contact person has an obligation under the process to monitor the voluntary assisted dying substance. They would be in regular contact with the patient. In fact, I would say that they would be in almost constant contact with the patient.

Clause put and passed.

Clause 67: Contact person may refuse to continue in role —

Mr S.K. L’ESTRANGE: Sorry, I was still thinking about the minister’s answer on clause 65, and then, Madam Acting Speaker, you just absolutely rushed through clause 66. This is a serious bill.

Ms A. Sanderson interjected.

Mr S.K. L’ESTRANGE: I know the member is in a hurry, but some of us actually want to critique this bill.

Ms A. Sanderson interjected.

Mr S.K. L’ESTRANGE: We were paying attention. We were listening to the minister’s answer and going through it in the bill.

The ACTING SPEAKER: Member, take a seat. The question is that clause 67 stand as printed.

Mr S.K. L’ESTRANGE: No. I will refer the minister in my questioning of clause 67 to some of the information in clause 66, which relates to some of the information in clause 104, which gets back to the concerns we all have about not having any restrictions placed on who the contact person can be. The Attorney General with his legal background would understand that if we are going to the trouble in clause 104—which is referred to in clause 66 and which leads to clause 67—to imprison somebody for 12 months if they do not do what they are asked, then we are putting in place a prison sentence to make sure that people do the right thing. Our concern is that there is no restriction on who that contact person can be and, notwithstanding that flaw in this bill, under clause 66(2) no time limits are attributed to that contact person for informing anybody of when the patient died. How is the minister going to ensure that this contact person, before they refuse to perform the role under clause 67, is the right person for the job?

Mr J.R. QUIGLEY: I could ask that as a rhetorical question: whom would you want near you when you come to die? We would want someone we trust. Therefore, this chosen contact person is someone the patient trusts. They do not need a medical degree, member, nor will the person who will wipe our brow or hold our hand as we take our last breath. It will be someone we have chosen, just as someone the dying patient will have chosen.

Mr S.K. L’ESTRANGE: The Minister for Health was in charge of the bill before the Attorney General came into the chamber, so the Attorney General would not have heard the minister’s answers. The minister indicated to us that the bill has been drafted so that that person can be a primary carer, as an example. I am putting that to one side, because nowhere in the bill is it stipulated that that needs to be the case. What if somebody were to choose a contact person who might have—this is what we mentioned earlier to the health minister—issues around reading, and there are instructions that go with the substance that has to be administered? What if they did not fully understand their obligations under the bill because they are not an educated person? They might be known by the patient, closely or not. It does not matter. They just have to be 18 years of age. We are quite concerned that the government is not taking the appointment, whatever appointment is made, seriously. Clause 67 relates to clause 66.
because the patient can still make another appointment, but there is no requirement for, or restrictions on, the appointment. Notwithstanding the Attorney General’s point, 99 per cent of the time we would expect that the person standing next to the patient would be somebody who is close to them. We would expect that. All we are saying is that in the event that that is not the case, this person can just be selected by the patient. The only requirement for a contact person is that the patient select them. There is no other requirement. They just have to be 18 years of age standing next to the patient would be somebody who is close to them. We would expect that. All we are saying is they are close to that patient, but they may have another life outside that and they are handling this substance that could put the community at risk? All we are asking is: why is there no restriction on who can be appointed under clause 67(2)(c)—because we missed clause 66—when the patient must make another appointment? We are simply asking the question: does the government not think that there should be at least some minimum standard for whom the contact person should be?

Mr J.R. QUIGLEY: May I answer that with a rhetorical question. Should the person whom the member wishes to accompany him as he draws his last breath have some prescribed minimum standard under a government regulation or should he be able to choose someone whom he wants near him as he dies?

Mr S.K. L’ESTRANGE: I will answer that rhetorical question. If I were in the situation, I would want that person to be somebody close to me, exactly as the Attorney General described. But that, actually, is not my question. I am hoping that that person will be with me regardless of whether they are the contact person. If we look at clause 66(1) on page 44 of the bill, we see that the contact person has the role of receiving the prescribed substance, possessing the prescribed substance, supplying the prescribed substance, and then giving the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer, as required by clause 104. Under clause 104, that has to occur within 14 days, and if none of that is followed properly, they can go to jail for up to 12 months. Therefore, absolutely, the person I would want with me would be somebody close to me who cares for me, but that would not have to be the contact person. I am suggesting that two people could be there if the person close to me did not qualify. However, in this instance, they would qualify because they have only to be 18 years of age. Does the government not think that some due consideration could be given to making sure that the contact person has some minimum standard of acceptability under the bill?

Mr J.R. QUIGLEY: At least the member has planted his flag in the mound. Come his day, he will not even be considering VAD and he will not even be considering a contact person; he will go the full distance. He has made that clear, and all pain to him. He has made that clear. He is against these contact people. He is against people handling this drug, so at least in the presence of the Lord he has said, “This is not for me. I will go the full distance.”

Mr S.K. L’Estrange: I said none of that. You are verballing me.

Mr J.R. QUIGLEY: Do not use your weasel words now; God was listening. Do not use your weasel words now. The next thing is, as far as criminality goes —

Several members interjected.

Mr J.R. QUIGLEY: I do not want interjections.

The ACTING SPEAKER: Just answer the question, minister.

Mr J.R. QUIGLEY: As far as criminality goes, already under the Medicines and Poisons Act, criminals can be prescribed schedule 4 and schedule 8 drugs, which are lethal. That is already in the poisons act. The member said that a patient might choose a contact person who had a criminal record. That might likely be the case in Indigenous communities, which the member does not care about. That might well be the case.

Several members interjected.

The ACTING SPEAKER: Minister, answer the question. Members, stop interjecting!

Mr J.R. QUIGLEY: It might well be the case in Indigenous communities that the person wants their son as the contact person and that son may have a criminal conviction and have been to jail under the former government’s mandatory sentencing laws, but they can still handle and still be prescribed schedule 4 and schedule 8 drugs. There is no limitation on prescriptions under the medicines act, as the member well knows. In relation to treating patients with a history of substance abuse, persons with a history of substance abuse within the previous five years, or recorded as oversupplied or drug dependent, can be authorised to receive schedule 8 medicines. Even though they have a history of drug abuse, under the medicines act, they may be prescribed schedule 8 medicines. Therefore, the point is rejected.

Ms M.M. QUIRK: I want to clarify one point the Attorney General made, and that is whether the contact person even needs to be present when the substance is administered. The contact person’s role is quite limited and the patient can have whomever they like with them, and it does not need to be the contact person.

Mr J.R. QUIGLEY: Correct.
Mr S.K. L’ESTRANGE: The Attorney General just said that they do not have to be present. Does anybody have to be present?

The ACTING SPEAKER: No, minister. Just answer the question.

Mr J.R. QUIGLEY: Sorry?

The ACTING SPEAKER: Answer the question, minister.

Mr J.R. QUIGLEY: I appeal to the umpire. I have not said a word. I got 50 metres and I had not said a thing!

The ACTING SPEAKER: Come on! Come on!

Mr J.R. QUIGLEY: Does anyone have to be present when the member dies —

The ACTING SPEAKER: Member!

Mr J.R. QUIGLEY: — or can he have his choice? This patient will have their choice, the same as he will have his choice when it comes to drawing his last breath. This government will not pass a law regulating who must be present or whether the person can die in peace and solitude. That is their choice, the same as the member has.

The ACTING SPEAKER (Ms J.M. Freeman): Can we get to the clause; it is clause 67. Member for Dawesville.

Mr Z.R.F. KIRKUP: Acting Speaker.

Mr J.R. Quigley: My friend from Dawesville.

The ACTING SPEAKER: I gave you the call, member for Dawesville.

Mr Z.R.F. KIRKUP: I appreciate that. It is always good to have the Attorney General here. I always appreciate it when the Attorney General is at the table, because, hopefully, I will get some relevant answers at some point.

The ACTING SPEAKER: Member, ask the question.

Mr Z.R.F. KIRKUP: If a coordinating practitioner receives two forms, which are dated, but perhaps in the morning the patient made a decision, signed the form, dated it, appointed the contact person and sent it off to the coordinating practitioner —

The ACTING SPEAKER: Sorry, member, are we on clause 67?

Mr Z.R.F. KIRKUP: Yes, clause 67, “Contact person may refuse to continue in role”. Clause 67(2)(c) states —

the patient must make another appointment under section 64(1).

I am curious about the date on the form. Obviously, the coordinating practitioner is obligated to try to find out from the patient who is the most relevant contact person. How might that practically occur?

Mr J.R. QUIGLEY: Of course, they would sort out which was the valid one. Yes, I agree.

Ms M.M. QUIRK: Under clause 67, a contact person may refuse to continue in the role. That might occur, for example, because the person is provided with information about what they are required to do in that position and they might baulk at that. Alternatively, English might be their second language and they do not fully comprehend their role and for that reason say, “This is all too hard. I don’t want to do it.” Is it prescribed in the legislation what exactly is instructed to the contact person and will that be available in languages other than English?

Mr J.R. QUIGLEY: That is all covered in clause 66. When the bill becomes an act and comes into force, the Department of Health will hand out information to the contact people. I know the member has studied the bill very closely and she would be well aware of clause 148, “Board to send information to contact person for patient”, which stipulates —

The Board must, within 2 business days after receiving a copy of a contact person appointment form for a patient under section 59(1)(b)(ii) or 65(4), send information to the contact person for the patient that —

(a) explains the requirements under section 104 to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer; and —

Conjunctively —

(b) outlines the support services available to assist the contact person to comply with the requirements referred to in paragraph (a).

That completely answers the member’s question.

Ms M.M. QUIRK: It does not actually, Attorney General, but that was a good effort. Clause 148, which the Attorney General referred to, requires information to be provided to the contact person, but not necessarily in another language. What I am saying is that that might be the cause of a person refusing to be a witness. They get official-looking documents and they do not quite know what their role is, whereas, in the Victorian legislation, there is provision for some certification that the contact person understood and that information was provided to them in another language.
Mr J.R. QUIGLEY: The bill provides for the use of interpreters when required. Furthermore, Western Australia adheres to the state government’s Western Australian Languages Services Policy 2014. The person is not providing information to someone in the language of this chamber, which I have heard this evening—a person is not providing information if they are talking double-dutch. The information has to be provided in comprehensible English or translated into a language that that person adheres to. There is not a problem there.

Ms M.M. QUIRK: I am not going to flog a dead horse, but clause 160 relates to the use of interpreters for patients, not contact persons.

Mr J.R. QUIGLEY: The contact person has to provide information to the patient. The department will be supplying the contact person with information in an inappropriate language. If the member wants to make a mountain out of a molehill on this, she should keep on going, but it is pretty straightforward; it is not rocket science. This is about giving information to someone who does not use English as a first language.

Ms M.M. Quirk interjected.

The ACTING SPEAKER: Thank you, Attorney General.

Mr J.R. QUIGLEY: I thought my time was still ticking. It is not rocket science to transmit information to someone whose first language is not English; we do it every day.

Clause put and passed.

Clause 68: Information to be given before prescribing substance —

Dr D.J. HONEY: Clause 68(1) states that the coordinating practitioner must “inform the patient, in writing, of the following”. I assume that provision is there so that the patient is fully informed of the process. Why is it specified as having to be in writing? In the case of someone who is quite ill, for example, they could be vision impaired and unable to read. Should there be a broader requirement to make sure that if someone is vision impaired or has some other difficulty, they can receive that information?

Mr J.R. QUIGLEY: I will paint a scene, member. Prostate cancer—I hope the member does not have it—has metastasised and the pain is immense. It is throughout a person’s bones, liver and kidneys. I know the member will not because he is voting against voluntary assisted dying and he will go the full distance—all power to him—but the person elects to access VAD. The doctor comes in with information to be given before prescribing the substance. The patient is in bed in agony and the doctor has to give them this information, and the member is asking why it has to be in writing. This poor person is in a wretched state and dying—I have been in a chemo lab; it felt like a chemo lab—in a chemo room and a doctor comes in and gives them the information outlined in paragraphs (a) to (f) and they are meant to retain it at all. They are meant to say, “Yes, I understand all of that. When my relatives come to visit me, I will be able to regurgitate that and tell them what went down.” No; it has to be in writing so that the person can ask their daughter, their dad, or whomever when they come what are the requirements. There it is in writing. It is called risk management. We know that the medical practitioner has given the information because there, in writing, is the information. It is risk management for the doctor and protection for the patient and their family, because they will know all the procedure.

Dr D.J. HONEY: It may be that the patient cannot take in that information. Might I say that I suspect the great majority of patients will not be writhing in agony, but regardless of whether they are, rather than prescribing it specifically in writing, surely there should be a requirement that it is communicated in a way that is appropriate for the patient’s condition, not simply in writing. I appreciate what the Attorney General has said about writing—that we can trust only what we see written down and all that. However, it may be that a patient cannot possibly understand that because of an affliction. Surely there should be a requirement that the information be communicated to the patient in a patient-appropriate form, not simply in writing.

Mr J.R. QUIGLEY: What is being postulated is that a patient who is non–compos mentis might not be able to understand the writing. If they are non–compos mentis, they would not qualify as a voluntary assisted dying candidate—end of story.

Dr D.J. HONEY: I am having trouble getting through to the Attorney General. I did not imply that the person was non–compos mentis, but simply that they may have an affliction that means that they cannot read the material. Surely there should be a requirement that it be communicated to them in an appropriate form. For example, they may be blind.

Mr J.R. QUIGLEY: If they cannot read, it would not be appropriate for them to self-administer. They might not be able to read the label on the bottle. They might want to take the substance, but instead swallow two aspirins because they could not read the label. This information will be in writing. Their visitors, mum or dad, or contact person will be able to read it. This is for the protection of the patient, and management of risks for the doctors.

This is, to me, a further example of the filibuster being carried on by certain conservative members of this chamber to slow this bill down as much as possible. When clause 68 is read, it will be seen that there is nothing controversial in it. But it is an opportunity for those members to dig in and bog down the progress of this bill—and so shall they be judged!

Extracted from finalised Hansard
Dr D.J. HONEY: I do not think that lecture offered much insight. I am trying to assist —

*Point of Order*

Mr M.J. FOLKARD: Under standing order 97, this is irrelevant.

The ACTING SPEAKER (Ms J.M. Freeman): We are not there, member for Burns Beach. Member for Cottesloe, ask your question.

*Debate Resumed*

Dr D.J. HONEY: Thank you very much for your guidance, Ms Acting Speaker.

I am trying to assist the minister. I have not asked a question for some considerable time because I did not see the need for it.

The ACTING SPEAKER: Let us move it on. Ask the question.

Dr D.J. HONEY: Ms Acting Speaker, I had what I would say are insults from the Attorney General as opposed to an answer before. I am trying to assist —

*Point of Order*

Mr J.R. QUIGLEY: Where is the question?

The ACTING SPEAKER: Sit down, Attorney General. Member for Cottesloe.

Debate Resumed

Dr D.J. HONEY: The question is that it surely would assist in making sure that a potential patient was fully informed if the bill included “or in a patient-appropriate manner”. I do not expect any more sense out of the Attorney General on that and have not had any so far. It is a genuine attempt to help to make this system more relevant to the broader range of patients other than those people who will access this process and will be full-sighted at the time.

The ACTING SPEAKER: I will take that as a comment. Member for Dawesville.

Ms M.M. Quirk interjected.

Mr Z.R.F. KIRKUP: We are not doing that.

I echo the concerns of the member for Cottesloe about the requirement to be provided in writing. I know that in circumstances in which someone might be visually impaired, information cannot be provided to them in writing. As part of all of this, is there any requirement that the information has to be acknowledged by the patient?

Mr J.R. QUIGLEY: Sorry. I got the good part—the preamble. I did not get the question.

Mr Z.R.F. KIRKUP: I will continue the question. The question is whether there is any requirement at all for patients to acknowledge that they have received the information that has been given to them; and, if not, why not?

Mr J.R. QUIGLEY: We do not want to go throwing legal requirements upon the patient. The patient is dying. We do not want to load the patient up with a whole lot of legal regulations. The patient has put their hand up and asked for VAD, and then gone to another doctor and asked for VAD. They have been ticked and ticked again. I remember when jack the dancer gave me a little visit —

Mr Z.R.F. Kirkup: I don’t know who that is.

Mr J.R. QUIGLEY: Cancer. When I went to the hospital of Peter MacCallum, and before they would administer the stuff, because it was a trial, the waiver of liability form was about an inch thick. I had to go up and see Craig Bennett, my mate from uni, whom I used to drink with. He said that it was going to be a horrible death and he had watched Paul Eddington go in St John’s Hospice in London. I had to go through all that because I was going onto an experiment. I was healthy, alert and, I would like to think the chamber would agree, sane.

Mr J.E. McGrath: Back then you were!

Mr J.R. QUIGLEY: Thank you, member, and long may I remain.

It was very burdensome. If a person is far more advanced than I was and is, dare I say, knocking on heaven’s door, should we tell them to sign legal forms of receipt to acknowledge all this? It is an unfair burden on a dying person. We want to make the burden as light as possible. They are going through the worst —

[Interruption from the gallery.]

Mr J.R. QUIGLEY: That was good! Someone does not come from a theatre family, because people from theatre families do not whistle inside, do they? Did the member for Dawesville know that?

Mr Z.R.F. Kirkup: I didn’t.

Mr J.R. QUIGLEY: It is because in the Victorian theatres, the props were worked by whistles. When someone whistled, they would pull it up or down, and if anyone else whistled, the wrong prop would come down. I do not know who was whistling from the gallery, but they do not come from a theatre family.
The person has already been thoroughly briefed on the process by not only the coordinating doctor, but also the consulting practitioner. They have gone through all this. How many hoops do we want to force a dying person to crawl through? How many hoops? This government is about not throwing burdens on the dying person, but building a fence of 102 safeguards around the process.

Mrs A.K. HAYDEN: Before I receive a lashing from the Attorney General, I want to say that the Minister for Health asked me to raise this in division 4, so I am asking this now, as the minister requested. In clause 68, “Information to be given before prescribing substance”, subclause (1)(c) states —

... the substance must be stored in accordance with the information provided by the authorised supplier who supplies the substance;

Obviously, we do not know what the substance will be, but will that be to keep the medication at the right temperature and so forth to make sure that it will be able to deliver what is intended, or will storage also include it being in a safe locked box out of harm’s way—if the Attorney General was listening to the second part of the question?

Mr J.R. QUIGLEY: Let us go back to subclause (1), which states —

(1) The coordinating practitioner for a patient who has made a self-administration decision must, before prescribing a voluntary assisted dying substance for the patient, inform the patient, in writing, of the following —

... (c) that the substance must be stored in accordance with the information provided by the authorised supplier who supplies the substance;

The doctor has to tell the patient to store the substance as the supplier says and not to be like the Attorney General, who has glaucoma and was told to store his medication in the fridge but he keeps it in his pocket. I use it to drop my eye pressure. I am not following the directions of Professor Morgan down at the Lions Eye Institute—sorry about that, professor—because I have it in my pocket. Professor Morgan told me where to store it. I was noncompliant. In this situation, the coordinating doctor is required to tell the patient to obey the directions on the bottle. If it says to store it in the fridge, the patient should store it in the fridge. If it says to store it in the AG’s pocket, they should store it in the AG’s pocket. The patient needs to follow the directions given by the supplier. That is what the doctor has to tell the patient.

Mrs A.K. HAYDEN: There was a second part to my question. I will repeat it. Is there anywhere in this bill that advises that this substance, once obtained and taken home, will be put in a safe place and locked away from harm’s way?

Mr J.R. QUIGLEY: I choose not to answer that question. It will be covered in clause 71, as the member knows in detail, so I will wait until clause 71.

Mrs A.K. HAYDEN: Further to that, this clause does not seem to inform the patient of any complications that might arise. Is there a reason that has not been included in the information to be given before prescribing substances?

Mr J.R. QUIGLEY: The patient will already have been informed of those possibilities by the coordinating practitioner and the consulting practitioner. Under the Medicines and Poisons Act 2014, that is a further requirement when prescribing schedule 4 and schedule 8 drugs.

Mr A. KRSTICEVIC: Following on from the Attorney General’s answer about his personal medication, obviously we are talking about a very serious substance in this case. He made the comment that he did not follow the instructions and he is doing the opposite to what he was told. In this situation, what consideration has been given to a patient who has the same attitude as the Attorney General; that is, they are not interested in what they are being told and they want to do it their way? They may contravene all the requirements of how to store the substance or give access to it or say where it is kept and they are happy to say that up-front. What guarantees are there that, firstly, people understand this and, secondly, that they will follow the instructions implicitly? More importantly, if they are not going to follow those instructions and are blatantly saying that they will do what they like and they do not really care what they are being told, what safeguards are there to ensure that they are not given that medication?

Mr J.R. QUIGLEY: If I might be permitted to say so, that is a very Liberal conservative question; that is, we will now police patients. We could perhaps anticpate an amendment from the member so that if a patient does not follow the instructions on the bottle, we can inflict a mandatory term of imprisonment. That is what the Liberal Party can do. It wants to go around policing patients. The Labor government is not in the business of policing patients. The Labor government is in the business of supporting patients who are dying and who wish to avail themselves of a substance that will relieve them of their burden. We are not in the business of allowing the health department to kick down their door and open their fridge and, if the substance is not at the right temperature, prosecute them. For heaven’s sake!

Mr A. KRSTICEVIC: I do not think we were talking about the medication being at the right temperature. We understand that the patient is following the procedures, especially from a safety perspective, to make sure that the medication does not end up in the wrong hands, it is administered properly and, after the event, the contact person returns the unused substance in the appropriate way. The contact person may already have a track record of not

Extracted from finalised Hansard
being the most honest person or may have a criminal record relating to substance abuse or some other record. It is really about making sure that they understand the procedures and they will follow them. If they say that they will not or there is no confidence that they will and things may be done inappropriately, there needs to be safeguards in that situation. The Attorney General cannot just say that the government is not in the business of monitoring a substance that can kill people and it does not really care how that person deals with it once we give them that substance. As long as they have the instruction booklet, all it cares about is giving them that pamphlet and whatever happens after that happens, and it will trust them to do the right thing and not take any responsibility beyond that point. That is a totally flippant answer. I think the Attorney General needs to give a more serious and concrete response so that the public can be confident that this substance will be looked after and managed properly and the right procedures and processes will be followed.

Mr J.R. QUIGLEY: I get the picture entirely of what the member is proposing. He is proposing that if the patient does not keep the substance in the manner set out on the bottle, instead of sending an ambulance to the house, we should send a police car and take the patient to the lock-up and prosecute them. We will not need VAD; they will be down at the lock-up. What a ridiculous proposition!

Mr A. KRSTICEVIC: What an absolute load of rubbish that answer is.

The ACTING SPEAKER: Member, you do not get to determine the answers; you just have to ask the questions.

Mr A. KRSTICEVIC: There was so little information of substance in the Attorney General’s reply that I was not able to link it to the question that I asked.

The ACTING SPEAKER: Just ask your question, member, and do not make it repetitive.

Mr J.R. QUIGLEY: If the member does not like it, he can go down to the morgue and prosecute the person because they will be deceased. We are not picking on patients who are dying. We have no intention of policing or prosecuting dying people. We intend to support them in their death. We have no intention of prosecuting them or enforcing procedures against them. Most members in this chamber would have poisons in their house. I do not want to kick in the member’s garden shed to see how he keeps his Roundup, but the bottle is clearly marked “poison”. A lot of people have schedule 4 or schedule 8 poisons around their house and they deal with it every day. The member can keep asking questions. This is as much as I want to contribute on this subclause.

Clause put and passed.

Clause 69: Prescription for substance —

Mr P.A. KATSAMBANIS: A lot of this clause is routine. The definition of “medication chart” is included in clause 69(1). There is a prohibition in subclause (4), which states —

The prescription cannot be in the form of a medication chart.

Why is there that prohibition? I think I can guess the answer but I reckon it would be more useful if it were on the record.

Mr J.R. QUIGLEY: It is as though people here have not been to hospital! They are such a healthy bunch that they have never been to hospital. There is a medication chart at the end of a patient’s bed. Every time a nurse takes a patient’s temperature or gives them an aspirin, they pull out the medication chart and fill it in. Never ever does a nurse pick up the medication chart and hand it to the hospital pharmacy, because it is not a prescription. The only person who can prescribe is a medical practitioner. In this case, it is a medical practitioner who has had voluntary assisted dying training; sans that, they cannot write a prescription. However, a nurse or nursing assistant enters what substances a patient is taking on their medication chart. Today it might be Panadol, but the bottle is clearly marked “poison”. The next day it might be something else. It will be recorded. The board will have to report all these deaths to the coroner and it will want to know—“Give us a look at the medication chart”—bang, done. It is not a prescription.

Mr P.A. KATSAMBANIS: That certainly was not the answer I was expecting. I do not think there is much point in examining this if the Attorney General is going to take this attitude. I will ask a different question around the same issue. If, as the Attorney General said, a medication chart cannot be a prescription, why is subclause (4) necessary?

Mr J.R. QUIGLEY: It cannot be used for VAD purposes. A medication chart cannot be used as a prescription for a voluntary assisted dying substance. It is impossible under the legislation.

Clause put and passed.

Extracted from finalised Hansard
Clause 70: Authorised supplier to authenticate prescription —

Mr P.A. KATSAMBANIS: I am trying to get a sense of how this will work. These are not loaded questions. Clause 70 places an obligation on the authorised supplier to confirm —

(a) the authenticity of the prescription; and

(b) the identity of the person who issued the prescription; and

(c) the identity of the person to whom the substance is to be supplied.

As the I understand it, and as the Minister for Health previously outlined, this will happen in a closed loop. It will not be in the form of a piece of paper that is given to a patient who runs down to the pharmacy. It will be delivered directly from the coordinating practitioner to the authorised supplier, I assume, by closed-loop technology of some form or other. What authentication steps are envisaged here? What in practice will a supplier have to do when they receive a prescription in their inbox that purports to be from someone who has the right to make that prescription, a coordinating practitioner? What will those steps be so that everyone is clear about the obligations on the authorised supplier so that they do not fall foul of the legislation?

Mr J.R. QUIGLEY: As the Minister for Health said, it will be a closed VAD loop. The only people who will have access to that loop will be certified VAD doctors. It will not be contained in a paper prescription whereby a person can pinch someone else’s prescription and run around pharmacy shopping. It will be in a closed loop. The authenticity of a prescription will be verified by the prescriber number of the VAD doctor. The identity of the person who issues the prescription, once again, will be confirmed electronically, because, as the member knows, he has already voted for electronic lodgements in the Supreme Court. How do we know that it is the plaintiff lodging the document? Because it is authorised under the legislation. All prescriptions for voluntary assisted dying medications will be sent directly from the coordinating practitioner to the authorised supplier only on a unique voluntary assisted dying medication prescription. We have already covered this in clause 69(6). This is irrespective of whether self-administration or practitioner-administration is chosen. This means there is no opportunity for the prescription to be taken to any other pharmacy.

Mr P.A. KATSAMBANIS: Again, we are trying to put information on the record to assist the users of the legislation. From what I heard the Attorney General say—I do not want to verbal him or put words in his mouth—receipt of the authorised prescription by the authorised supplier within that closed loop will prima facie be taken to be authentication of the prescription. Is that correct or will the authorised supplier need to take additional steps outside of accepting the fact that it was received within the closed loop?

Mr J.R. QUIGLEY: The contact details on the prescription, the details of the coordinating practitioner and the telephone number of the patient will enable the authorised supplier to make the necessary checks to confirm the matters aforementioned. The Western Australian Medicines and Poisons Regulations 2016 outline a number of requirements for prescriptions in part 4, division 1, regulation 10, which include the details of the prescriber; the details of the patient; the description, quantity, dose strength and form of the medicine; the directions for use; and other relevant supply directions. The authorised supplier will have to check by driver’s licence number or some other identifier that the prescription has been written for that person. When I say “written”, I mean electronically on a closed portal in which no-one can shop around.

Clause 71: Information to be given when supplying prescribed substance —

The ACTING SPEAKER: Member for Dawesville.

Mr Z.R.F. KIRKUP: Thank you very much, Madam Acting Speaker.

Mr J.R. Quigley: This will be better.

Mr Z.R.F. KIRKUP: Thank you. The Attorney General has thrown me.

Are there penalties if the supplier, recipient or agent does not follow what is contained in subclause (3); and, if so, are the prescribed penalties contained at the back of the legislation or are the penalties prescribed in other acts?

Mr J.R. QUIGLEY: Clause 70 deals with an authorised supplier having to authenticate the medication. Clause 71 deals with information to be given when supplying the prescribed substance. If the recipient is not the supplier, the authorised supplier must, when supplying the prescribed substance, advise the recipient the information provided under proposed subsection (2) to the patient. That is a requirement of the legislation. If a pharmacist issues the drug without supplying the information in proposed subsection (2), that will constitute an offence of misconduct and they will be prosecuted by the Pharmacy Registration Board of Western Australia. I have conducted those prosecutions. It is the only time that I have been a prosecutor. I went home feeling really lousy because I got a chemist struck off and I thought, “That’s the end of it.” Regulations in that industry are tightly administered by
the pharmacy board. I appeared there and this guy was struck off. I went home thinking, “How’s he going to pay his mortgage?” I felt terrible. The board is very strict. Although it is not an offence under this legislation, it is an offence under pharmacy regulations and it is professional misconduct.

Mr Z.R.F. KIRKUP: Would the Australian Health Practitioner Regulation Agency have a role in investigating that and then possibly disbaring the practitioner? Would that be the case and would it be AHPRA?

Mr J.R. QUIGLEY: The Pharmacy Board of Australia is under AHPRA, so it would be investigated and prosecuted if there was any suggestion that the pharmacist had issued this without going to subclause (2). I thank the member very much for his assistance.

Ms M.M. QUIRK: The Attorney General has read out portions of clause 71(2). In circumstances in which the recipient is an agent rather than a contact person, as I understand it under paragraph (d), somehow the agent needs to contact the contact person, who still has the obligation to give the substance to an authorised disposer. Is that a correct interpretation?

Mr J.R. QUIGLEY: The agent is of course not the contact person. The agent is someone who has been appointed to receive the substance. The contact person has a whole host of obligations to which we have already referred and will be referring further. The contact person has a completely different set of legal obligations from an agent. The agent could be a local delivery service or something like that, someone who is authorised to pick the substance up from the airport and transport it to the contact person, but the contact person has onerous obligations once they accept that responsibility.

Ms M.M. QUIRK: Under subclause (2)(d), if a patient decides not to self-administer, they would still have the substance. Somehow, the contact person might not be around. The agent or the recipient would have to make sure that the contact person contacts the authorised disposer. I am trying to ascertain the sanctions, if the recipient or agent does not contact the contact person.

Mr J.R. QUIGLEY: It is the interplay between clause 71 of this legislation and the Medicines and Poisons Act and Misuse of Drugs Act. There will be offences under the Misuse of Drugs Act for someone who improperly deals with a schedule 8 drug, as there is already for any other schedule 8 drug, and this is what the agent would be laying themselves open for—a very, very serious misuse of drug prosecution.

The ACTING SPEAKER (Ms J.M. Freeman): We will now have a short break and I will leave the chair.

Mr A. KRSTICEVIC: I refer to clause 71(3), which states —

If the recipient is not the patient, the authorised supplier must … advise the recipient to give the information provided under subsection (2) to the patient.

Does the authorised supplier have only to advise but not make sure that the information is passed on? Is there no requirement for the recipient who picks up the substance to sign something that says they will do that or confirm they have done it? What will happen if the patient is not advised at all?

Mr J.R. QUIGLEY: It is between the patient and the agent. If the recipient is not the patient, the authorised supplier must—it is compulsory—when supplying the prescribed substance, advise the recipient to give the information provided under subsection (2) to the patient. The authorised supplier must pass on the information that the authorised supplier has given to the recipient.

Mr A. KRSTICEVIC: Obviously, it says the supplier must advise the recipient to give the information to the patient. It requires the supplier only to advise the recipient to give the information to the patient. It does not say that the recipient must give the information to the patient. They must only advise the patient that this information might be worth giving to the patient. The bill does not require that the recipient must give the information to the patient. How can it be confirmed that the recipient has given it to the patient? After the recipient has given the information to the patient, is there a requirement to confirm with the supplier that they have given the information to the patient? Would it not be a breakdown in the chain of communication if the patient is not given information on how to store the substance or how to prepare and self-administer. There is no way to confirm they have received that information because only one person has said to another person, “By the way, you might want to give them instructions when you get there; that’s all you need to do. You do not have to confirm that you have done it. There is no requirement for you to advise anyone you have done it. We’ll just assume that now that I’ve given it to you, you will do the right thing.” Can it be confirmed even at the start that the authorised supplier has told the recipient they have been given the instructions? Does the supplier then get a signature from the person picking up the medication, stating, “I sign that I’ve picked this up, you’ve given me all the instructions, I will give it to the patient when I get there at the end of the process, and I will confirm that when I get back”?

Mr J.R. QUIGLEY: In Utopia, it would be lovely to have a requirement that members actually read the subclause before asking a question. In a Utopian parliament, that would probably be happening. However, here, of course, this is not about the recipient or the patient. This is about the authorised supplier. It is an obligation put upon only the authorised supplier of what the authorised supplier must do. Not the recipient; not the patient.
Mrs A.K. HAYDEN: I asked this question when we were debating clause 68(c). The Attorney General told me to raise it in clause 71, which we are now debating, which is titled, “Information to be given when supplying prescribed substance”. Clause 71(2)(b) states —

how to store the substance in a safe and secure way;

Can the Attorney General give an example of that?

Mr J.R. QUIGLEY: Sure—out of reach of children.

Mrs A.K. HAYDEN: Is that it?

Mr J.R. QUIGLEY: Is that it?

Mrs A.K. HAYDEN: Yes.

Mr J.R. QUIGLEY: Well, we would not want children to get it! That is it. The member wanted an example; I gave her one.

Mr A. KRSTICEVIC: I go back to the previous answer about reading the clause, I know we are talking about the authorised supplier here, but the authorised supplier is giving the medication to someone who is not the patient. When they supply the medication, they need to advise the recipient and give them the information. What guarantee is there that the patient at the end of this process has actually received the information that the authorised supplier has given to the recipient if the recipient is not the patient? That is the question. This is important information that the patient must receive, because it contains the instructions on a whole range of very critical issues. I would think that it would be incumbent on the patient being able to confirm somewhere in this process somehow that the recipient has given them the instructions. The Attorney General talked about a closed loop, whereby there is a requirement at the end of the process for the patient to potentially phone either the authorised supplier or the consulting physician to say, “I have received the medication, I have received the instructions, I understand them.” Therefore, we know that the loop is now closed, the patient has received the information in the prescribed way, and the patient has received the instructions that the authorised supplier must give to the recipient, if the recipient is not the patient; therefore, we know that everyone is fully informed of what their obligations are, and there is no way that the wrong procedures can be followed. It is a very simple question. It cannot be that hard for someone to make a phone call, sign a document, send an email or go into this closed loop and tick a box, or something to say that the patient has received the medication and the patient has received the information on how to use the substance and what to do with it. At this stage, all I am hearing from the Attorney General is that, well, the authorised supplier has given it to the recipient, and we will just assume that it has all happened, because that is what is supposed to happen in the natural course of events. The process will be obvious, nothing can go wrong, the process is perfect, and human nature or human processes do not fall down, even though the Attorney General has given us a perfect example of him not following the right process with his own medication. That is nowhere near as important —

The ACTING SPEAKER (Ms S.E. Winton): Member for Carine, can we get back to a question?

Mr A. KRSTICEVIC: It is a very important part of the question, because —

The ACTING SPEAKER: I appreciate that, so can you ask a question?

Mr A. KRSTICEVIC: The Attorney General has put on the record that he does not follow his medication, so now his physician will know and will have that information when he reads Hansard, but how will we know in this case that the patient has received the information? It cannot be that hard. This is a very serious piece of legislation. Someone could get to the end of this process and have no way of confirming that they have received the information they need. The Attorney General is saying, “It doesn’t really matter. As long as the authorised supplier’s done their bit and given it to whoever the person is who’s picked it up, the rest is irrelevant. Who cares? We just assume that the patient has got the information. We don’t really care if they have or haven’t. We just assume that they have and that’s good enough for me.” I just do not think that is good enough. I would like the Attorney General to tell me how we can guarantee that the patient, at the end of this process, has received the information. How do we know 100 per cent that the patient has received this very important information, given that this is a very serious piece of legislation that has consequences that cannot be wound back? We need to make sure. It cannot be that difficult. By the time they have gone through the process to get to this point, to say to someone, “Well, you need to make a phone call or you need to sign a document or send an email or do something” is an insignificant step, but it is a critical step relative to all the other steps that have been laid out in this piece of legislation. I just want the Attorney General to give us confidence and assure us that we know 100 per cent that the patient, at the end of the process, has received the medication and the information.

Mr J.R. QUIGLEY: Clause 71(3) does not deal with the patient; it deals with the authorised person. The answer I gave to the member stands as before. I have no further comment.

Mr A. KRSTICEVIC: I know the clause relates to the authorised supplier, not the authorised person, just to correct the Attorney General. It deals with the authorised supplier, so I hope we are talking about the same process.
The authorised supplier is the one who must provide the information to the recipient, if the recipient is not the patient. We all know it is the authorised supplier. That is not in dispute here. We are not talking about how the process starts; we are talking about how the process finishes. How do we know that the patient has received the information that the authorised supplier may have given to the recipient, if the recipient is not the patient? More importantly, at the point when the authorised supplier gives the information to the recipient, is there some way to confirm that the authorised supplier has actually given the information to the recipient? If the recipient is not the patient, they may not even have been given the information, unless they can confirm or sign a document or do something to say, “Yes, I have received this. I will sign this. I have received the medication. I have received information. I have signed a receipt.” If a courier comes to bring a phone attachment, one has to sign on the electronic document to say, “I’ve received this parcel.” This is not exactly a parcel in that respect; it is a much more serious delivery that is coming than a part for an iPhone or a computer or something. I just want to make sure that the patient, at the end of this process, has received the information that the authorised supplier has given to the recipient, when the recipient is not the patient. How do we know the recipient has the information and, more importantly, how do we know whether the patient has the information? It is important to make sure that both those people are given the information so that, at the end of the day, the patient knows the processes, procedures and instructions that they need to follow.

Mr J.R. QUIGLEY: It is the same answer as before, but I also invite the member to read clause 73, which we will get to presently.

The ACTING SPEAKER: Member for Carine, do you have a new question?

Mr A. KRSTICEVIC: This is not a very difficult question.

The ACTING SPEAKER: Member for Carine, do you have a different question?

Mr A. KRSTICEVIC: The Attorney General has not answered the question. He refuses to answer the question. It is a very simple question. It says here —

The ACTING SPEAKER: Member for Carine, the Attorney General has given you an answer. Do you have a different question to ask? He has given you his answer twice now; I do not think he is going to give you a different one. Unless you have a different question, I would like to put the clause.

Mr A. KRSTICEVIC: I will ask the question in a different way. I really do not understand. The clause is very self-explanatory. I have not heard anybody else dispute the question I have asked, apart from the Attorney General. It cannot be that hard to answer this question and to tell me in very simple terms —

The ACTING SPEAKER (Ms S.E. Winton): Member for Carine, are you asking a new question?

Mr A. KRSTICEVIC: — how do we know that the information provided has been provided to the patient? It is a very simple question.

The ACTING SPEAKER: Thank you. Attorney General, would you like to answer again?

Mr A. KRSTICEVIC: It cannot be that hard.

The ACTING SPEAKER: Thank you, member for Carine.

Mr A. KRSTICEVIC: I know that the Attorney General does not want to answer the question. Perhaps he does not know the answer and the Minister for Health can answer it.

The ACTING SPEAKER: Member for Carine! You have asked your question so let the Attorney General answer it again.

Mr A. KRSTICEVIC: He is not answering the question at all.

Ms M.M. QUIRK: Before our break I was inquiring about an agent who is the recipient, and in particular clause 71(2)(d), which states —

… if the patient decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal;

I asked a question, and to be fair the Attorney General did answer it but not with enough specificity so that I can find out what the particular sanction is. In those circumstances, the contact person may not even know that the patient has decided not to self-administer. He does not know that he is under an obligation. What sanctions are on the agent in relation to his role and, for example, notifying the contact person that the substance is not going to be used?

Mr J.R. QUIGLEY: As stated before, there are pretty heavy sanctions under the Misuse of Drugs Act.

Ms M.M. QUIRK: Perhaps at some stage the Attorney General could supply me with the section involved. I have had a bit of a look and I am not quite sure where to find it. Given that the contact person has authorisation for possession of the same, what is his obligation to notify the contact officer?
Mr J.R. QUIGLEY: Under this legislation, they are authorised to supply the drug to the patient. If they supply it to anyone else or fail to supply it to anyone else, then they are not authorised under the act and any such—I was going to say “dealing” but that implies a monetary thing—passing on of that drug to any person other than the contact person for the patient would not be covered by the act and be an offence under the Misuse of Drugs Act and the Medicines and Poison Act as well.

Ms M.M. QUIRK: I will risk the wrath of the Acting Speaker at the moment. Can I ask what sections —

Mr J.R. Quigley: The member can ask anything she wants to; it is the Parliament of Western Australia.

Ms M.M. QUIRK: What are the sections of the legislation supplied by the Attorney General? I will give the Attorney General a specific example. The contact person is out of the jurisdiction. He or she has gone on holiday. The patient appoints someone as an agent to collect the substance from the post office or the chemist or wherever it is. The agent then goes to the patient, gives them the drug and the patient, for whatever reason—irrelevant for present purposes—decides not to self-administer. The agent goes on his or her way. The contact comes back from holidays and does not know that any of this has occurred but is nevertheless under an obligation to give the substance to an authorised disposer.

Mr J.R. QUIGLEY: It is all to do with the concept of knowledge—criminal law 101, mens rea. If the contact person does not even know that the patient has received the drug, there is no obligation on the contact person. It is beyond their knowledge and we cannot prosecute people for things that happen without their knowledge. If a drug is delivered to a patient by the agent and the contact person is not there and does not know about it, the contact person does not know about it.

Ms M.M. QUIRK: I am asking about the obligations of the agent. Also, I am still waiting for advice on what sections of the Misuse of Drugs Act and the Medicines and Poisons Act the Attorney General believes may possibly be in play.

Mr J.R. QUIGLEY: The agent does not have any legal relationship.

Clause put and passed.

Clause 72: Labelling requirements for prescribed substance —

Mr Z.R.F. KIRKUP: Clause 72 is relatively straightforward, so I will ask a series of clarifying questions in one batch. The container will have a statement that warns of the purpose of the dose of the substance, states the dangers of administration of the substance and states that if it is supplied for self-administration, it must be stored in accordance with advice and the like. I understand that that needs to be affixed to the container, or however the substance is provided, in some way, shape or form. Under subclause (1)(a), the purpose of the dose is to cause death, so I assume that that has to be stated quite clearly. Can the Attorney General confirm that? I assume that under subclause (1)(b), the dangers of administration of the substance would be death, but it might also cover side effects other than death. If that were the case, what would they be?

Mr J.R. QUIGLEY: Yes; it depends on the substance. I agree with the member.

Mr Z.R.F. KIRKUP: I assume that it is substance specific; is that the case, Attorney General? Of course, we are aware of other jurisdictions where there have been some adverse reactions to something like that. I assume that that would be stated, but it would be according to the substance that has been prescribed; is that the case?

Mr J.R. Quigley: Yes.

Mr P.A. KATSAMBANIS: The protections in this clause are wise and good. The container must have a label that warns of the purpose of the dose, states the dangers of administration and, if it is to be self-administered—so, it is given to the non-medical patient—states how the substance is to be stored and that any unused or remaining substance must be given to an authorised disposer. That is all well and good and I think it is important. It will be on an approved form, so I think that is good too. The authorised suppliers will not be freelancing; there will be an approved form. The question I have is based on the fact that right now we do not know the range of substances or what the delivery package will look like. If the container is the size of the one that the Attorney General pulled out of his pocket before the suspension, which I think he said was his glaucoma medication and was quite a small bottle, it would be very difficult to fit that sort of information on the label. Would the approved form require the labelling that is necessary under clause 72 to be in a particular size or could it be shrunk to the tiniest possible size to fit on the container? I see the one that the Attorney General has in his hand now, but he would know, having been in the Peter MacCallum Cancer Centre, how some phials could be even smaller than that container. I ask for a little bit of clarity. We know that for people who will use this substance, obviously it will cause death.

Mr J.R. Quigley: Hopefully.

Mr P.A. KATSAMBANIS: That is their intention, and that is fine and good. But if it is mixed up with other medication in a household, it could fall into the wrong hands. The other problem that we could face if the typeface

Extracted from finalised Hansard
is too small is that the person who is self-administering, who chooses to do it on their own, because they can, might not be able to read the label and end up taking the wrong medication, so I seek a little bit of clarity around that. I am not trying to be tricky or sneaky or cute. I just want to know what the approved form is going to look like.

Mr J.R. QUIGLEY: Yes, certainly. Clause 72 states that the label must be attached in writing to the relevant package or container. If it is a little tiny vial, it is okay to attach it to the package. I returned to my seat in the chamber to get the medication to which the member refers. Members will see that it is a very small bottle with the label being a little tag attached to the very small bottle—even a person of my age with glaucoma can read it quite well—and that will happen with this material. It can either be on the box if it is a little, weeny vial with a very potent subject, or it can be attached to the actual container containing the potion. The label will clearly identify that it is a VAD substance and distinguish it from other medications, and it is not intended that the ingredients of the substance be provided on the external packaging for obvious safety reasons.

Mr P.A. KATSAMBANIS: That last point, in particular, has been emphasised in the rest of the debate. Will there be a stipulation for a minimum font size? That answer is all I want to seek for clarity.

Mr J.R. QUIGLEY: It has to be in an approved form. To be approved, it has to be readable. It has to be legible.

Mr Z.R.F. KIRKUP: Attorney General, is the approved form that is referenced there approved by the CEO? Is that likely to be made public, or is that going to be decided as part of the implementation process? Why is it that we do not decide to define that more now?

Mr J.R. QUIGLEY: I take that the member has asked that question on behalf of the chamber, because I know the member knows the answer to that, and that he is asking that on behalf of the other members. It is the old principle of the barrister: you never ask a question you do not already know the answer to. I respect that member and he would not ask a question that he did not know the answer to. The problem is we cannot prescribe the size of the label and the size of the print on the label because the substances, which we are not going to reveal, will come in various-sized containers. If it is a little, weeny container with a very potent potion inside of it, the labelling might be on the box in larger print than it would be if it were on a small bottle with the label attached to the bottle. I am heartened. The member is nodding in consent. He did know the answer all the while, but I thank him for asking on behalf of the other members who did not think of this point. Due to the variation of the containers and bottles et cetera, we cannot prospectively prescribe the font, the size of the font or anything. It will be legible and intelligible and in accordance with the law.

Mrs A.K. HAYDEN: Attorney General, previously, I asked a question about labelling requirements under clause 57 to the Minister for Health, and I was asked to bring it up in division 4. There does not seem to be a need for an expiry date. Can the Attorney General tell me whether current substances that are being used in other jurisdictions have an expiry date, or are these substances able to be used forever and a day?

Mr J.R. QUIGLEY: It is the same as any other poison or substance that is prescribed. The manufacturers prescribe the expiry date. It will expire the same as a bottle of milk. The manufacturer puts the last date the milk should be drunk by on the bottle, and it does the same with its other products. Or if the member buys pre-wrapped meat at the butchers or the Independent Grocers of Australia, it will have a use-by date.

Mr J.E. McGrath: Farmer Jack’s.

Mr J.R. QUIGLEY: Farmer Jack’s Supermarkets—Freddy Fairthorne is my old schoolmate. The manufacturer will put the expiry date on it.

Ms M.M. QUIRK: I want to explore whether, given that the drugs will be going to remote communities, any thought had been given to having some pictorial notifications. In the old days, it used to be the skull and crossbones, I think, on things like Ratsak or what have you. I am wondering whether there is any possibility of having a pictorial representation as well.

Mr J.R. QUIGLEY: The labelling will be consistent with the Medicines and Poisons Act 2014. This is a poison, and it will be consistent with the Medicines and Poisons Act. There might well be, optionally, a skull and crossbones or something like that on it. I am not joking—they put that on placards on trucks to say that something is dangerous. But apart from that, it will be —

Mr P.A. Katsambanis: They do that with some of the substances you buy at hardware stores.

Mr J.R. QUIGLEY: That is right—they put a skull and crossbones on them. I was not being flippant. That signals to the population that this substance is dangerous, but the rest of it will comply with the information provided in the act.

Mrs L.M. HARVEY: I refer to clause 72(1)(c), which reads —

states that, if the substance is supplied for self-administration —

(i) the substance must be stored in accordance with the advice given by the authorised supplier; and

(ii) any unused or remaining substance must be given to an authorised disposer by the patient to whom it is supplied or their contact person.

Extracted from finalised Hansard
How are we going to be sure that the substance is actually stored in accordance with the advice given by the authorised supplier? Will somebody check on that? Do we just take people on good faith, hoping that the contact person fully understands their responsibilities? I seek the Attorney General’s advice about what kind of compliance effort might be put into ensuring that these substances will be stored and secured in the appropriate way. That is the first question. The second question I have is: is it likely that the substance is going to have the person’s name and other details on the label, like any other prescription?

**Mr J.R. Quigley:** The first question—I make no criticism, implied or otherwise by this—was answered earlier when the member was not in the chamber. Many members were not in the chamber. I am not making any particular criticism, but I am just going back to this point. This government is not in the position of wanting to prosecute dying people. If a dying person fails to store the substance for self-administration in the manner instructed, this government has no intention of sending the police around to kick in their door and arrest them for not complying with the act. This is a dying person whom we are supporting by giving an option. There will be strict enforcement against coordinating doctors, consulting doctors, authorised suppliers et cetera, but there will be no enforcement, but rather support for a dying person, if that dying person has failed to keep the drug in the manner in which he or she was directed to store it. They can be safe from prosecution by a Labor government.

As to the second point, that deals with the prescribing of drugs under the Medicines and Poisons Act. The drug will have to bear the name of the person for whom it is prescribed. I have never seen any drugs—like these things I have in my pocket to keep my eyeballs straight—that do not bear the name of the patient. Forget about a VAD drug—I cannot go down to the pharmacy and pick up any drug without my name being printed on it. I am talking about drugs that do not require a prescription, member for Hillarys.

**Mr P.A. Katsambanis:** They have cough medicines and the like behind the counter, and you have to ask for them and give details.

**Mr J.R. Quigley:** But they are not prescribed. Anything a person puts a prescription down on the counter for, the pharmacist goes away and types it all up on their little computer these days and by the time it is taken to the cashier, there is a label on it bearing the person’s name and the directions for the drug.

**Mrs L.M. Harvey:** I heard the Attorney General’s earlier answer about it obviously not being in the public interest for police to prosecute a dying person. It would be a nonsense and is not what I am trying to understand. The contact person will be involved as well. They will have a wide range of responsibilities under this legislation and will play a very important role. What kind of compliance effort will be put into chasing up the contact person to ensure that they are looking after the security of the substance and making sure that it is being stored appropriately? If the patient is very sick and bedridden, they may not be able to get up to check that the substance is stored in a cupboard, but I expect that the contact person would be able to. I do not think it is unreasonable to expect that some kind of effort might be put into that. Perhaps it could be an SMS to their mobile phone asking them to give assurance that the substance has not been used, is still intact, and is being stored appropriately—I do not know. That is just an option, but I think some assurance is needed from the Attorney General that there will be some kind of compliance effort put into ensuring that the contact person, who will ultimately have custody of any portion of the substance that is left after an individual who has accessed voluntary assisted dying has passed away, does the right thing. Who will chase them up? What effort will be put in? How will we make sure that the contact person is keeping the substance safe from other people in the household?

**Mr J.R. Quigley:** Here are two scenarios. While the patient is still alive, there will be no obligation on the contact person at all.

**Mrs L.M. Harvey:** Even if the patient is incapacitated?

**Mr J.R. Quigley:** If the patient is alive, there will be no obligation on the contact person. The contact person will be a hand-holder. There will be no obligation on the contact person—end of story! However, if the patient has passed away as intended but has not consumed the whole of the substance, there will be an obligation on the contact person because they will be the person in the room with the drug who is still alive. Those obligations are set out in clause 104 of the bill, and include imprisonment of up to 12 months. We can deal with that clause when we get there.

Do not forget that this person will be dying. The coordinating practitioner—the doctor—will be able to check at any time that their patient is properly storing the drug in accordance with how they have been directed. There will only be an obligation on the contact person if the person whose brow they have been wiping and whose hand they have been holding dies. That will obviously extinguish the obligation of the patient, because they will be dead, but will enliven an obligation on the contact person to dispose of the excess drug in accordance with clause 104 of the bill, on pain of imprisonment if they fail to do so properly.

**Mrs L.M. Harvey:** I have one further question on this. Does any responsibility shoot back to the coordinating practitioner with respect to the storage of these substances, or is it only the contact person in the event that the patient has expired?
Mr J.R. QUIGLEY: We have to bear in mind that the contact person might actually be the coordinating practitioner. There is nothing to stop the patient from choosing their doctor as their contact person, so there would be an obligation in that. But the coordinating practitioner does not have to go around kicking in the door of the dying patient to check that they are complying with directions given.

Mr J.E. McGrath: But if they are their doctor, they might have an interest in making sure that everything goes right.

Mr J.R. QUIGLEY: Correct, if they are the contact person as well. I will tell members about another drug. I had my knee chopped out and they gave me this stuff called oxycodone.

Mr J.E. McGrath: It’s very good.

Mr J.R. QUIGLEY: I would not take it. There is a box lying around the house somewhere. I would not take it because I read in The New York Times that it is very addictive, so I stuck with Panadol, but they give people this stuff to take home. Every medical procedure is now meant to be without pain, according to the population, so they dish out these opioids. But in this particular case, this is a very powerful drug. It is up to the patient to be responsible for its storage, but if they die, the contact person has an obligation enlivened under clause 104 of the bill.

Mrs A.K. HAYDEN: I have two questions, but the first one follows on from the question asked by the Leader of the Opposition. From what the Attorney General just said, the contact person has no responsibility whatsoever for looking after the substance.

Mr J.R. Quigley: That is not what I said.

Mrs A.K. HAYDEN: Under clause 66, the contact person can be authorised by the patient to receive the prescribed substance from the supplier, possess the prescribed substance for the purpose of supplying the prescribed substance to the patient, and give the prescribed substance or any unused portion back to the authorised disposer.

Mr J.R. QUIGLEY: That is correct.

Mrs A.K. HAYDEN: I am glad, because I am reading it from the bill! For example, a contact person is authorised by a patient to go and collect the substance and is told how to store and keep that substance. The patient is not told that, because the contact person went and collected the substance. But there is no obligation on the contact person to ensure that that substance is stored correctly.

Mr J.R. QUIGLEY: It is not their drug; it is the dying patient’s drug. The dying patient will have an obligation to store the drug, not the contact person. Remember, the script is written out for a patient who is dying. Once that script is filled, the drug is not owned by the contact person; it is owned by the patient. What the member has described relieves the contact person, who receives the drug and gives it to the patient, from any criminal liability under the Misuse of Drugs Act. It is the patient’s drug and they are responsible for storing it, until they are no longer of this world, at which point an obligation is enlivened in the contact person under clause 104.

Mrs A.K. HAYDEN: On that note, if the instructions say that the substance must be kept at a certain temperature or the substance will not be maintained, and the patient uses a substance that has not been kept at that temperature—we do not know what it is—and its quality is not maintained, we could have a problem with that substance not doing what it is meant to do because it was not stored as prescribed by the supplier. The contact person is the one who collected it. The contact person is the one who has the information, because the person who is not well, who is ill, is not up to reading the instructions. They are trusting their contact person. That is why they have them. All of a sudden, the contact person, who is the only person who understands how this substance is meant to be kept, is not obliged to make sure that that is done so it is effective for the purpose it is to be used for.

The DEPUTY SPEAKER: The question is that clause 72 stand as printed.

Mrs A.K. HAYDEN: Am I getting an answer to that or not?

The DEPUTY SPEAKER: The Attorney General is not standing, so I assume not.

Mrs A.K. HAYDEN: Deputy Speaker?

The DEPUTY SPEAKER: Do you want to ask another question, member for Darling Range?

Mrs A.K. HAYDEN: I had two questions. My second question refers to the question I asked earlier about the expiry date. The Attorney General said that as per the Medicine and Poisons Act, the expiry date and information about whatever the substance is and whatever is required for it will be on the label. My question is about the expiry date. We do not know what it is; we do not know what its lifespan is. I did ask a question that did not get answered: in other jurisdictions are there any substances with expiry dates? I am trying to find out how long this substance could last. If it has only a short lifespan, will there be a requirement that that substance be returned and not used after the expiry date?

The DEPUTY SPEAKER: The question is clause 72 stand as printed.

Clause put and passed.
Clause 73: Authorised supplier to record and notify of supply —

Mr Z.R.F. KIRKUP: Thank you, minister; it is good to see you. Clause 73(3) states —

Within 2 business days after supplying the prescribed substance, the authorised supplier must give a copy of the completed authorised supply form to the Board.

That could conceivably take place after the substance has been taken; is that correct? I would like that clarified. It is obviously not a concern about the board’s time constraint or responsibilities for monitoring the application of the act.

Mr R.H. COOK: Technically, yes. The member will observe that “within 2 business days” is the standard language used in the context of professional obligations.

Clause put and passed.

Clause 74: Disposal of prescribed substance by authorised disposer —

Mr Z.R.F. KIRKUP: Clause 74(3) states —

The authorised disposer must dispose of the prescribed substance as soon as practicable after receiving it.

This triggered me to go down a weird rabbit hole on the destruction of medications and things like that. Is there any particular reason that a time frame is not specified? Most of my understanding about how medication is destroyed, certainly in hospital settings, is that it is done in batches, effectively. Is there any reason that the bill does not prescribe that it has to be done within a certain time? I would have thought it would have been relatively practicable to prescribe, say, two business days, as the minister pointed out. I am curious why that is not stated clearly in the legislation.

Mr R.H. COOK: No. I am advised this is the usual manner. An authorised disposer must dispose of prescribed substances as soon as practicable after they receive the substance. Currently, most pharmacies accept unwanted medicines from consumers and dispose of them in RUM—Return Unwanted Medicines—bins. RUM is a national not-for-profit program funded by the commonwealth government to address the safe disposal of medicines. It is a free and safe method for the disposal of unwanted and expired medicines.

Mr Z.R.F. KIRKUP: One of my questions was going to be about RUM, which is one of the things I discovered when I was following this through. It is a good thing that it exists. I was curious about whether this would apply, but of course as for every other schedule 8 substance, they have to deal with that already—right?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: I assume that transport is not taken into account in the obligations that exist for hospitals or for an authorised contractor to take the medication from where it might be received at site A to the destruction point. I know the state has transport contracts in place to move medication to be destroyed. I assume that the medication gets to the facility and has to be destroyed there within a practical time line; is that right?

Mr R.H. COOK: That is right. All Return Unwanted Medicines bins are securely transported to an Environmental Protection Authority–accredited high-temperature incinerator facility where the sealed RUM bin is destroyed, ensuring that no traces of any medicine remain. The EPA-approved incinerators are the most efficient and environmentally friendly option for removing unwanted or expired medicines from the community.

Mr Z.R.F. KIRKUP: This question probably relates to subclause (4). Could the minister provide us with some more information? If someone who is charged with the disposing of a substance fails in their duty to do so, what penalties apply? I assume the legislation is the Medicines and Poisons Act 2014, but I was curious whether the minister might have on hand what those penalties might be. If the minister has that information, do any time constraints apply to those parts of the act? Does it have to be done within seven days or 21 days or anything like that?

Mr R.H. COOK: There are two facets to this. If the person does not comply with the provisions of this legislation, particularly clause 10, professional misconduct or malpractice provisions may impact on them. In this context I am thinking of a pharmacist. If there is a contravention of the Medicines and Poisons Act, part 2, “Offences”, and particularly section 22, applies. Section 22(1) states —

A person who stores, handles, transports or disposes of a poison other than in accordance with regulations made under subsection (2) commits an offence.

The offence is covered in section 115 and is a penalty of a $45 000 fine and imprisonment for three years.

Clause put and passed.

Clause 75: Authorised disposer to record and notify of disposal —

Mr Z.R.F. KIRKUP: I refer to subclause (1), which states that once the prescribed substance is disposed of, the disposer must immediately complete the approved form. I assume the form will be part of the suite of forms issued by the CEO.

Mr R.H. Cook: That is correct.

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: Again, is that immediately? There are probably many authorised disposers around the state. I presume they go through their own processes as per the Medicines and Poisons Act, which from my reading does not require an immediate notification. I imagine disposers go through volumes of prescribed medications that are destroyed. Why is there now an immediate requirement rather than two business days? Is there any particular reason for that?

Mr R.H. COOK: It is still two business days; they must immediately complete the form. Under subclause (3), it is within two days. That is at the top of page 51.

Mr P.A. KATSAMBANIS: There is a list under clause 75 of the things that the authorised disposal form must include. I note that the type of substance that has been received or returned and the quantity that has been returned is not required to be included. Is there a reason that is not required to be included? I would have thought, simply to complete the cycle, when all the paperwork went back to the board, knowing that the same substance that was prescribed was returned and having some idea over time, simply for statistical purposes if not for anything else, how much gets returned, might be useful information to include on such forms.

Mr R.H. COOK: As we have observed before, this is the bare minimum that will be required. It may be that the chief executive officer of the Voluntary Assisted Dying Board will want to have extra insight into that. Ultimately, we do not want the sort of information that needs to be recorded to be too onerous on the authorised disposer. I assume that the member is asking whether what is left over might be material as some sort of insight into how the medication is used. We cannot obviously get much insight simply from the amount that has been returned, other than to be satisfied that that amount was returned. I take the point that the member is making, other than to say that this is the bare minimum that we would anticipate. There is potential that the chief executive officer might want to include other information on the form.

Mr P.A. KATSAMBANIS: I ask this for a number of reasons, and I think the first one around what substance is returned is self-evident. We want to know that what is going out is coming back, but as far as quantity is concerned, there is probably a number of things. Firstly, how much is being left over? Secondly, perhaps some of this medication could be extremely costly, so if over time we are finding that an amount is being returned, there might be a better quantity prescribed in the first place that could reduce the cost to the public purse or to the people undergoing these treatments. I think for a multitudinous number of reasons, we could see that having a complete trail might be rather useful, as well as a protective mechanism.

Mr R.H. COOK: The intent of this provision is to record the details relevant to the disposal of the prescribed substance and to ensure that the Voluntary Assisted Dying Board is progressively notified of the person who has participated in the voluntary assisted dying process, including the outcome of each assessment. That will be to monitor that the correct process has been followed in each case of voluntary assisted dying and to maintain complete and accurate statistics of participation of the voluntary assisted dying process. Regarding the actual disposal, it is, I guess, pertinent that we understand that a portion has been disposed of. That there is half left or all of it left may be information that the Voluntary Assisted Dying Board would wish to inform itself of later down the track, but it is not necessarily material to what we are trying to achieve with this clause.

Mr Z.R.F. KIRKUP: One part of the disposal process that the minister spoke about was the Return Unwanted Medicines program, RUM. I am trying to understand a bit more about RUM. I understand that in a pharmacy setting—my mother works in a pharmacy—RUM is literally a yellow tub that sits in the pharmacy. That tub is then taken into the logistics chain—someone picks it up and takes it to the authorised disposer. Within it would usually be some schedule 4 and possibly already some schedule 8 drugs. As part of the implementation, has Health anticipated how a VAD substance versus a non-VAD substance might be identified as being in a RUM bin? As best as I understand it, the pharmacist notes it, then it is dropped into the bin and they then provide that bin to the transport company. I am keen to understand the logistics of how that goes at the other end. If the supplier does something wrong, they are possibly liable for a $40 000 fine and a couple of years in jail.

If there is a massive tub and one small container that is meant to be the VAD substance, how is it distinguished if it is mixed in with everything else? Have we anticipated what that might look like?

Mr R.H. COOK: Under the Medicines and Poisons Act, for the disposal of any drugs, there is a range of obligations on everyone involved in the supply chain from manufacture right through to disposal. In that sense, these poisons, like myriad other poisons that sit in the Return Unwanted Medicines bin, have the same level of scrutiny around them. It may be of interest that smaller portions of the same drug could be for other patients although in different amounts performing very different functions. It is simply appropriate that we capture all these schedule 4 and schedule 8s that sit within that. The RUM bin process is fairly robust and is one we have some experience of now. No extra safeguards are needed on top of the process that is already very secure. Does that answer the member’s question?

Mr Z.R.F. KIRKUP: I think so. I absolutely agree. I think the process is inherently safe. As I understand it, usually the bin is handed over with a log. How is it distinguished given that within that tub there is a schedule 8 or schedule 4 returned medication that might have been used for VAD? The minister is quite right: a small portion of the substance could already be in the RUM bin but how will they know it was for the VAD? I do not know how that will be noted.
Mr J.E. McGrath: Why do they need to know?

Mr Z.R.F. KIRKUP: There are obligations on the disposal form. My concern is: how will people know there is a VAD drug in there given they will need to fill out the form? I want to best understand how that will be practicably described.

Mr R.H. COOK: There are no extra obligations with these schedule 8 drugs over any other. Clause 75 provides information to the Voluntary Assisted Dying Board so it has oversight of or can monitor the full process. Filling out the form, I guess, is as much completing the loop with that information process.

Mr Z.R.F. KIRKUP: As part of the disposal process, I suspect the pharmacist might have an additional obligation to provide an indication to the eventual end-point disposer that there is VAD medication in there; that is all.

Clause put and passed.

Clause 76: Disposal of prescribed substance by administering practitioner —

Mr Z.R.F. KIRKUP: Clause 76(2) states that the administering practitioner is authorised to dispose of the prescribed substance. I assume that refers to the Return Unwanted Medicines process. Is that right?

Mr R.H. COOK: Yes.

The DEPUTY SPEAKER: The question is that clause 76 stand as printed. All those in favour say “aye”.

A government member: Aye.

Mr Z.R.F. KIRKUP: Sorry.

The DEPUTY SPEAKER: Yes, be quick. Go ahead, member for Dawesville. Sorry, I mean to be quick to get up.

Mr R.H. Cook: Make it snappy. Come on, onto your feet. Leap to your feet.

Mr Z.R.F. KIRKUP: I appreciate the rush, but I am here.

The DEPUTY SPEAKER: Jump up and ask for the call.

Mr Z.R.F. KIRKUP: Thank you very much, Deputy Speaker.

The DEPUTY SPEAKER: I am going as slow as I can.

Mr Z.R.F. KIRKUP: I thought you and I had a connection already and you knew I was getting up.

The DEPUTY SPEAKER: Perhaps we should not talk about that in the house, member!

Mr Z.R.F. KIRKUP: We will keep moving forward, minister. Subclause (3) states —

The prescribed substance must be disposed of by the administering practitioner as soon as practicable …

There are not two business days or anything like that, as best as I can understand it. It is not addressed later in the legislation.

Mr R.H. Cook: That’s right.

Mr P.A. KATSAMBANIS: I want to understand this. The administering practitioner is effectively also authorised to dispose. There is no need to hand the substance on to an authorised disposer. How does that interact with a nurse practitioner? Do nurse practitioners ordinarily deal with the disposal of schedule 4 and schedule 8 medications in their practice? How would nurse practitioners be dealt with? In practice, would there be any difference from what a medical practitioner would do in the same circumstances?

Mr R.H. COOK: There would be no difference.

Mr Z.R.F. KIRKUP: If administering practitioners have the ability to dispose of the substance, do they have to dispose of it through the prescribed disposal contractor, or can they incinerate it themselves? I want to clarify that.

Mr R.H. COOK: In effect, member, they become the authorised disposer. They still have to go through the process using the Return Unwanted Medicines bins and things like that.

Mr Z.R.F. KIRKUP: They are not incinerating it in their backyard.

Mr R.H. COOK: No, that is right.

Mr P.A. KATSAMBANIS: I was going to ask this question when we debate clause 78, but since the minister mentioned it, I will ask it now: the administering practitioner in effect becomes the authorised disposer, but—correct me if I am wrong—they do not need to obtain authorisation as an authorised disposer under clause 78. Just for clarification, is it correct that they do not need to obtain a separate authorisation as a disposer under clause 78?

Mr R.H. COOK: Under clause 76(2)(b), the administering practitioner is authorised to dispose of the prescribed substance.

Extracted from finalised Hansard
Ms M.M. QUIRK: I refer to clause 76(6), which the member for Dawesville has already referred to, which states —

The unused or remaining substance must be disposed of by the administering practitioner as soon as practicable after the patient’s death.

How long is a piece of string when we use the words “as soon as practicable”? Given that there are stringent time frames up until the patient’s death, what does the minister envisage “as soon as practicable” means in that subclause?

Mr R.H. COOK: The reason we use the phrase “as soon as practicable” is that it would be within the clinical boundaries of an administering practitioner, so they already have in place all the mechanisms to keep medicines secure, the protocols in relation to the handling of those medicines, and things of that nature. The time lines are not as crucial as they would be if the medicines were sitting in a patient’s home, for instance.

Ms M.M. QUIRK: Given the provision in clause 76(2) that administering practitioners can dispose of the prescribed substance themselves, why can we not use the term “immediately”? I do not understand why the words “as soon as practicable” are consistent with subclause (3) at clause 74, “Disposal of prescribed substance by authorised disposer”. From that perspective, I think it is perfectly appropriate. In the same way as an authorised disposer would have all those protocols, management regimes and arrangements in place for their practice, an administering practitioner would have the same arrangements as part of their practice.

Ms M.M. QUIRK: It just seems to me to be a different scenario. In clause 74(3) there is an authorised disposer, so it is a question of when that person receives it. There may be delays along the way. In the case of someone who has actually administered the drug, I cannot see why terms like “forthwith” or “immediately upon the patient’s death” could not be used. I do not understand why we would have the same time line there as we do when someone is relying on a third party to supply the drugs to them.

Mr R.H. COOK: Again, the member will remember that an administering practitioner is working in the context of a practice and, in that sense, already has protocols in place. The words “as soon as practicable” are consistent with subclause (3) at clause 74, “Disposal of prescribed substance by authorised disposer”. From that perspective, I think it is perfectly appropriate. In the same way as an authorised disposer would have all those protocols, management regimes and arrangements in place for their practice, an administering practitioner would have the same arrangements as part of their practice.

Mr R.H. COOK: We are treating the authorised disposer and the administering practitioner in the same vein, in this sense. They are both health practitioners and both working within a particular practice or service centre with protocols in place. Once the authorised disposer has received the unused portion of the medications, they must dispose of it within a practicable time, and an administering practitioner must do the same. An authorised disposer must immediately fill out the form; an administering practitioner must do the same. We are essentially treating them on a par. Both are caught under the same obligations and the same time lines, with the same sense of urgency. They are treated the same for the reason that we know that they will both have the same protocols, frameworks and rules in place for the management of those medications.

Mr P.A. KATSAMBANIS: I just want to clarify something. Again, I am not trying to be obtuse or difficult. I just want to clarify, in a practical sense, when the actual disposal occurs. This is important in the context of reading clauses 76 and 77 together, because as the minister rightly said in his previous answer, the administering practitioner needs to complete the approved form immediately upon disposal and then notify the board within two days. As I understand it, medical practitioners have a bin or a receptacle, if you like, a secure bin, where they dispose these types of medicine within their practice. Then, at some point in time, a contractor of sorts will come along, take the bin and dispose of it in a particular way. The average garden-variety practitioner does not have an incinerator in the backyard to do that. Is the disposal point the process of putting the substance into the approved bin and it remaining within the practice, or is it when the contractor comes along and takes the bin away? In some circumstances, that could happen some considerable time after the substances have been placed in that bin.

Mr R.H. COOK: It is the return of unwanted medicine bin. The administering practitioner would have the RUM bin; the pharmacist would have the RUM bin. They would chuck it in the RUM bin, seal it, fill out the form, and the form goes off.

Clause put and passed.

Clause 77: Administering practitioner to record and notify of disposal —

Mr Z.R.F. KIRKUP: I note that under clause 77(2) the requirements for the practitioner disposal form are quite detailed, and I think rightly so—the details that the board will be furnished with. Part of this provision deals with the date on which the patient has died. I am curious to understand why we would not include something like the location. Is that something the minister imagines the board might seek? I realise that we have asked questions like this previously and the minister has suggested that it is the bare minimum. Does the minister imagine that location might be identified in time?

Mr R.H. COOK: Yes, member, I would anticipate that that information would be sought. These are the very basics that the board would need under the legislation.

The DEPUTY SPEAKER: The question is that clause 77 stand as printed.

Mr R.H. Cook: Welcome back, member for Cottesloe!

Extracted from finalised Hansard
Dr D.J. HONEY: Thank you very much. I told the minister that I would come in only when I needed to.

The DEPUTY SPEAKER: Member for Cottesloe.

Dr D.J. HONEY: Thank you very much, Deputy Speaker.

The DEPUTY SPEAKER: Members, I know it is late, but it is helpful if you can mention when you are on your feet. I am trying to keep my eyes on the member for Girrawheen as well, so if I am looking over there, I might not see you. Go ahead, member for Cottesloe. I know you are tall and she is short! Go ahead, member for Cottesloe, now we have that sorted!

Dr D.J. HONEY: I could have asked this question on any of the clauses. Is there any intent to have any sort of audit process to check compliance? As the minister knows, we have talked a number of times about the diversity of human behaviour. Some people hang onto things because they like to for whatever reason. If I was looking at this in a manufacturing sense or as a process that I was in charge of, I would have some sort of process to follow up and audit to make sure that the material really had been disposed of. Will there be some requirement for photographic evidence or will there be some process of audit so that compliance is periodically checked rather than simply relying on someone signing a form?

Mr R.H. COOK: Under the health act, the Medicines and Poisons Act and the Misuse of Drugs Act, the chief executive officer has all kinds of powers of inquiry, and that is ultimately delegated through officers who act on his or her behalf. This would be captured under the same regime. It would not ordinarily be an audit of everyone, but it would basically be a process of keeping an eye on the landscape and inquiring into any anomalies that came up from time to time. We do hear that from time to time; for instance, there was a pretty in-depth inquiry into the disappearance of schedule 8 drugs from Fiona Stanley Hospital at one time, which was conducted by the chief executive officer under his powers. It would be captured under the same regime, remembering of course that the Voluntary Assisted Dying Board will also be able to engage with the chief executive officer and request that that person undertake an inquiry on its behalf.

Dr D.J. HONEY: Just to follow up—I will not labour the point—are there audits for other drugs such as opioids and the like? Are there periodic audits, for example, of hospitals and the like that would be a template for this?

Mr R.H. COOK: Yes, that is right. We are getting better at this sort of stuff all the time. For instance, nowadays Perth Children’s Hospital has highly digitalised systems whereby drugs can be taken out of a drawer only if it is authorised by two people and things of that nature. That stuff gets tightened up continuously, and not before time.

Mrs A.K. HAYDEN: The form will have all the other details required. I am guessing here, because I have not seen a disposal of poisons and medicines form before. Is there one form for all poisons and medicines or will this be a separate form just for this substance and will that be labelled on the form when it is submitted?

Mr R.H. COOK: Yes, it will be a different form. Obviously, there will be obligations under the Medicines and Poisons Act and the Misuse of Drugs Act. This will not escape that. This just understands that it is a voluntary assisted dying substance, so there is an extra level of accountability.

Mrs A.K. HAYDEN: The clauses that we have debated so far provide for the board to collect all these forms. What will happen with that? Will there be a check and balance to say that so much has been dispensed, so much has been used and so much has been returned? What will happen with all these forms that are provided to the board?

Mr R.H. COOK: Member, I doubt it would have the granularity of portions and size of that matter. But, certainly, all of these forms are collected for two things: first, so that the Voluntary Assisted Dying Board can monitor the process to make sure that the system is operating as it is anticipated; second, so that it can continue to collect data about what is going on and make sure that the improvements that can be made are done so; and third, to provide an annual report, under clause 154, on the operation of the act and any issues of interest about that.

Mr Z.R.F. KIRKUP: Minister, the point that the member for Darling Range raised was about the volume of the substance. I appreciate the minister’s response. I am interested in hearing a little bit more. I imagine that the board would perhaps want to understand how much has been returned in terms of volume. If we imagine a situation in which a little bit or a significant amount has been returned, that is possibly within the oversight of the bill and the board may be interested in it; although, I appreciate that it is not the granularity in the legislation, as the minister pointed out.

Mr R.H. COOK: Potentially, that could be the case, member. I can imagine the board could be interested in knowing, for instance, whether the substance was returned at all because it would want to know who passed away without using the substance and the circumstances around that. If any substance is left over—we cannot account for spillage in the home, but there will be that level of interest in it.

Mrs A.K. HAYDEN: How will the board know what was left if we do not have a quantity on the form?

Mr R.H. COOK: As I have explained before, member, these are the very basics that would be required in terms of the accountability under the act. The board may be interested in other information and it could include that in the form.

Clause put and passed.

Extracted from finalised Hansard
Clause 78: Authorised suppliers and authorised disposers —

Mr Z.R.F. KIRKUP: Minister, I assume that authorised suppliers mean pharmacies. Would that be an appropriate summary?

Mr R.H. COOK: Member, I am advised that an authorised supplier will be a registered health practitioner at a hospital, pharmacy or medical facility who has been approved by the CEO of Health to supply a voluntary assisted dying substance for the purposes of the act.

Mr Z.R.F. KIRKUP: In anticipation of a couple of questions about this, would an authorised supplier exist in a community pharmacy setting, rather than a hospital pharmacy?

Mr R.H. COOK: No, I think it is highly unlikely. The authorised supplier will be limited to registered health practitioners who are authorised under the Medicines and Poisons Act to supply schedule 4 and 8 poisons. It is likely that the authorised supplier will include a public health service hospital or pharmacy, with pharmacists and practitioners who are also authorised under the Medicines and Poisons Act 2014. These registered health professionals, including pharmacists, are already bound by professional obligations, which require them to act within the scope of practice in the area of expertise.

Mr Z.R.F. KIRKUP: To clarify, is it basically only in a hospital or clinical environment; is that the case?

Mr R.H. COOK: Yes, that is right, member. The protocols in a hospital pharmacy are much higher than in a— I do not mean this disrespectfully—corner store, basically.

Mr Z.R.F. KIRKUP: I am trying to imagine a situation in a regional or remote context that will, obviously, present some challenges. What do those circumstances look like in the north west or the Kimberley, for example, where the hospital pharmacy might not be easily accessible for the practitioner or the person’s agent? Is there any other mechanism that the CEO might be able to grant approval for?

Mr R.H. COOK: It is anticipated that the hub-and-spoke model may work best for Western Australia as a way of balancing appropriate access with appropriate control. For example, a central pharmacy service, potentially based in one of the tertiary hospitals, with a number of regional pharmacy hubs, such as selected regional public hospital pharmacies. The central pharmacy service would likely act as the central ordering and storage point for approved voluntary assisted dying medications and also have governance over the training requirements and certification of any authorised suppliers, such as pharmacists at regional hub pharmacies who are involved in supplying voluntary assisted dying medications. We may anticipate that, potentially, Sir Charles Gairdner Hospital might be considered as the central pharmacy, but it may liaise with Broome Health Campus for distribution from there.

Mr Z.R.F. KIRKUP: Just to confirm my thinking there, it is not dissimilar to Victoria where there is a singular hospital pharmacy. Obviously, the patient goes and picks it up, or whatever it might be, but the idea is that there is a centrally tasked hospital pharmacy that provides this. I appreciate the hub-and-spoke model, but is the government effectively envisaging that there might be a tertiary hospital? Does the minister imagine that there will be a single one, or more than one in the early stages? Do we have any insight into what that might look like?

Mr R.H. COOK: I can confirm that Victoria uses one—it is such a small, dinky little state, so it probably needs only one.

Mr P.A. Katsambanis: It is not in a very easy to get to spot, either.

Mr R.H. COOK: What, Victoria?

Mr P.A. Katsambanis: No, the hospital. I am not sure whether it is publicly known. I know where it is, but I am not sure whether it is publicly known.

Mr R.H. COOK: It is anticipated that we would have a hub-and-spoke model, based upon one single central pharmacy, but obviously it is for the chief executive to determine in the implementation stage.

Mr Z.R.F. KIRKUP: One last question —

The DEPUTY SPEAKER: You said that a minute ago.

Mr Z.R.F. KIRKUP: Yes, but the minister has opened up a little bit more.

The DEPUTY SPEAKER: Come on. You said one more—bundle them.

Mr Z.R.F. KIRKUP: Will the up-to-date list of authorised suppliers mentioned in subclause (6) specifically state, using the Sir Charles Gairdner Hospital model that the minister spoke about, that the pharmacy within that hospital would be the authorised supplier? Would it have the name of the pharmacist themselves? What does that look like?

Mr R.H. COOK: It would be the name of the health services, not the individual pharmacists.

Mr Z.R.F. KIRKUP: Obviously, there are some protections for pharmacists who are conscientious objectors who choose not to participate in the dispensation of these substances, and, additional to that, if the authorised disposer is a contractor, would that contractor’s information be provided, and why is it necessary that that information be published on the website, just out of interest? Why is that considered to be important public information?

Extracted from finalised Hansard
Mr R.H. COOK: An example would be if someone wants to take some medication to the authorised disposer, and cannot find the coordinating practitioner. If they really want to get rid of the stuff, they can source an authorised disposer.

Mr Z.R.F. Kirkup: And it is the same for a conscientious objector?

Mr R.H. COOK: I am nodding to that one, yes. They can conscientiously object.

Mrs A.K. HAYDEN: The member for Dawesville touched on this. Subclause (2) states —

A person who is authorised under subsection (1) is an **authorised supplier**.

In Victoria, they are using the term “pharmacist”. Can someone other than a pharmacist be an authorised supplier?

Mr R.H. COOK: As I said before, an authorised supplier will be a registered health practitioner at a hospital, pharmacy or medical facility who has been approved by the CEO of the Department of Health to supply the voluntary assisted dying substance for the purposes of the act. The member will recall from earlier that “health practitioner” has a wide definition. In this context, these are the people who will be authorised to supply.

Mrs A.K. HAYDEN: So that I can understand, an authorised registered health practitioner may not be a pharmacist. If they are not a pharmacist, I am a little confused about how they will have the authority to prepare the substance. Could the minister explain that and explain why the government has chosen to go with “authorised supplier” instead of “pharmacist”, as Victoria has?

Mr R.H. COOK: Authorised suppliers will be limited to registered health practitioners authorised under the Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons.

Mr P.A. KATSAMBANIS: I am seeking some clarification. The minister indicated that for authorised suppliers the current intention is that there will be a central point, most probably located in a public hospital in Perth, and there will be a hub-and-spoke model that will utilise—I do not want to put words in the minister’s mouth but I heard this—public hospital sites around the state. Is it envisaged that authorised suppliers outside the public health system—that is, private pharmacists or pharmacy technicians or the like—may be involved in the system as authorised suppliers? If so, in what circumstances is that envisaged?

Mr R.H. COOK: It will not be so much about whether it is a public facility, but whether it has a public contract. It could potentially be a private facility that operates under a public contract, as, I have just been informed, takes place in the Kimberley. But it would not be a community pharmacy.

Mr P.A. KATSAMBANIS: It is important to have on the record that it will not be a community pharmacy, or that is not the intention anyway.

Mr R.H. Cook: That’s correct. Ultimately, the CEO will be responsible for implementing the program.

Mr P.A. KATSAMBANIS: I understand that, and the drafting leaves it open, so it could be in some circumstances. We are just looking at intention here. I refer to the authorised disposer. Is it envisaged that a similar model would apply for authorised disposers, or are we likely to have a broader range of authorised disposers? Again, for completeness, will the authorised disposers likely be within the public health system or will the initial point for the authorised disposers be a bit more distributed and in the private system as well?

Mr R.H. COOK: The authorised disposer will be a registered health practitioner—for example, a registered health practitioner in a hospital, pharmacy or medical facility, who has been approved by the CEO of the Department of Health to dispose of a voluntary assisted dying substance for the purposes of the act.

Dr D.J. HONEY: I refer to the suppliers. Is there any anticipation of how many people will be authorised as suppliers for this purpose?

Mr R.H. COOK: No. I do not have a sense of how many folk would be involved. In the first instance, it will be up to the chief executive officer to get the appropriate governance in place, have a central hub and make sure that they develop the protocols and the workforce that can manage that, then grow it beyond that to make sure that we have properly trained authorised suppliers in regional health facilities.

Dr D.J. HONEY: My understanding, from answers to earlier clauses, is that the state will pay for this material. What mechanism is in place to make sure that there is adequate cost control over the price of the material? Is there going to be a fixed price or is there going to be a free-market approach and we will pay whatever the market wants to charge? Obviously, where I am heading with this is whether we will end up with a monopoly supplier or duopoly suppliers, which could effectively gouge the state government for the cost of these materials.

Mr R.H. COOK: I seem to recall that Dr Grube made the observation that Hawaii actually specified the drug involved and the value of that drug went from $50 to $7 000 overnight. That is one of the reasons the state would obviously want to play its cards close to its chest. But the state is a big purchaser of drugs and it would come in the context of its overall supply arrangements. In that sense, one of the key responsibilities of the CEO of Health, as the member would know, is to keep costs down, because it makes the Treasurer very nervous when he or she does not.
Dr D.J. HONEY: I am not trying to put words in the minister’s mouth, but I take it that part of that strategy may be to make sure that there is certainly more than a couple of potential suppliers so that there is an intrinsic mechanism driving a lower price.

Ms M.M. QUIRK: I just want to follow on from the member for Cottesloe. I am curious. Is the CEO the only one who will make the decision about who is an authorised supplier? In other words, will it go through the normal procurement protocols in the department or will there be preferred suppliers? I am just trying to work out whether this is a subset of what normally occurs for the acquisition of drugs.

Mr R.H. COOK: As I have said previously, it is likely that an authorised supplier will include a public health service, hospital or pharmacy with pharmacists and practitioners who are also authorised under the Medicines and Poisons Act. They will be internal to the system. It will not be a process of going out and seeking a private provider beyond what we already provide within the system.

Ms M.M. QUIRK: Can the minister confirm that under clause 78(3), the CEO’s authorisation will just be an administrative matter and not subject to delegated legislation?

Mr R.H. COOK: That is correct.

Clause put and passed.

Clause 79: Certain directions as to supply or administration prohibited —

Mr Z.R.F. KIRKUP: Subclause (2) states —

The coordinating practitioner for a patient cannot direct an authorised health professional to supply a prescribed substance to the patient, the contact person for the patient or an agent of the patient, unless —

(a) the authorised health professional is an authorised supplier; and

(b) the direction is in the form of a prescription for the prescribed substance given directly to the authorised supplier.

If the coordinating practitioner fails to comply with a particular element, what penalties will apply? The penalty clause had a general $10 000 fine. Is that what that is? I would not mind some clarification of that.

Mr R.H. COOK: As the member observed, this clause prohibits the coordinating practitioner from directing an authorised health professional to administer a prescribed substance to a patient. I am informed this clarifies that. Under the Medicines and Poisons Act, other people can prescribe various schedule 8 and schedule 4 drugs. For the purposes of this act, it is made clear that notwithstanding the authorisation under the Medicines and Poisons Act, a practitioner must be specifically authorised under the Voluntary Assisted Dying Act to prescribe these medications.

Mr Z.R.F. KIRKUP: Therefore, if a practitioner does not comply, the penalty is a $10 000 fine; is that right? I realise there is the Australian Health Practitioner Regulation Agency side to that as well, but what is the specified monetary fine, and is there an imprisonment element to the penalty? What would that look like if it is incorrect? I imagine there would be a severe breach if that were done wrongly or fraudulently.

Mr R.H. COOK: It is consistent with section 115 of the Medicines and Poisons Act, which is a fine of $45 000 and three years’ imprisonment.

Mr Z.R.F. KIRKUP: The minister said that it is a $45 000 fine or three years in jail. Clause 79(3) states —

The coordinating practitioner or administering practitioner for a patient cannot direct an authorised health professional to administer a prescribed substance to the patient.

Can the minister clarify why that was inserted in the clause?

Mr R.H. COOK: My understanding is that subclause (3), in a similar way to subclause (2), overrides the Medicines and Poisons Act in relation to authorisation. Under the Medicines and Poisons Act, for instance, a practitioner can authorise another practitioner to administer a particular medication. But this makes it crystal clear that in this context the only person who can undertake this task is the coordinating practitioner or the administering practitioner or the patient themselves. Regulation 15 further constrains them.

Mrs A.K. HAYDEN: Following on from the member for Dawesville’s question, did the minister say that 115 were listed under authorised health professionals in the Medicines and Poisons Act?

Mr R.H. COOK: It is in section 115 of the act, which specifies the penalties in relation to this part of the Voluntary Assisted Dying Bill.

Mrs A.K. HAYDEN: In that list I assume there is a wide range of things; I do not have it in front of me. Is a veterinarian listed under this and is that what this is meant to avoid? Is it to make sure that a veterinarian is not able to become an authorised supplier?
Mr R.H. COOK: I cannot speak for the veterinary surgeons, but they are certainly not captured by this clause. This specifically refers to regulation 15 of the Medicines and Poisons Regulations, which relates to a direction by a prescriber to administer medicine that is a schedule 4 or 8 poison. It is a further constraint to make sure that it is crystal clear that that regulation cannot be relied upon in the context of voluntary assisted dying.

Clause put and passed.

Clause 80: Structured administration and supply arrangement not to be issued for substance —

Mr Z.R.F. KIRKUP: Subclause (2) states —

A person cannot issue a structured administration and supply arrangement in relation to the administration or supply of a medicine for the purpose of voluntary assisted dying.

Is this to ensure that there is not a consistent supply arrangement in place or something like that? I would just like some clarity about that subclause.

Mr R.H. COOK: Not dissimilar to the previous clauses, this is to override the Medicines and Poisons Act so that that particular aspect of the act cannot be utilised in the context of the Voluntary Assisted Dying Bill.

Mr P.A. KATSAMBANIS: I just want to try to get some clarity on this. The way I read this, and I would like the minister’s comment, is that it is to make the administration of the prescribed substance under this legislation a standalone procedure that is not combined with any other treatment or groups of treatment being undertaken by the patient. Is that correct? It is just one standalone process separate from all the other treatments.

Mr R.H. COOK: The member could anticipate that a patient at the end of life has already been administered a range of medications and things of that nature that, in the normal course of events, would all be administered under the Medicines and Poisons Act, so this is to ensure that those medications that the patient accesses—that is, the voluntary assisted dying substances—are captured by these extra clauses that essentially divorce these provisions from the Medicines and Poisons Act.

Mr P.A. Katsambanis: Okay, I am good with that.

Clause put and passed.

Debate adjourned, on motion by Mr D.A. Templeman (Leader of the House).

Legislative Assembly

Wednesday, 18 September 2019

[page 6953]

VOLUNTARY ASSISTED DYING BILL 2019

Consideration in Detail

Resumed from 17 September.

Debate was adjourned after clause 80 had been agreed to.

Clause 81: Notification of death —

Dr D.J. HONEY: The minister is probably aware from previous discussion that this clause gives rise to particular concern. One of the issues that has been raised in discussing this bill is the need to provide protections to ensure that things are done properly and there is adequate review. Clause 81 deals with notification of death. However, there is no requirement that the notification of death record the fact that the person died through the use of the voluntary assisted dying process. I honestly find that dumbfounding. I also find that dangerous. There are several aspects to this. I am sure other members will want to explore this, so I will not dominate all of the time. If we do not record that fact, there will be no way historically that people will be able to understand the relationships, what led to the death, and whether the protections were adequate. There will also be no way of knowing whether the cause of death that is reported on the death certificate is accurate.

An estimate is made that the person will die from something. We have heard in this place, and we know from talking to the experts, that it is only an estimate. It might be an educated estimate. We also know that under this bill, there is no requirement that the two medical practitioners have any expertise in the illness that the person could die from—none whatsoever. The practitioners make an estimate, using whatever knowledge they have, that the person will die from a certain cause. However, no-one can have any idea about whether the person will die from that cause. I will give an example. I am not trying to reduce this to a ridiculous extreme. A person could live for six months or 12 months longer than they were estimated to live. We have heard in this place that it could be
17 years or longer. We have heard of people who lived for an extraordinary length of time. These are not rare examples from some exotic part of the world. Examples have been given in this chamber of people who have lived for decades after their diagnosis. A person could walk out the door and be run over by a bus. People die from any number of causes. If a person dies as a result of the voluntary assisted dying process, it is because they either self-administered, or someone else administered, the poison that killed them. The member for Morley is shaking her head. I would be delighted if she could tell me that that will not be the case. The assumption is made that the person will die from some other cause. I am not sure what the member is laughing about. It is a serious matter. Those assumptions are often completely wrong. Although members of this place are only a tiny subset of the population of Western Australia, members have given a large number of examples of how doctors’ estimates have been completely wrong, yet that will be put down as fact on the death certificate. I believe that is fundamentally wrong.

I have said in this place that there is no shame in this. There is no shame in suicide. If some poor person is driven to that desperate act, there is no shame on them. There may be shame on society for not supporting the person enough, but, for that individual, there is no shame. There is no shame if a person accesses voluntary assisted dying. However, in this clause we are denying the simple fact that the person died because they either ingested or were administered a poison. We are also denying the historical record that that occurred, and therefore any opportunity for assessment, review and research about the efficacy of the process. I find that absolutely dumbfounding. I do not know why that has been done. There seems to be an attempt in this bill to say that although voluntary assisted dying is important and is something that everyone wants, we should hide everything so that no-one will know that it has happened.

Mr S.K. L’ESTRANGE: Madam Deputy Speaker, can I hear some more from the member for Cottesloe?

The DEPUTY SPEAKER: I think you should. Go ahead, member for Cottesloe.

Dr D.J. HONEY: Thank you very much. I will not go on at length, because I am not trying to delay this process. However, I believe that we need to be open about this process. We are collectively not ashamed about this process. I know that the member for Morley is genuine and is very proud that this legislation is coming forward and that this option will be available to people. I see no reason whatsoever that we should try to hide from this fact. I am not sure of the appropriate form of words to use. I understand that other jurisdictions may have appropriate forms of words that we can use. We do not want people to make up a cause of death. Make no mistake; they are making it up. They are assuming that someone is going to die from another cause. The minister would know, and the members of the expert panel must know, that when people have one particular illness, quite often they have a range of illnesses and may die from something unexpected, not the main illness. Quite often people die with a serious illness but not because of that serious illness. I see no reason why we should essentially look to falsify a public document by putting down a cause of death that actually was not the cause of death. I think that is a fundamentally wrong thing to do. Honestly, I can see no motivation for it. There is no shame in this and I do not think anyone here is implying that. I do not see why we should react as though there is some shame in it by trying to hide the fact. I would really like the minister to give a very serious explanation, or a very detailed explanation at least—I know the minister is always serious—for why there is this need to try to hide the cause of someone’s death on a death certificate.

Mr R.H. COOK: Member, the intent of this provision is to prevent circumstances in which the information is released into the community by persons who may see the certificate cause of death, which is provided by the medical practitioner to a person making funeral arrangements, for instance. It would not be appropriate for several communities, for cultural and faith-based reasons, for information about the patient accessing voluntary assisted dying to become more widely known. This sentiment was reflected in the consultation led by the ministerial expert panel and the Department of Health. I am informed that the ministerial expert panel very strongly recommended the importance of making sure that we have a system that is compassionate and sensitive to the needs of the person accessing voluntary assisted dying.

I want to address a couple of issues the member discussed and I am sure he will have other questions. Firstly, it comes down to accountability. Under the act, it will be required that a separate report, or form, is made available to the Voluntary Assisted Dying Board. The Voluntary Assisted Dying Board will be required to provide an annual report on the legislation, so we will have an extra level of accountability and transparency. Rather than the member’s contention that this legislation is hiding information, the bill explicitly makes that information available to the community. This is important because it is a very serious event that takes place and we want to make sure that we have line of sight on how the legislation is operating. That will be a fundamental role of the VAD panel.

The member contended that a person could die of causes unknown to the medical practitioners, who are essentially making a guess about what ultimately was the cause of that person’s death. Two medical practitioners, independent of each other, have to make a finding that the death is imminent and the patient will ultimately pass in six months’ time. Two medical practitioners have to make this call. Clearly, this is an extra level of analysis and examination of that patient. We know the cause of the patient’s death, because that death is imminent and on the balance of probabilities would take place within six months.

Extracted from finalised Hansard
Additionally, the member talked about us hiding information. Currently, if a cancer patient is provided a very large portion of morphine and they are ushered into the other place, in relation to their passing, we do not have on that patient’s death certificate “morphine overdose”. Similarly, if a patient withdraws from their medication or ceases to eat or take fluids, we do not put on that patient’s death certificate “starved themselves to death”. That is obviously not what we intend to do. Clearly, we are on the side of the patient and we will protect the dignity of that patient in their final acts. The medical certificate cause of death and the public death certificate will not make reference to voluntary assisted dying. This includes making any references to a self-administered or practitioner-administered death. The Voluntary Assisted Dying Board will receive a separate notification, so the information will absolutely be available. We are not hiding this information. We are making it available to the community so that it can form a view about how well the legislation is operating. To suggest that we are somehow hiding that information really does not do justice to the intent and the desired outcome of this legislation.

Dr D.J. HONEY: I was going to ask to hear more from the minister, but thank you very much, Deputy Speaker. I thank the minister for that explanation, but I do not think it answers my question. I want to clarify something. I have not used the word “guess” in terms of what is going to kill a person; I used the word “estimate”. Top of mind, I can recall hearing in this place three examples of when estimates were given by qualified medical practitioners, often with specialists involved. In one case, death was imminent in hours and the person went on to live for a couple of decades almost. Other examples were of people given months to live who went on to live for many years. In fact, again, in another example a person lived for a couple of decades. I appreciate what the minister is saying. I had a good study of the accuracy of estimating a person’s time of death. The wording “the balance of probabilities” is used in the legislation because people estimating a probable period for someone to live is the most accurate estimate that medical practitioners make. That is why that wording has been used and that comes out of the research on that. All the research is quite clear; that is, at the end of the day, it is only an estimate and many people live much longer. If we heard of an example from some exotic country of one person who lived for a couple of years longer than expected, I would be saying, “I’m pretty confident these guys get it pretty right most of the time or all of the time, essentially.” Given that we in this chamber are such a tiny subset of the population of Western Australia and we have heard examples of people living for an extended time, we know it is only an estimate.

I appreciate what the minister said about cultural sensitivity; there may be a more appropriate form of words to use here. I would be really pleased if the minister could let me know whether that information will go to the VAD board and it will simply record that someone died under the provisions of this legislation. I am not sure how that will benefit any research or provide any insight into causes of death or the relationship of that cause with someone’s life and other sorts of information that people research when they are looking at issues related to mortality. I am not sure how that will provide any information. I cannot understand why that is necessary given that there is no shame in this. I think everyone in this place would agree with that. I have not heard anyone in this place express an alternative view to that.

I spoke to a number of specialists in the area on the application of morphine. Morphine is given to people for pain relief. It may be that the amount of morphine applied to achieve the required level of pain relief affects a person’s ability to breathe and the like. In that case, the patient’s date of death is not estimated to be six or 12 months; they know that that person is literally on their deathbed at that moment. That may be the case when this legislation is applied, but it definitely may not be the case. In fact, a person who takes the substance may be perfectly able to stand up, walk around and carry out their normal activities but it is just that they have decided that their life is unbearable and there is a prognosis that they will live for only around six months in the case of a physical disease or 12 months in the case of a neurodegenerative disease.

Mr S.K. L’ESTRANGE: I have a short series of questions linked to this that drive to the practical aspect of just reporting. What was the view of the Registrar of Births, Deaths and Marriages, the Law Society of Western Australia and the Australian Medical Association on this clause?

Mr R.H. COOK: To the best recollection of the people at this table, the Registrar of Births, Deaths and Marriages was happy with the policy position.

Mr S.K. L’Estrange: With this particular clause?

Mr R.H. COOK: Yes. The Law Society was not and the AMA was silent on the particular point. However, each had the view that it was important that the information was collected and, therefore, that the information was available to understand the incidence of voluntary assisted dying. The reporting to and the reports from the board fulfil that requirement.

Mr S.K. L’ESTRANGE: I notice that one of the advisers provided the minister with information while he was giving his answer. Could the minister let us know what that was about?

Mr R.H. COOK: Yes, it was just that there was concern particularly to enable the collection of accurate statistics and for record keeping. The role of the Voluntary Assisted Dying Board in the collection of accurate statistics and for record keeping should assist to address those issues. I have further information on the AMA’s position, if that is helpful.

Mr S.K. L’Estrange: Sure.
Mr R.H. COOK: It is stated on page 87 of the Ministerial Expert Panel on Voluntary Assisted Dying report —

‘AMA … proposes for completion of death certificates:

- The cause of death would be the underlying condition for which a patient has sought assisted dying
- The mechanism of death would be voluntary assisted dying, either:
  - Self-administered
  - Assisted by a third party including health practitioner’

Mr S.K. L’ESTRANGE: If the person’s death is caused by the physician-administration or self-administration of a schedule 4 or schedule 8 poison that was administered for the purpose of causing that person’s death—as the member for Cottesloe said, that could be six or up to 12 months in some cases out from the expected point of death—why are medical practitioners to be placed in a position of having to misreport the cause of death by this clause?

Mr R.H. COOK: They are not; they are reporting on the underlying cause of the patient’s condition. This is the point I made to the member for Cottesloe. Currently they do not put “morphine overdose” or “starved themselves to death” on the form. They report on the underlying condition that ultimately would have provided for that person’s death.

Mr S.K. L’ESTRANGE: Let me give an example. Some tragic cases have been outlined in this chamber of people who committed suicide because they feared end of life from the terminal illness they faced. Some of those suicides were incredibly tragic; weapons were used and it sometimes involved hanging. We know how hard that is on the patient and how difficult it is for the families. It is incredibly distressing to families. However, those causes of death are not changed. Those causes of death are still recorded as they are. The minister says in his second reading speech that this is a more compassionate approach to those people. It says to them, “Don’t go down the path of a violent, tragic suicide when there is a voluntary assisted dying path here for you.” That is a real premise of the government’s case for why it brings this legislation forward. If somebody commits suicide and it is recorded as a suicide, but somebody else takes a drug six to 12 months out and that is not recorded, why does the minister not accept that given the premise of this legislation is around compassion and, through the minister’s second reading speech, an acceptance by the community of this, why is it not simply being recorded as what it is?

Mr R.H. COOK: We are protecting the dignity and privacy of the patient. Ultimately the patient may not want that information to be in the public domain. Whether we regard it as a good thing or not is not for us to judge in the case of that patient. A suicide is not a regulated planned event; it is something that is ultimately unplanned, unregulated and often unsupervised. To provide the member with some insight on this matter, I will talk about the current process for death certification. The form for the medical certificate into the cause of death is completed by a medical practitioner who was responsible for the person’s medical care immediately before death or a medical practitioner who examined the deceased person’s body. Under section 44 of the Births, Deaths and Marriages Registration Act, that medical practitioner is required to complete the “Medical Certificate of Cause of Death”. That form requires the medical practitioner to define the disease or condition directly leading to the death and the causes of conditions that contributed to the death. Those details inform what is on the death certificate and also data collected at state and national levels. The form is forwarded by the doctor to the funeral director, who in turn provides it to the Registrar of Births, Deaths and Marriages. However, that form is not completed by the medical practitioner if the death is a reportable death for the purposes of the Coroners Act. The government is saying that this is not a reportable incident under the Coroners Act. We will manage this process under a separate act, the Voluntary Assisted Dying Act. From that perspective, it is not appropriate to record it in the manner in which the member described.

The DEPUTY SPEAKER: Member for South Perth or member for Churchlands again?

Mr S.K. L’ESTRANGE: Thank you.

The DEPUTY SPEAKER: I remind the member for Churchlands that if the minister is not giving the answer he wants, he cannot keep asking the same question.

Mr S.K. L’ESTRANGE: You will find that I am asking separate questions each time, Madam Deputy Speaker.

The DEPUTY SPEAKER: That is good. Off you go; thank you.

Mr S.K. L’ESTRANGE: This is a serious matter. It is about recording a person’s death. I will not labour the point, but the minister mentioned in his answer that if somebody commits suicide, that is almost some sort of random event, but they have still had to come to a decision point to make that decision, just as somebody has to come to a decision point to make the decision to go down the path of voluntary assisted dying. Either way, they are decisions made by the patient—some in tragic circumstances, and some influenced by mental health issues and some not. However, that is a fact; this is not in dispute. I am simply saying that in essence the minister is doctoring a cause of death certificate by excluding from it any reference to the process of voluntary assisted dying. That is a fact, and we are highlighting that we do not think it is an accurate reflection of what is going on in the administration of the process that the patient has undergone. With that in mind, what penalty or consequence will result should a medical practitioner record the factual cause of the patient’s death on the patient’s death certificate when that is either the physician-administration or self-administration of a voluntary assisted dying substance or approved poison?
Mr R.H. COOK: Clause 10 of this bill sets out the failure of a medical practitioner to act in accordance with this legislation. In that context, it may be regarded as unprofessional conduct. From that perspective, they would be the elements in which it was captured. Essentially, it is a requirement that a medical practitioner, in participating in the voluntary assisted dying process as set out in this legislation, does so in accordance with the legislation.

Mr S.K. L’ESTRANGE: What impact will clause 81(6) have on record keeping and data collection in this state?

Mr R.H. COOK: It will have no material impact on the state records. As I said to the member for Cottesloe, if someone undertakes the voluntary assisted dying process, the person recording the death has to make a report to the board. The board must record and retain statistical information about a range of issues associated with the functions carried out under this act, including the disease, illness or medical condition of the patient that met the requirements of the VAD process, and whether a patient has died after self-administering or having been administered a voluntary assisted dying substance. We will have more rather than less information at hand from the state record perspective.

Mr S.K. L’ESTRANGE: I have almost finished my line of questioning on this clause. Does the minister concede that there is a risk to the collection of accurate data because the Registry of Births, Deaths and Marriages and the cause of death certificate will not make any reference to the VAD process?

Mr R.H. COOK: I reject the assertion, member.

Mr S.K. L’ESTRANGE: We will have to agree to disagree, minister.

In an earlier answer, the minister mentioned that a voluntary assisted dying death would not be reported to the coroner. How might a voluntary assisted dying death be reported to the coroner?

Mr R.H. COOK: I draw the member’s attention to clause 166 on page 96 of the bill. We will come to that in due course.

The DEPUTY SPEAKER: Member for Churchlands, do you have another question?

Mr S.K. L’ESTRANGE: I am on my feet to make sure of that. The minister has referred me to clause 166, so I will have a look at it before we move on. I guess the minister’s reference to clause 166 is about subclause (2), which states —

... does not apply to a ... death of a person who immediately before death was a person held in care.

Notwithstanding that, we are talking about the notification of death, which, at worst, goes to whether a coroner needs to be involved. Although we can see that in clause 166, it sits right here with the notification of death. I know that when somebody dies, normally the police or someone has to be notified that day. Notwithstanding that, if there is any evidence of malpractice, will that not trigger the need for the coroner to be involved?

Mr R.H. COOK: Yes, it would. I was pointing out that under clause 166, death under the voluntary assisted dying legislation would not be a reportable death to the coroner. It is the same at the moment for someone who dies in palliative care or is ushered into the other place; that is not a reportable death either. The member asked: what is the relationship to the coroner? In that context it would not be a reportable death to the coroner. If it is malpractice, that is very different. The death would not be reportable to the coroner only if it was consistent with the act. If the death was not consistent with the act, the coroner absolutely will have to be alerted.

Mr J.E. McGrath: I was a member of the Joint Select Committee on End of Life Choices. I have to support the recommendation of the Ministerial Expert Panel on Voluntary Assisted Dying. That expert panel, as the minister mentioned, looked at this and said that we need to respect the person’s dignity. I know that suicide has been mentioned. However, if we put that on the death certificate, it will lead to all sorts of innuendo and supposition about what happened. I know people whose loved ones have committed suicide. One does not ask them what happened. They are not going to say that their loved one committed suicide. They do not say that, because it is a terrible thing. This is not suicide. Members have spoken about this and there is a difference. These people are dying. They have been treated for a condition that is going to end their life within either a six-month or 12-month period. If the fact that a person underwent a voluntary assisted dying death was put on the public record, what would their family say if someone asked them what happened to their mum, their dad, their brother or their sister? They would say that they died of cancer. They might explain how they ended their life in good circumstances and that they were all there for the occasion. In Victoria, the cause of death is not entered on the register but it is recorded by the doctor on his papers. I do not think it is put on the public death certificate, which is what we have to be careful about. These people have made a very conscious decision at the end of their life. Suicide has no resemblance to voluntary assisted dying death. People commit suicide for all sorts of reasons and most of them are not dying before they make that decision. We have to have some empathy for these people. We have to show some compassion and we have to support this provision in the legislation. As the minister pointed out, people now are dying of palliative starvation and by not taking water and of the potential effect of terminal sedation or double effect, but there is no reference to any of these practices on the death certificate. It is noted that they died of whatever they were suffering from, and that is how it should be.

I also want to refer to an article by Nick Bruining in The West Australian that refers to insurance. It states —

... it is likely that if a person dies using —

_extracted from finalised Hansard_
The voluntary assisted dying legislation —

... the cause of death will be the underlying medical issue. In other words, if a person has terminal cancer and is able to access the assisted dying process, the death certificate will record the cause of death as cancer. That means if your super fund has life insurance or you have a policy operating outside of superannuation, there would be no issue with the cause of death.

That is another issue that we need to bear in mind. This legislation is here to support those who want to make a conscious decision about their death, not put them in a difficult circumstance. They will have to put a lot of thought into this decision and go through a very strict process. They will be very ill; they will not be healthy people. We need to allow them to die with dignity and we have to protect their family after they have passed away.

Dr D.J. Honey: In response, I do not think there is any lack of care, concern or support in this place. I think that every person in this house has as much compassion as the other person. I do not think that any of us in this debate are not being compassionate. However, the general topic has been explored. I find it perverse that if a person accessing this process walked out and was run over by a bus, that would be recorded as the cause of death. If they decided to commit suicide, that would be recorded as the cause of death and no-one sees any problem with that. People who commit suicide are typically very distressed and at the end of their tether. We have no difficulty whatsoever recording that on their death certificate and in that case we are not concerned about whether we show compassion, but in the case of VAD, even though it is a different form of someone taking their own life or someone taking their life by administering a substance, we say that it is different. I honestly cannot fathom the philosophical difference between those points.

I want to move on to the question of autopsy. As the minister knows, not just I but also others have a concern. In a great majority of circumstances, this process will occur as the proponents of the bill want it to. We know that, but we also know that there are the Philip Nitschkes of this world who are proponents of quite radical voluntary euthanasia laws.

Point of Order

Ms A. Sanders: Madam Acting Speaker, I draw your attention to the standing order around relevance. This clause does not refer to the coroner or autopsy in any way and I would seek your guidance in this matter.

The Acting Speaker (Ms S.E. Winton): Thank you, member for Morley. Member for Cottesloe, continue, but can we stick to the clause, please.

Debate Resumed

Dr D.J. Honey: Absolutely. Thank you very much, Madam Acting Speaker.

Why is there no compunction in this bill to have an autopsy? I am not concerned with a great majority of circumstances. I know, as the minister knows, that in the great majority of circumstances, this process will go forward as people want it to go forward and the estimated time of death will probably be reasonably accurate, but we also know there are people who will take this to the fringe. There will be VAD practices, wherein two practitioners will set up the equivalent of a Nitschke-type practice, that will test this legislation to its limits; they will take it to its limits. That will happen. Why? That is the nature of people. Some people will take this to its limits. I know it is the genuine intention of the minister and the people who put this bill together that that is not allowed to happen. How do we know —

Point of Order

Ms A. Sanders: This clause deals with the death certificate and what is on the death certificate. This is not relevant to this clause. The coroner is dealt with in clause 166, later in the bill. This is about what is on the death certificate. It is not relevant.

The Acting Speaker (Ms S.E. Winton): Thank you. Member for Cottesloe, do you have a question for the minister?

Dr D.J. Honey: I do, thank you very much, Madam Acting Speaker.

Mr S.K. L’Estrange: You have two minutes to make your question.

Dr D.J. Honey: Exactly, thank you very much, member for Churchlands.

Mr D.J. Kelly: It just has to be relevant.

Several members interjected.

The Acting Speaker: Thank you, members!

Debate Resumed

Dr D.J. Honey: We have progressed in pretty good faith so far, guys.

Extracted from finalised Hansard
Why is this type of death not automatically referred to the coroner? I know that that may come up later in the bill, and I will not duplicate questions if we consider those questions now, in the spirit that we have continued in so far. Why is it? How do we know that there will not be people who will operate at the fringes, who will, in fact, falsify that information and make a misdiagnosis of the estimated time of death to bring people into the envelope of this legislation? If it is not reviewed by the coroner, how will we know that? Otherwise, it is just bits of paper. I would like to understand why that is not a compulsory part of the legislation.

**Point of Order**

Ms A. SANDERSON: Madam Acting Speaker, the member is straying into a later clause—that is, clause 166. I ask that you bring him to relevance, which is about the death certificate.

Mr Z.R.F. KIRKUP: Madam Acting Speaker, I find it interesting that the member for Morley has interrupted the member for Cottesloe three times, trying to make the same point about a standing order that you have already ruled on.

The ACTING SPEAKER (Ms S.E. Winton): What is your point of order?

Mr Z.R.F. KIRKUP: I ask that she respect your ruling.

The ACTING SPEAKER: Thank you, members. I think members are entitled to make points of order when they so feel. Member for Cottesloe.

**Debate Resumed**

Dr D.J. HONEY: I have asked my question. I am happy if the minister deals with it later.

Mr R.H. COOK: This issue is dealt with later in the bill under clause 166. Essentially, though, if a death is in accordance with the act, there is no need to refer it to a coroner or for an autopsy. I cannot imagine the distress that would provide to the family in any event. If a death is outside the construct of the bill, obviously there would need to be further investigation. I take the member’s point about extremists and such things; there are extremists in all elements. If an act is unlawful, it is unlawful. As the member can see through careful consideration, this bill details to great granularity how a voluntary assisted dying death is within the confines of the bill. If it fell outside that, further investigation would be required. A voluntary assisted dying death would not ordinarily need to be referred to the coroner, because it is within the framework of the bill.

Dr M.D. NAHAN: The debate on information about the cause of death has been debated, so I will not reiterate that, but it seems to me that we have been focused on listing only one cause. I went to the relevant information at the Australian Bureau of Statistics on cause of death information on death certificates in Australia. It points out a couple of things. Four out of five death certificates in Australia have multiple causes. The main one is the underlying cause, and I readily accept that the underlying cause will be whatever the cause of death would have been without VAD. But if we look at some of the statistics of death certificates, we see that they include all sorts of other causes. The data is very important and I think it is worthwhile quoting it —

The statistical data obtained from the Medical Certificate of Cause of Death is only as accurate and complete as the information on the actual certificate. Medical Practitioners have a vital role to play in the production of high quality mortality data, by ensuring complete, accurate and detailed information is recorded on the certificate.

Therefore, if someone has cancer, that is the underlying cause of death. Often contributing factors are also listed. People often have different types of morbidity that will not cause death and are not the underlying cause, but also listed are unrelated causes of death not related to morbidity. This goes back to ensuring that we have accurate information. The decision is that we will be adding a new address to people in the last periods of life—that is, VAD—and we are saying that we will excise that from the data collection process to protect, I think, the sensitivities of the person. That is a generalisation. Maybe the minister has data that shows that some people would be sensitive to it. I am not sure that that is altogether accurate, I was not on the committee, but I can assure members that relatives of people who commit suicide or die of a drug overdose often do not want that on their death certificate. There are also causes of death that people would be sensitive about being on the death certificate, but they are included.

This is really important data. Yes, we are going to collect some other information in the reporting process, but that will not be collated with the death certificate data. That will be a separate database. It will be very difficult to collate it with this information. I used this type of data when I was an undergraduate. I had a job to go through all the morbidity data in Hawaii and analyse the cause of death by race and so on over periods of time. It is extremely valuable data. I will just make a statement. The minister’s justification for leaving VAD off the death certificate does not hold water. It is not justified. Yes, I accept that it is not the main cause of death that would have happened, but we now have on death certificates all sorts of morbidities. Four out of five death certificates have a variety of contributing factors for death. One is the main cause, but there are other factors, which provide information to

Extracted from finalised Hansard
researchers about the circumstances of the death, and VAD should be listed as such. After all, I think this bill, if passed—I suggest it will be—will become a rare but standard procedure in addressing people at the end of their life, and therefore it is going to be part of our health system. I struggle to see why we would leave it off.

Mrs A.K. HAYDEN: Madam Speaker, I would like to hear more from the member for Riverton.

The ACTING SPEAKER (Ms S.E. Winton): Minister.

Mr R.H. COOK: The Western Australian Ministerial Expert Panel on Voluntary Assisted Dying recommended that none of the death certification documents include information pertaining to—

Mrs A.K. Hayden interjected.

Dr M.D. Nahan: No, I will just listen.

The ACTING SPEAKER (Ms S.E. Winton): Member for Darling Range, I am giving the minister the opportunity to respond to the member for Riverton’s comments, if that is all right.

Dr M.D. Nahan: The minister stood and I would like to hear.

Mr R.H. COOK: The ministerial expert panel recommended that none of the death certification documents include information pertaining to voluntary assisted dying. It recommended—I am informed that this was widely advocated by the community—that a separate reporting mechanism should be used, whereby only the doctor should notify the Voluntary Assisted Dying Board. The panel’s concern was that if a third party, such as a funeral director, leaked any death certification documents, the knowledge could be used to cause distress or negative interactions between family or community members. I provided the same response to the member for Cottesloe when he made the point that we are losing data in this situation, and that we do not have insight into the nature of incidents that occur under this bill.

We have been very careful to make sure that the bill’s approach is that it protects the family’s privacy and enables data collection. The data collection is by virtue of the separate reporting that goes to the Voluntary Assisted Dying Board and the information that it then provides to the community about the activities that have taken place under the act. Indeed, they should all be publicly available. I accept the member’s final contention: yes, the member is right that this event will be rare, but we want to make sure that we get the balance right.

Dr M.D. NAHAN: I have a follow-up question. The death certificate date and other collected information is widely used for research. Will the data collected under the VAD process be collated with the existing death certificate data so that it can add value, or bring it back in? That way, perhaps we could protect the privacy of the loved ones of the person who has accessed VAD, but still bring the data from the Voluntary Assisted Dying Board into the assessment process. Can those separate databases be brought together for accurate research purposes?

Mr R.H. COOK: It probably goes to a completely different act of Parliament, but, yes, my understanding is that it would be. Obviously, one of the clear advances that we have made in data analytics is the cross-matching of different datasets.

Mrs L.M. HARVEY: It seems to me that this could probably have been cleared up a bit earlier if there had been a cross-reference to the Births, Deaths and Marriages Registration Act. As I understand it, that act is quite broad in prescribing what is to be recorded on a death certificate in any event. There are causes of death, such as a specific injury, a disease, or something that leads to a person’s death; then there is the manner of death, which might be a traffic accident, a suicide, a homicide, or undetermined—whatever it might be. It seems to be fairly broad. I seek the minister’s advice on a situation in which, for example, an individual who is quite ill has access to a lot of boxes of OxyContin, as can happen. After my late husband passed away, I checked what I had in the safe, and I had box loads of OxyContin, tramadol, fentanyl lollipops, and a whole range of things, which gave me a bit of a shock, actually. I put it all into a box and took it to the pharmacist for them to dispose of. But if an individual had access to drugs such as that and decided that they could not be bothered with the rigmarole of going through the voluntary assisted dying process, overdosed on OxyContin and ended their life prematurely, how would that be recorded?

Mr R.H. COOK: Exactly as that, member. I think the member raises a very important point. The coroner reported to the Ministerial Expert Panel and the Joint Select Committee on End of Life Choices that 10 per cent of suicides are, in fact, people who are confronted end-of-life choices. That incidence would definitely be a death that takes place outside the voluntary assisted dying act; therefore, it would have a different recording on the death certificate.

Mrs L.M. HARVEY: Would that be recorded on the death certificate as heart failure due to OxyContin toxicity, for example, or a suicide or some other cause of death linked to the initial disease?

Mr R.H. COOK: I cannot provide the member with that information from my understanding or expertise in the issuing of a death certificate, but I simply observe and emphasise that that death would take place outside the voluntary assisted dying act, so it would be captured under the normal processes associated with the issuing of a death certificate.

Mrs L.M. HARVEY: I have one further question on this matter. I suggest it might be helpful if the minister could get some advice from the State Solicitor or from the Attorney General on how that circumstance might be recorded.

Extracted from finalised Hansard
I know it is of interest to quite a number of members. Perhaps it might help them understand the way in which these deaths are recorded now, and potentially deaths by voluntary assisted dying may not be recorded in a different manner from how those deaths are recorded at present. If we could perhaps get some clarification prior to the third reading debate, I think it might be helpful for members to understand how this would work, and if it will operate differently from how those other circumstances are recorded at present.

Mr R.H. COOK: I am happy to provide that information.

Ms M.M. QUIRK: I have a couple of questions. Whilst the majority of submissions to the ministerial expert panel certainly supported the approach taken in the legislation, I note some consideration was given—I gather it is the path that Victoria has gone down—to a situation in which a public extract issued for a death does not make a notation of the exact circumstances of the death, but the medical practitioner nevertheless records the relevant information. In my view, to do otherwise further corrupts the role of medicos. We put store and faith in those certificates, and if we cannot be completely certain about the cause of death, I think that further corrupts their role.

Mr R.H. COOK: We were conscious not to create a whole new separate process with the passage of the medical certificate. In Western Australia, the medical certificate goes from the medical examiner to the funeral director, who ultimately passes it on to the Registry of Births, Deaths and Marriages. That is not necessarily the case in other jurisdictions. From that perspective, we have crafted a system that fits within the processes of Western Australia.

Mr P.A. KATSAMBANIS: I must say that I find clause 81(6) to be one of the most egregious provisions in this bill. It has nothing to do with the subject matter of the bill that I find it so egregious. It is because this legislative provision authorises the falsification of a state record. As other members have pointed out, including the member for Riverton, birth, marriage and death certificates have been used as primary historical records for generations—I would say for centuries. They have been relied upon as a historical reference point and as an important data source for both genealogy and the breadth of state records, including for statistical purposes. This clause in the bill not only permits, but also mandates, the falsification of a state record—that is, a death record—because it says that the medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

I understand the sensitivities and I also understand about respecting the wishes of the patient involved in the case. I totally understand that, but, as other members have pointed out, those sensitivities are handled all the time in dealing with death and recording the cause of death. I would have expected that a provision in a bill such as this would have encompassed both the underlying cause and the eventual use of an assisted dying method. The proponents of the legislation, including the minister, tell us that this is welcomed by the public and ought to be discussed openly and that there is no shame in this process, yet despite going through a legislative process, we will be hiding one of the ultimate causes of death. I do not discount at all that the underlying cause is a factor and it ought to be recorded on the death certificate. I am not suggesting that it ought not be included, but I think the ultimate method of death—the assisted dying method—ought to be incorporated. It could be done very easily. It could simply be an addendum, with the word “assisted” in brackets. If the underlying cause was lung cancer, it could say, “Cause of death: lung cancer (assisted)”. It could be very simple and completely and utterly factual for historical purposes. I do not think it would offend the sensitivities of anybody, particularly someone who voluntarily chose to partake in this system, which will be the law of the land if this bill becomes law. I find it egregious that an act of Parliament would mandate the falsification of a state record. I just wanted to put that on notice. It is a strong concern of mine. I know that the minister has made his point. Take it as a statement, if you like, minister, and we can move on.

Mr K.M. O’DONNELL: Greetings, Madam Acting Speaker.

The ACTING SPEAKER (Ms S.E. Winton): Greetings to you.

Mr K.M. O’DONNELL: Firstly, I voted with the government on this. However, I have only one issue with the bill and it is in clause 81(6). I have learnt in the two and a half years that I have been here that a full stop, a comma or one word can change the interpretation of something. Under subclause (6), the medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person. They are very strong words—“must not”. I have said this numerous times and I do not want to bore people again, but as a police officer for 34 years, I attended many, many deaths—accidental deaths, car deaths and suicides. When my partner and I were given a job to go to a place where somebody was deceased, we would cross our fingers that a death would occur. We do not have any police on the road that day. Many times when autopsies were done, from memory, the cause was myocardial infarction atherosclerosis—basically, a heart attack. I sat here for about 25 minutes trying to remember those words! I knew it was something. It did not just say “heart attack”—full stop; it said myocardial infarction atherosclerosis.

Extracted from finalised Hansard
This is an open bill. The public is divided on it; it is not necessarily 50-50 but the public is divided. I think that if someone is dying and they shorten their remaining time by three months, six months or five days, voluntary assisted dying will have had an impact on that death. A person may be dying of something, but they would have lived if they had not taken the substance. If someone is dying from cancer but they are shot by police on the street because they did not do what they were told, their doctor would know that they are dying from cancer—this is extreme and I do not want to go down this path, but it is an example—but the post mortem would not say that they died of cancer. The death certificate would not say that. They have been shot, but they died as a result of something else, whether it be a substance or an implement. I have been to a suicide by hanging and the doctor said that the person was going to die, but they could not issue a death certificate and the cause of death was death by hanging. Would there be an issue if voluntary assisted dying was included on the certificate? What problem would that create?

Mr R.H. COOK: There was very clear advice from the ministerial expert panel that was informed by community consultation that people did not want voluntary assisted dying to be recorded on the death certificate, but obviously there is a requirement that we capture the data and have some line of sight over the incidence of voluntary assisted dying. That position was informed by the ministerial expert panel and the plethora of community consultations that it undertook.

Mr K.M. O’DONNELL: I thank the minister. I think it would take a strong-willed person to die by voluntary assisted dying. I refer to Belinda Teh’s mother, who was a staunch Catholic. She would have jumped at this if this had been law. If I were to go down the voluntary assisted dying path, the last thing I would think of would be saying that I did not want this recorded on the death certificate. If someone was dying from prostate cancer, prostate cancer would be on the death certificate, not voluntary assisted dying. I will finish, minister; I will not go on. I would bet five cents that this —

Several members interjected.

Mr K.M. O’DONNELL: Times are hard. I do not mean to belittle or humour this in any way, but I cannot see the upper house accepting clause 81(6), which precludes any reference to voluntary assisted dying on the death certificate. I have not discussed this with any member, or any of my party, but I firmly believe that subclause (6) will cause a lot of angst. This is my opinion. I fully support the bill, and I am still running with the minister, but I believe that that will need to be looked at. I think that was it. One last thing was that, when the government was elected, words that I remember were “gold-plated transparency”, and I know from community consultation that it has come out that people do not want this. I believe in having that transparency. There is no shame. If someone has voluntary assisted dying when this bill gets passed, I believe it should be included on the death certificate. It is not for the public to go and look up to see who died of what, but voluntary assisted dying is not shameful. In my opinion, if anybody does it, and it is on the death certificate, I am not saying it is a badge of honour, but if somebody had that I would know that they were in so much pain and they were so strong that they opted for voluntary assisted dying. I believe in being open and transparent. I believe that this subclause should be taken out, and it should be included on the death certificate. I am sorry to go on, minister.

Division

Clause put and a division taken, the Acting Speaker (Ms S.E. Winton) casting her vote with the ayes, with the following result —

**Ayes (42)**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms L.L. Baker</td>
<td>Mr M. Hughes</td>
<td>Mr S.A. Millman</td>
<td>Ms J.J. Shaw</td>
</tr>
<tr>
<td>Dr A.D. Buti</td>
<td>Mr D.J. Kelly</td>
<td>Mr Y. Mubarakai</td>
<td>Mrs J.M.C. Stojkovski</td>
</tr>
<tr>
<td>Mr J.N. Carey</td>
<td>Mr Z.R.F. Kirkup</td>
<td>Mr M.P. Murray</td>
<td>Mr C.J. Tallentire</td>
</tr>
<tr>
<td>Mrs R.M.J. Clarke</td>
<td>Mr F.M. Logan</td>
<td>Mrs L.M. O’Malley</td>
<td>Mr D.A. Templeman</td>
</tr>
<tr>
<td>Mr R.H. Cook</td>
<td>Mr R.S. Love</td>
<td>Mr P. Papalia</td>
<td>Mr P.C. Tinley</td>
</tr>
<tr>
<td>Ms M.J. Davies</td>
<td>Mr W.R. Marmion</td>
<td>Mr S.J. Price</td>
<td>Mr R.R. Whitby</td>
</tr>
<tr>
<td>Mr M.J. Folkard</td>
<td>Mr M. McGowan</td>
<td>Mr D.T. Punch</td>
<td>Ms S.E. Winton</td>
</tr>
<tr>
<td>Ms J.M. Freeman</td>
<td>Mr J.E. McGrath</td>
<td>Mr D.T. Redman</td>
<td>Mr B.S. Wyatt</td>
</tr>
<tr>
<td>Ms E.L. Hamilton</td>
<td>Ms S.F. McGurk</td>
<td>Ms C.M. Rowe</td>
<td>Ms A. Sanderson (Teller)</td>
</tr>
<tr>
<td>Mrs L.M. Harvey</td>
<td>Mr D.R. Michael</td>
<td>Mr P.J. Rundle</td>
<td></td>
</tr>
<tr>
<td>Mr T.J. Healy</td>
<td>Mr K.J.J. Michel</td>
<td>Ms R. Saffioti</td>
<td></td>
</tr>
</tbody>
</table>

**Noes (10)**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr D.J. Honey</td>
<td>Mr S.K. L’Estrange</td>
<td>Mr D.C. Nalder</td>
<td>Mrs A.K. Hayden (Teller)</td>
</tr>
<tr>
<td>Mr P.A. Katsambanis</td>
<td>Ms L. Mettam</td>
<td>Mr K. O’Donnell</td>
<td></td>
</tr>
<tr>
<td>Mr A. Krsticicic</td>
<td>Dr M.D. Nahan</td>
<td>Ms M.M. Quirk</td>
<td></td>
</tr>
</tbody>
</table>

Clause thus passed.

Extracted from finalised Hansard
Clause 82: Terms used —

Ms M.M. QUIRK: Part 5 deals with review by the State Administrative Tribunal. I would like to ask what resources are likely to be allocated to the tribunal for dealing with these applications.

Mr R.H. COOK: I am not quite sure which part the member is looking at.

Ms M.M. Quirk: We are dealing with clause 82, but if you want to deal with that at a later stage, we can.

Mr R.H. COOK: It may be more appropriate to dig in a bit longer. Obviously, those issues will be dealt with in the implementation phase, in conjunction with the Department of Justice.

Ms M.M. QUIRK: Is there no clause within this bill on which we will be able to canvass the anticipated workload on the tribunal?

Mr R.H. COOK: No, member.

Dr M.D. NAHAN: Paragraph (b) of the definition of “eligible applicant” states —

an agent of a patient referred to in paragraph (a); …

How is “agent” defined? Who is an agent? I could not find a definition of it. I will provide a hypothetical example. If a relative of mine were going through this process and I was on the periphery of it and had some concerns, could I be an agent of my relative and go and make an appeal to the tribunal to have the process reviewed?

Mr R.H. COOK: Yes, member, we anticipate that it could be a family member. It will obviously be someone who acts on behalf of the patient, so the patient will have to engage that person. It might be a family member or someone else.

Dr M.D. NAHAN: Could the minister explain some of the delimiting factors of who is and who is not an agent? I could not find a definition of “agent”. For instance, let us say that my relative, who is the patient, is very keen on this process but I, as the relative, am concerned about coercion or something else but the patient does not give me permission. Can I act on their behalf out of, let us say, reverence to my relative rather than with my relative’s authorisation or indication that I am their agent?

Mr R.H. COOK: In that case, member, you would not be the agent but you might come under paragraph (c), which provides for —

any other person who the Tribunal is satisfied has a special interest …

A person who has a special interest in the medical treatment and care of a patient may also apply to the tribunal. However, merely being a member of the person’s family is not, alone, intended to be sufficient to constitute a special interest for the purpose of this clause.

Dr M.D. NAHAN: This is very important. When I read the words “special interest in the medical care and treatment”, I took it to be the coordinating practitioner or one of the many people involved in that process. I understand that thoroughly. However, I can envisage other circumstances. I will give a good example. People who will undergo the voluntary assisted dying process will often want relatives to come from wherever they live to see them in their last days. There might be a relative who has been distant from the process but who is closely intimate with the patient as a member of the family. There might not be very much time before the substance is taken, but this person has significant data that no-one else might have access to because of the relationship. Can the minister explore, for the record, what he thinks will be the delimiting factors of who can act as an agent? The minister did say that being a relative does not justify it. Is there some other criteria that will be used?

Mr R.H. COOK: I stress that the agent must be chosen or authorised by the patient. Again, I think what the member is exploring is whether the person he described is someone who will have a special interest and will be able to take an action to the tribunal which the patient has not authorised. The member gave the example of someone who comes to visit their aunt before she passes away and considers themselves to have a legitimate reason to go to the State Administrative Tribunal to intervene in the process. That person would not be going to the tribunal as an agent but they may be appealing to the tribunal as a person who the tribunal is satisfied has a special interest. In that context, the agent is someone who is there on behalf of the patient. It might be a family member or it might be a lawyer or somebody like that who they have asked to take particular issues to the tribunal.

Ms M.M. QUIRK: As the minister mentioned, under paragraph (c), an eligible applicant includes —

any other person who the Tribunal is satisfied has a special interest in the medical care and treatment of a patient …

What kind of people would the minister contemplate will come under that provision? For example, could it be the proprietor of a nursing home in which the applicant resides, or are there other people whom the minister has in mind?

Mr R.H. COOK: In this instance, we consider that the tribunal will consider someone who is a relative carer of the patient to be someone who would have a special interest. This is someone who has gone on the journey with
the patient or has special insights into them. Ultimately, it would be up to the tribunal to make the decision about whether someone who comes before it has standing to bring a particular issue to the tribunal’s attention. In relation to that, the tribunal is its own agent.

Dr D.J. HONEY: There are two parts to this. I know the minister has made a number of comments about this bill being patient-centric. As I understand it, one part of the appeal process is that the patient feels that the doctor has got it wrong in terms of the estimate and so on. Obviously, it will be their right to do that if this process were to exist. The other concern is around someone believing the process is wrong. The minister will recall that back when we were having a debate around clause 15 and the issue of coercion, there was considerable discussion of the fact that there are many circumstances in which someone might be motivated to encourage someone to go into this process when it would otherwise not be the patient’s free decision—it could be motivated out of love, all the way through to a terrible motivation of greed. I will not go through that whole debate, but by its very nature, that is typically something that occurs in private and is hard to detect. Quite often, many people may not be aware of it, but a cleaner in the house may be aware of it. They may see a son or daughter come in and put constant pressure on the mother or father or some like thing. I appreciate this is an estimate, but will someone who is not a direct relative but who is in a position to observe what occurs in a household and that there could be undue influence be able to go to the SAT?

Mr R.H. COOK: Yes, they could certainly make an application. Obviously, the sort of scenario the member has painted is one that would be very serious. But it is ultimately up to the tribunal, once the application is made, to decide whether they will hear the case that has been put before them.

Dr D.J. HONEY: I thank the minister for that. When we were discussing this back in clause 15 and thereabouts, one of the concerns I expressed was that although many people in this place may regard going to the SAT as being a fairly simple matter, in fact it is quite a daunting process. A staff member from my own office went to the State Administrative Tribunal on a private matter. It was a complex matter; it was not trivial at all. Simply getting the application in was a complex matter. I appreciate that it is a small amount of money, and it would not cause someone like our learned consultant here to even blink an eye, but for many ordinary people going to the SAT is a bit like saying they are going to climb Mt Everest. When we were having that discussion, I asked whether there was a simpler path for someone to make a complaint. I believe the minister said that a person could also refer a matter to the board if it was too daunting for them to go through the SAT. Is that option open or could someone only make a complaint to the SAT to intercede in this process?

Mr R.H. COOK: Another remedy might be that they go to the Voluntary Assisted Dying Board to alert it about some part of the process. The Voluntary Assisted Dying Board can then refer the matter to a range of agents. It could be the chief executive officer who could investigate under the powers of the Health Act or this legislation. It could also be the Health and Disability Services Complaints Office or the police force. There are obviously a range of remedies that people can take before having to go to the SAT. Another body people could go to is the Australian Health Practitioner Regulation Agency, for instance, if they think a doctor or a health practitioner is behaving in a manner that is not consistent with their obligations.

Dr D.J. HONEY: I thank the minister; that is really reassuring. This is more of a statement than a specific question. As I say, I have heard reference in this place many times that we go to the SAT, and I appreciate that for members here it seems simple, but it really is daunting for the great majority of people, and I think those simpler mechanisms will provide some comfort for people and allow them to go down that simpler path.

Clause put and passed.

Clause 83: Application for review of certain decisions by Tribunal —

Ms M.M. QUIRK: I have a proposed amendment on the notice paper, but before I deal with that, I want to ask a question. As the State Administrative Tribunal is a trier of fact, it will be reviewing assessments of whether a person is ordinarily resident in Western Australia, does or does not have decision-making capacity and is or is not acting voluntarily without coercion. Is it contemplated that there will be special expert members on the SAT to assess that? If not, will they be subject to the same training regime as will be put in place for medical practitioners?

Mr R.H. COOK: By and large it is up to the State Administrative Tribunal to make a decision about the way it manages things. As I continue to talk and talk, we will identify a clause that provides that. Clause 91 provides for the SAT to seek advice from experts in a particular field about any matter before it.

Dr D.J. HONEY: A thought just occurred to me. If the process goes to the board or the SAT, is it on hold until the review is complete or will it continue to go forward?

Mr R.H. COOK: If the process is in front of the SAT, it is on hold. Obviously, it depends upon the veracity of the claim being brought to the attention of the board.

Ms M.M. QUIRK: I placed on the notice paper a proposed amendment to this clause relating to the eligibility criteria, but since we were unsuccessful in putting the amendment to clause 15 about whether a person is or is not...
ordinarily a resident of Western Australia, I do not intend to proceed now with my amendment. Given that the existing eligibility criteria states that at the time of making the first request, the person has or has not been ordinarily resident in Western Australia for a period of 12 months, there were some concerns expressed that people would get the diagnosis of a terminal illness in another jurisdiction and then move to Western Australia for the purposes of availing themselves of voluntary assisted dying. Have there been any thoughts about how this might be addressed? Have there been any estimates of numbers or whether any similar occurrences have occurred overseas? Is the minister confident that this will not be a further drain on our health system?

Mr R.H. COOK: Yes. Again, I reflect on the comments from the member for Riverton about this. It is anticipated this would be a relatively small number of patients and I think they will be adequately covered by the resources of the health system.

Clause put and passed.

Clause 84 put and passed.

Clause 85: Consequences of review application —

Mr Z.R.F. KIRKUP: My question is about clause 85(2), which states —

If the request and assessment process in respect of the patient has not been completed, the request and assessment process is suspended and no further step in the process is to be taken until the review application is determined or otherwise disposed of.

Do we have an understanding of how long that might take and what it looks like? I assume we would want that process to be relatively expedited.

Mr R.H. COOK: I have been advised that we have been advised by the SAT that it would happen very quickly.

Mr Z.R.F. KIRKUP: I appreciate that it would happen quickly. Excuse me for my ignorance, but does the SAT sit over weekends? Are we looking at weekdays or business hours only? I am just trying to get an understanding of extraordinary circumstances that might exist.

Mr R.H. COOK: I am advised that the SAT has an expedited hearing process that involves longer sittings or sittings on the weekend, and obviously we clarify these things in the context of the implementation period.

Mr Z.R.F. KIRKUP: Is this something the clinical expert panel would work together with the SAT on, or would the minister work on this with the SAT? I am just trying to understand how the implementation would be fleshed out.

Mr R.H. COOK: The chief executive officer would undertake that process basically to make sure that there are clearly understood pathways, protocols and procedures in place.

Mr Z.R.F. KIRKUP: Has there been any conversation, perhaps with the Attorney General or someone like that, about the need for extra resources at the SAT? I realise we have spoken about a relatively small number of people who might seek to access this process, but obviously if there is the need for it to be expedited, more people might need to be brought in. What might that look like?

Mr R.H. COOK: We have had conversations with the president of the State Administrative Tribunal about this. Ultimately, there will be liaison and discussion with the Department of Justice. Again, this is the nature of the functions of government.

Mrs A.K. HAYDEN: Clause 85(1) states —

This section applies if a review application is made in relation to a patient.

Other than a patient, who else may be subject to a review application?

Mr R.H. COOK: Maybe I can stand for just a moment and reflect on a whole bunch of things.

Debate interrupted, pursuant to standing orders.

[page 6983]

Resumed from an earlier stage of the sitting.

Clause 85: Consequences of review application —

Debate was interrupted after the clause had been partly considered.

Mr Z.R.F. KIRKUP: Subclause (1) states —

This section applies if a review application is made in relation to a patient.

Can the minister define the need to include that subclause? I assume there is no capacity for there to be a review application made on anyone other than a patient, or can there be a review application made on a practitioner or someone else?

Extracted from finalised Hansard
Mr R.H. COOK: This clause clarifies the effect that an application to the tribunal has on the existing voluntary assisted dying process. I gave this response to the earlier question of the member for Cottesloe. Essentially, it stops the process. Whether that process is midway or has been completed and is awaiting the voluntary assisted dying part of the process, it is essentially to clarify that the consideration of the application stops everything.

Mr Z.R.F. KIRKUP: I refer to subclause (2). I am curious to understand whether the coordinating practitioner is informed about the review that is being undertaken. I appreciate that they will obviously be informed in relation to their patient, but are they advised of this as part of the consequences of a review application? I imagine they might have to be informed, but I am not entirely certain.

Mr R.H. COOK: Yes, that is correct, member. They are informed in order for the process to stop, and I am informed that is effected by clause 93, “Notice requirements”.

Mr Z.R.F. KIRKUP: Subclause (3) states —

If the request and assessment process in respect of the patient has been completed, the process for accessing voluntary assisted dying under Part 4 is suspended and no step under that Part … is to be taken in relation to the patient until the review application is determined or otherwise disposed of.

Can I have a bit of exposure as to what would occur if the administration decision has already been made, unless I am reading it wrong, and the patient is already in receipt of this substance, for example? How does that have a practical impact under this subclause?

Mr R.H. COOK: Obviously, as the member observed, it is pretty straightforward if the person has made an administration decision that involves an administering practitioner, but this is not part of the process if the person has made a decision around self-administration. This is not the staff of the State Administrative Tribunal seeking an intervention by the police or something of that nature, if they were at that end of the process. From that perspective, if it is self-administering, obviously, they would take other remedies.

Mr Z.R.F. KIRKUP: I thank the minister. In practical terms, if a review has been lodged with the State Administrative Tribunal after the administration decision has been made, it has the ability to refer that to the police if it has some concerns and it finds that there is an issue, or something like that, and the clock has to stop. If the clock stops and there has been no issue found at this point in time, would it still dispatch police or some other intervention mechanism to stop the access to that substance while the clock has been stopped, whilst the application is under review?

Mr R.H. COOK: I am seeking advice in relation to how clause 85, which essentially stops the process, might be affected. I am advised that clause 97, “Interim orders”, on page 65, would essentially provide the SAT with the authority to undertake the interventions that the member spoke of.

Ms M.M. QUIRK: I probably should have asked this question when we were debating clause 83, but given that the minister made some remarks about expediting matters under clause 85, I crave his indulgence. Clearly, in these applications, the intention or objective is not to delay the nine-day process too much. Would that be correct?

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: I understand from the remarks made by the minister earlier that the minister has already been in some preliminary discussions with SAT concerning this process.

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: The third issue is that I had occasion to make an application for guardianship recently with SAT, and I found the process very cumbersome. The application had to be done online. If there was a semicolon or a dial code in a phone number in the wrong place, I literally could not go on to the next screen. I also could not print off a hard copy of the application. I have complained to the Attorney about that. This is really by way of editorial comment. I think an easier form of application has to be made than the one that currently exists, for example, for getting guardianship over an individual, because it is a shocker.

Mr R.H. COOK: I thank the member.

Mr Z.R.F. KIRKUP: I have one other question that I just thought of then. As part of the review process, we spoke about the coordinating practitioner being informed. I assume that if other parties are part of this process, such as the contact person, they will be equally informed. Would that be an appropriate assumption? I think this falls under clause 93 or clause 97; is that right?

Mr R.H. COOK: Yes. The member will see in clause 93 a list of parties who must be informed. It is not an exhaustive list. It simply suggests those people who must be informed about tribunal decisions. I am reluctant to go into detail because I will go into more detail on clause 93. It also relies upon the State Administrative Tribunal Act for other notice-giving powers.

Clause put and passed.

Debate interrupted, pursuant to standing orders.
Resumed from an earlier stage of the sitting.

Debate was interrupted after clause 85 had been agreed to.

Clause 86: Review application taken to be withdrawn if patient dies —

Mr R.H. COOK: Mr Acting Speaker, with your indulgence, may I make a quick statement of clarification. I wish to clarify a statement made yesterday in response to a query from the member for Darling Range about the patient being informed about complications from the medication. Rather than it being a requirement under the Medicines and Poisons Act, it is a requirement under the code of conduct of the Medical Board of Australia that practitioners discuss management options with their patients, including potential benefit and harm. This code is issued under section 39 of the Health Practitioner Regulation National Law Act 2010. As noted at the time, the bill also specifically requires the coordinating practitioner and consulting practitioner to provide this information under clauses 26 and 37 respectively.

Mr P.A. KATSAMBANIS: Clause 86 is relatively simple. It states —

A review application made in relation to a patient is taken to be withdrawn if the patient dies.

That, in its ordinary reading, makes a lot of sense.

Mr R.H. Cook: It is not counterintuitive.

Mr P.A. KATSAMBANIS: It is not counterintuitive at all; it is totally intuitive. However, was any consideration given to allowing the tribunal a small opportunity to determine—perhaps by using words along the lines of, “unless the tribunal determines it is in the interests of justice not to”? I ask that because we are dealing with a jurisdiction that is brand new. We are dealing with multiple issues that could arise. We are also not quite sure where in the process a matter might be. The matter might not have been heard yet, in which case it should be good to lapse at all times. The application might have been brought by the patient, so it would obviously make good sense for it to lapse. However, there might be the possibility of an adverse finding against a practitioner, or an area of law might have been argued, the arguments have been heard, and the tribunal is ready to make its decision, and, irrespective of whether the patient has passed away, it might serve the interests of justice for the tribunal to continue to either make a decision, or conduct a hearing and a process. I know that those matters are likely to be rare, but out of simple administrative efficiency for a tribunal, and to inform the public and to have better judicial or quasi-judicial outcomes, as tribunals provide, I wonder whether consideration had been given to that? If it has not been given, would consideration be given to it in the passage of this bill between the houses? I do not think it weakens the intent of this clause in any way, but allows for that potential externality—that one in a thousand—where it may just be the right thing for the tribunal to still deliver its decision even if the patient has passed away.

Mr R.H. COOK: Obviously the tribunal might pursue something following the death of a patient for the sake of creating a precedent in law or clarifying some particular issue around the law. I can certainly see some application in the Supreme Court that ultimately has the capacity of becoming involved in matters dealing with vulnerable citizens. However, the tribunal will be making decisions around a limited scope of issues. It is essentially there to resolve issues around changing or reviewing a decision that would have effect with regard to that patient. If the patient has passed away, there is no more need for the tribunal to continue to make that change or review. Because there is no dispute, ultimately it is impossible for the tribunal to arbitrate because clearly one of the parties is not there to advocate on their own behalf. From that perspective, it was not considered, but I understand the point that the member is making. I refer the member to the following clause, which will be discussed in a short while. It refers to the review application made in relation to a patient that the tribunal may decide upon. It sets out the context and the issues around which the tribunal may make a decision. In that sense, it is a fairly limited function as well, but ultimately the tribunal is there to resolve the issue for the patient. If the patient is not there, the issue about the patient accessing voluntary assisted dying is a moot point and there is no point in persisting with the inquiry.

Mr P.A. KATSAMBANIS: I do not want to labour this point but the minister pointed to clause 87, which states —

In determining a review application made in relation to a patient the Tribunal may decide that —

(a) at the time of making the first request, the patient had been ordinarily resident in Western Australia for a period of at least 12 months;

That could be something that had already been well argued in the tribunal, the tribunal was ready to make its decision and the patient died. It may well be in the interests of justice, especially in the early days of interpreting this legislation, for the tribunal to deliver a decision so that other people are aware of what the tribunal’s precedent, if you like, is likely to be in this sort of area. That is why I couched my suggestion in clause 86 around the matter of the tribunal making the decision because it was in the interests of justice to continue. If the government does not want to do that, that is fine, but it would be an improvement to the legislation and an improvement that would ensure the public was informed about how the tribunal would interpret these clauses in this legislation, if that small change could be made in the future.

Extracted from finalised Hansard
Mr R.H. COOK: The member is probably more familiar with the role of a tribunal versus a court and such things, so I will not argue that particular point.

Mr P.A. Katsambanis: Probably more than anyone in this place, having served on two for six years!

Mr R.H. COOK: Of course, yes.

Indeed, there is already case law relating to the particular issue that the member described. In any event, I appreciate that he is using that as an example of something around which he might want to create some precedence. I guess, from that perspective, I appreciate the observation the member is trying to make. I will resist the opportunity to make an amendment, but I will reflect on it, so thank you very much.

Mr P.A. KATSAMBANIS: For completeness, and perhaps I did not spell it out right at the outset, it is an axiom of administrative law that upon the withdrawal of an application, a tribunal loses jurisdiction completely. It is not as if the matter is deemed to be ceased or the tribunal will no longer continue to hear the matter, it is as if the tribunal never received the matter in the first place. Its hands are completely tied in those circumstances. There is no need to respond, that was just for completeness.

Mrs A.K. Hayden: Acting Speaker.

The ACTING SPEAKER (Mr S.J. Price): Member for Dawesville—Darling Range, sorry.

Mrs A.K. HAYDEN: I have deja vu! We are doing it again.

Mr R.H. Cook: I will observe that at this point in the proceedings last night, the Deputy Speaker offered an opinion about the relative good looks between the two members, so we are inviting you to do the same this evening.

Mr S.J. Price: That was very brave of the Deputy Speaker.

Mrs A.K. HAYDEN: That is very kind to call them brave. Thank you minister and thank you Acting Speaker.

Clause 86 states —

A review application made in relation to a patient is taken to be withdrawn if the patient dies.

I apologise, I was out of the chamber for the previous clause, but that is that the voluntary assisted dying application will stop so the tribunal review will start. I do not want to assume, but just for the record, is that if the patient dies of natural causes? Is that correct?

Mr R.H. COOK: Member, I guess the legislation is silent on that. The review application is the application made by the patient. Ultimately, regardless of the manner in which the patient dies, the application ceases because there is no-one to advance the application on their behalf.

Mrs A.K. HAYDEN: Thanks minister, that is what I want to be sure of. It is not that they have the substance and have used VAD or anything, it is before then and they have not had any access to it. I just wanted to make that perfectly clear.

I know that the member for Hillarys asked a question about this, but I do not understand why the review would be stopped if an error has occurred or been investigated by the tribunal. Why are we not following through on that to make sure that that error does not occur again? I understand—if I have it wrong please correct me—that if a coordinating or consulting practitioner has made an error in the request or the assessment process, that is one of the reasons that the review has been done. Just because the patient has passed away, should we not be checking that if an error has occurred it will be fixed and rectified for any future patients?

Mr R.H. COOK: Regarding the role of the State Administrative Tribunal and the review process concerning whether a patient can continue to pursue or proceed with the voluntary assisted dying process, if the patient passes away, they can obviously not proceed with the voluntary assisted dying process, so there will be no decision for the tribunal to make. The SAT’s decision ultimately would not be required because it would have no effect. It would not be able to say, “Yes, this patient should have access to voluntary assisted dying” because the patient will have already passed away and vice versa. From that perspective, the action will lapse because the tribunal could no longer make a decision on that patient continuing with the process.

Mrs A.K. HAYDEN: We can debate this in clause 87, “Decision of Tribunal”, but clause 87(c) states —

the patient has decision-making capacity in relation to voluntary assisted dying;

I understand that this review will occur if someone believes that it has not been done properly. It will be checked and reviewed to make sure it is accurate so a decision will have been made. Will every case go through SAT or only those referred to the tribunal?

Mr R.H. COOK: The tribunal’s role is, essentially, to decide whether a patient may have been rejected because they do not have decision-making capacity. The patient could say, “I think I do have decision-making capacity and I disagree with the coordinating practitioner, so I will go to SAT to prove my point.” If the patient is no longer alive to continue the application, obviously it will lapse. That is essentially the reality of the process that would be undertaken.

Extracted from finalised Hansard
Mrs A.K. HAYDEN: If, for example, as under paragraph (e), the patient is acting voluntarily and without coercion and has gone through the review because they have been told they are acting without coercion and someone else believes they are being coerced, what will happen when they have passed away? How do we make sure that coercion does not continue? If it becomes a dispute and goes to the tribunal and the patient passes away, can someone else say they believe the patient has been coerced by their brother? The daughter and brother are arguing; they do not get along and the mother has decided to access VAD, and the daughter believes the mother has been coerced. What will happen then? If the patient dies of natural causes, how do we follow through to make sure there was no coercion?

Mr R.H. COOK: If a patient believes that they are acting voluntarily and without coercion, and the coordinating practitioner says, “Look, I think your aunty has a bigger role to play in this decision, I do not think you are acting voluntarily”, that patient may go to the State Administrative Tribunal to press their case. I suspect it would be a very rare occasion, but it may be that an interested party who has a fairly high level of involvement may similarly go to the tribunal on behalf of a patient. Ultimately, the tribunal will make a decision about that, but it will not make a finding of criminality. That would be the responsibility of the chief executive officer, or, indeed, the police, if they believe that coercion is involved in the process. In that instance, I do not think the tribunal is playing the role that the member is potentially visualising. It is not there to make a punishment or to assess the seriousness of a finding; it is there simply to make a finding. It is then the responsibility of associated parties. Perhaps the tribunal would refer the matter to the police if it thought that there was a serious case of coercion, but that is not the intent of the tribunal’s role in this process. It will form a view about these things, and if it believes it to be serious and of a criminal nature, then, obviously, the police have to step in, from that perspective.

Mrs A.K. HAYDEN: I thank the minister for that explanation. One last quick question, because that will make it very clear. In a situation where it is believed that coercion was occurring, and the patient dies, does that review stop, or is there another avenue for the review to continue? As the minister said, is there a responsibility for the investigation to be passed on to the authorities after the patient has died?

Mr R.H. COOK: The tribunal’s role stops, but, obviously, if people are concerned that coercion has been involved or there has been some behaviour which falls outside the voluntary assisted dying laws, then, clearly, they would refer it on. I am advised that, obviously, coercion cannot continue if the patient is deceased. The Voluntary Assisted Dying Board and the State Administrative Tribunal could report to the appropriate authority if they suspected any criminal behaviour; I think I made that comment before. Specifically, there is no role for the tribunal to make a decision, because it is not a party that is subject to the hearing, but that does not mean other people cannot investigate what has gone on. As the member knows, the chief executive officer, the Health and Disability Services Complaints Office, the Western Australia Police Force and the Australian Health Practitioner Regulation Agency all hold a whole range of powers of investigation into these things.

Dr M.D. NAHAN: Just to follow up on that hypothetical: If the tribunal looked at an issue and found that there was coercion, or the coordinating practitioner decided that he was not going to approve the process, the patient brought it to the tribunal, and the tribunal found an egregious case of coercion that actually did not work—the tribunal ruled against it, or the person died, or whatever—could the minister explain what the process would be? If that came to pass, and there was a decision by the tribunal, in this case, or the coordinating practitioner might say, “This is just over the top and what you’re doing is really wrong”, would the tribunal, the coordinating practitioner or one of the other practitioners report that to the police or to the Voluntary Assisted Dying Board? How would they take action?

Mr R.H. COOK: I will give the member a similar response as I gave to the member for Darling Range: it might be a tribunal member; it might be a doctor observing another doctor’s behaviour. There is a whole range of avenues that people could use to bring something to the attention of the authorities. One could imagine: if they thought there was something of a criminal nature or particularly insidious going on, they would take it to the police. If they thought it was simply a doctor not taking care in a professional context, they might take it to AHPRA. If they felt there was something completely inappropriate happening, they would take it to the chief executive officer of the Department of Health. Maybe, ultimately, if the board is involved in some level of oversight, it, too, could refer matters to those sorts of authorities, but these are avenues that are available to any citizen.

Dr M.D. NAHAN: I would like to explore it because one of the issues is the potentially insidious nature of coercion. We hear that this review process with the tribunal might flesh it out more, and I think it would, to my mind at least, strengthen the bill if we had a statement somewhere that later on we will enforce a penalty of life imprisonment for someone who coerces someone to pursue voluntary assisted dying. Let us say we do not go that far. Will the board make rulings or provide guidance to practitioners that if they find undue coercion—that word would have to be defined, and lawyers are good at that—it should be reported to the board, because it could have a negative outcome? If it is covered later, we can go through it then, but I think we have hit on something—anything that has a review process. If we find out that people are unduly coercing their loved one to pursue this process inappropriately or against that person’s underlying will, it would be positive for this. I want to know if the minister can explain. Let us say a coordinating practitioner finds egregious coercion. They might go to the tribunal or they might just say, “No”. It seems to me that if a coordinating practitioner finds egregious coercion, it is incumbent upon that person to take it to a higher authority. I think this would strengthen VAD quite significantly.

Extracted from finalised Hansard
How is that practitioner going to be informed how to do that, should they do it, noting that this is a very delicate situation in which someone is dying? Where are the pathways for the interested parties, the tribunal and practitioners to take it to a higher authority when they see what they perceive to be, or what is designated in the legislation to be, improper behaviour?

Mr R.H. COOK: Certainly there are offences for that, and we will come to them in due course. This simply makes the observation that if there is no-one to progress the patient’s application because the patient has died, the process ultimately stops. With regard to the member’s observation about a coordinating practitioner finding coercion, there are a number of things they would do. If I may make an observation, they have obligations as medical practitioners under their own codes of conduct and the laws that govern their profession. If they are an individual within the community and they are aware of behaviour that is potentially criminal, they have an obligation as a citizen to undertake activities in that regard as well. There are certainly clauses coming later on that deal with the issue of coercion and the offences that deal with it.

Clause put and passed.

New clause 86A —

Ms M.M. QUIRK: I move —

86A. Tribunal review of Board’s decision in relation to notice of no objection —

(1) The Board is a party to the proceeding for a review application made in relation to a decision of the Board to give, or refuse to give, the coordinating practitioner for a patient a notice of no objection under section 117A.

(2) In determining a review application made in relation to a decision of the Board to refuse to give the coordinating practitioner for a patient a notice of no objection under section 117A, the Tribunal may set aside the decision to refuse to give the notice if satisfied that there were no reasonable grounds for the refusal.

(3) If the Tribunal sets aside the decision under subsection (2), the Board must give a notice of no objection to the coordinating practitioner.

(4) In determining a review application made in relation to a decision of the Board to give the coordinating practitioner for a patient a notice of no objection under section 117A, the Tribunal may set aside the decision to give the notice if satisfied that there were reasonable grounds for refusing to give the notice.

(5) If the Tribunal sets aside the decision under subsection (4), the notice of no objection has no effect for the purposes of section 57(1)(b) or 58(1)(b).

The minister may recall that I talked about this yesterday in the context of making the work of the board real time—in other words, the board can issue a notice of no objection under proposed new clause 117A, which is yet to be moved. The scheme is about the board being able to issue a notice of no objection to the matter proceeding. That means that it looks at all the various criteria and forms that have been submitted to the board and issues what is known as a notice of no objection. Clause 86A is the right of appeal to the tribunal in the case of the board either giving or refusing to give a patient a notice of no objection under proposed new clause 117A. For the reasons that we talked about yesterday, we are concerned that the board is really only dealing with historical issues and there is no capacity for it to have contemporaneous oversight of the process.

Mr P.A. KATSAMBANIS: I stand in support of the amendment moved by the member for Girrawheen. The issues around proposed new clause 117A were well canvassed yesterday. I do not intend to repeat them. This is one of the amendments that flows on from that. I think proposed new clause 117A is an important provision to include. Once it is included, obviously the tribunal needs to have the power to review that sort of decision, and so that is what this new clause that is before us does. Given that I have already indicated my support for proposed new clause 117A, I also indicate my support for the consequential amendments, including this one.

New clause put and negatived.

Clause 87: Decision of Tribunal —

Dr D.J. HONEY: Minister, looking at this clause, I assume the point of it is to try to restrict the scope of the tribunal in terms of the decision that it can make. That is pretty clear from this clause. I have a problem with clause 87(e) in which the patient is acting voluntarily and without coercion. I want to read out a couple of definitions to aid this discussion. Looking at a definition of coercion, which I think is reasonable, it is the action or practice of persuading someone to do something by force or threats—the keywords being “force or threats”. Therefore, coercion is a very active thing in which someone is actively doing something—we would assume—for a bad purpose. Whether it is bad or not, it is something that is very forceful. I have had a lot of discussions. I can say that every lawyer whom

Extracted from finalised Hansard
I talked to about this bill raised the issue of undue influence, because it is so pervasive in commercial transactions, in particular, between relatives and friends or when someone can benefit. In this case, the benefit may be relief from stress or financial relief. The definition for undue influence, which, again, I think is a reasonable definition, is the influence by which a person is induced to act otherwise than by their own free will or without adequate attention to the consequences. I think the minister can see that that is quite different from coercion, which is about force or threats; whereas, undue influence is induced. It may be induced through using a familiar relationship or through someone expressing concern about the difficulty that this person is causing them but is in an otherwise caring relationship.

I wondered why the definition in this clause is limited to coercion. Does the minister consider—I think this is important for the interpretation of this in the future when people are reading this act and this debate—that his definition of coercion also includes undue influence? Does the minister think that this is an unintended oversight and that undue influence should be included? Alternatively, does the minister think that the State Administrative Tribunal should not consider undue influence when it reviews the matter?

Mr R.H. COOK: We canvassed these issues extensively on clause 15, so I do not mean to go over them again. Language such as “voluntary” and “coercion” is already used in the context of the tribunal. If someone has been the subject of undue influence, he or she is not, by definition, acting voluntarily and without coercion.

I understand the point that the member is making but, as I observed, we canvassed this extensively on clause 15. As I expressed then, we are perfectly comfortable with the language that is used, which captures the behaviours that have been described.

Dr D.J. HONEY: I am not trying to be repetitive, but I am concerned. I can see this clause limiting, to some extent, what the State Administrative Tribunal can do. To make that very clear, does the minister believe that, in deciding whether a certain act or a decision of a doctor or the like was appropriate, the tribunal can consider whether there was undue influence? I just want that to be very clear.

Mr R.H. COOK: Yes, and we sought feedback from SAT about these clauses and it has said that they are absolutely appropriate.

Mr Z.R.F. KIRKUP: I am trying to get an understanding about the tribunal having to be aware of the issues outlined in paragraphs (c) to (f). An extensive training program will be put in place for practitioners. Will something similar be put in place for tribunal members if they have to be on the lookout for coercion or something like that? I am keen to understand whether they would be exposed to a similar training program.

Mr R.H. COOK: Obviously, tribunal members will be able to draw upon expert evidence or witnesses on these issues. These guys are already experts in a lot of respects. They already make decisions under the Guardianship and Administration Act and other acts of Parliament. They deal with issues around coercion and so on. From that perspective, obviously, we would expect them to have the skills but, in addition, they can draw upon the work of expert witnesses. Essentially, this is stuff they do.

Ms M.M. QUIRK: Again, I have an amendment on the notice paper, which states —

Page 58, line 14 — To insert after “application” —

(other than an application covered by section 86A)

That new clause was not passed, so I do not need to worry about that amendment. I move the next amendment —

Page 58, after line 15 — To insert —

(aa) the patient is ordinarily resident in Western Australia; or

(ab) the patient is not ordinarily resident in Western Australia; or

I have made this clear before. The only eligibility requirement is that for the last 12 months the patient has been resident in Western Australia. I think we need to raise the bar and have the same eligibility criteria as applies in Victoria. I will not take the matter to a vote, however.

Amendment put and negatived.

Clause put and passed.

Clause 88: Effect of decision under s. 87(a), (c) or (e) —

Mr P.A. KATSAMBANIS: I want to focus on clause 88(1). I am not questioning the intent; I am questioning whether the wording of paragraph (d) works in all cases, and I seek the minister’s assistance in this. I will go through it carefully, and I hope I make my concern very clear. It is really a concern about whether the language in paragraph (d) works in all circumstances envisaged. Clause 88(1) indicates that if the tribunal finds (a), (c) or (e) in clause 87—that is, the tribunal finds that the person is ordinarily resident in Western Australia for a period of 12 months or it finds that the patient had decision-making capacity in relation to voluntary assisted dying or the patient was acting voluntarily or without coercion—basically, the tribunal gives a tick. Then clause 85 ceases to apply, and if the request for an assessment process in respect of the patient has not been completed, the process
Clause 89: Effect of decision under s. 87(b), (d) or (f) —

Mrs A.K. HAYDEN: I would like to hear more from the member for Hillarys.

Mr P.A. KATSAMBANIS: I am not questioning the intent in any way. I think a gap has been missed in the drafting. I am raising it because, despite the fact that I philosophically do not support the concept of legislation that canvasses how to take someone’s life, if this bill is to be passed, I want it to be as safe and secure as possible. I am concerned that clause 88(1)(d) is drafted in a way that will not achieve that.

Mr R.H. COOK: Subclause (d) is conditional upon meeting the requirements of subclauses (a), (b) and (c). If, for instance, in the case the member raised, the coordinating practitioner said that the person did not have decision-making capacity, that is the decision that will be reviewed. Ultimately, if the tribunal believes that person does have decision-making capacity, that review will be set aside and subclause (d) will come into play and take the process to the next step. Subclause (4) will only be activated if the decision is set aside. If it is not, the patient will be told that the tribunal agrees with the coordinating practitioner. I am advised that clause 89 will then come into effect.

Mr P.A. KATSAMBANIS: I am not prepared to accept that that is the case. I know that we cannot always do these things on the run. Perhaps the minister might undertake to at least have a look at this between the houses. As I said, if an application is made questioning a finding that the person has capacity, we have the tick. The decision will be to affirm the original decision. However, if the application is couched in negative terms and the decision being reviewed is one that they did not have residency or capacity, or has acted voluntarily or without coercion. The only set-aside decision envisaged is to reverse that. It could be either/or because either/or matters will be allowed to go to the tribunal, including from the patient themselves. I am not sure whether I made it clear. I am happy to continue for a moment.

Mr R.H. COOK: Perhaps we can take the discussion offline. We respectfully disagree with the member’s interpretation of it, so let us dig into that a bit more. As I said in a previous discussion, these clauses were crafted with the assistance of the tribunal to make sure that they are consistent with its processes, so I appreciate that the member might find the language unusual or unhelpful. Obviously, we want to be consistent with the way in which the tribunal operates. I take the member’s interpretation of it in good faith. Our interpretation is different, so let us have that conversation.

Clause 89: Effect of decision under s. 87(b), (d) or (f) —

Mrs A.K. HAYDEN: Clause 89(a) states —

the patient is taken to be ineligible for access to voluntary assisted dying for the purposes of the request and assessment process in respect of the patient; …

Extracted from finalised Hansard
What happens if a patient is found to be ineligible to access voluntary assisted dying? Can the patient reapply?

**Mr R.H. Cook:** If a decision is made by the tribunal in line with any of the three conditions—that is, they had not been ordinarily resident et cetera, the patient does not have decision-making capacity, or the patient is not acting voluntarily and without coercion—then the patient is ineligible for access to voluntary assisted dying. The process, at whatever stage it is at, will come to an end; that is, no further action will be taken in the voluntary assisted dying process. A person will not be excluded from reapplying for access to voluntary assisted dying if the person was previously found to be ineligible for access to voluntary assisted dying due to a decision of a tribunal. This is because a person may, at a later stage, satisfy the eligibility criteria.

**Mrs A.K. Hayden:** I thank the minister. I understand that a person may not be eligible for a certain reason, such as that they have not been in the country for 12 months, but once the 12 months passes, they will be able to reapply. What if they have been disqualified for another reason, such as for being coerced, because they were not acting voluntarily, or for a more serious matter? Will they be able to keep reapplying? Is there a limit? It will be a waste of the tribunal’s time if it has to keep coming back with the same answer once, twice or three times. How many times will a patient be able to apply if they keep getting knocked back for the same reason?

**Mr R.H. Cook:** I want the member to bear in mind that this is someone who will be making an end-of-life choice. This will be someone who is extremely frail and is coming to the end of their life. Ultimately, their circumstances may change. In crafting the laws, we have to contemplate that that may happen. We do not see this as being a scenario that will repeat itself very often. The person has the right. If they believe they are now much more lucid than they were and that they now have decision-making capacity, they may wish to make an application. They may reflect on the fact that maybe they were a bit coerced before, but they have had time to reflect on it and are now convinced that this is something that they want. We have to contemplate that that may happen.

Clause put and passed.

**Clause 90: Coordinating practitioner may refuse to continue in role —**

**Mrs A.K. Hayden:** Clause 90(2) states —

A coordinating practitioner who refuses under subsection (1) to continue to perform the role of coordinating practitioner must transfer the role of coordinating practitioner in accordance with section 155.

What happens if the coordinating practitioner does not want to take on that transfer?

**Mr R.H. Cook:** If a tribunal has made a decision contrary to the decision or review decision that a coordinating practitioner has made, that coordinating practitioner may decide that they are not comfortable continuing with the process and that they had better bow out. However, that coordinating practitioner will have a duty of care to then hand that patient on to another coordinating practitioner, which, as the member observed, is facilitated for under clause 155. They cannot just leave the patient and say, “I’ve had jack of this”; they have an obligation to transfer the role.

**Mr P.A. Katsambanis:** I want to know how this would work in conjunction with clause 89. I understand that clause 90 is drafted in that either/or fashion so if a practitioner makes a decision that a person does not have capacity and that goes to the tribunal and it finds they have capacity, the practitioner would feel uncomfortable, but the tribunal would have said, “Carry on here; off you go.” Why would a coordinating practitioner need to make any decision if the tribunal found that, irrespective of the coordinating practitioner’s view, the patient did not have capacity? In that case the application would cease, or is this simply limited to those determinations in which the coordinating practitioner is effectively told, “You got it wrong but this must continue”, not “You got it wrong and this ceases”; is that right?

**Mr R.H. Cook:** That is right. The tribunal can make a decision that the coordinating practitioner has got it wrong around any of those issues; that is, if a coordinating practitioner decides that a patient is not eligible, the patient appeals and the tribunal finds that they were. The coordinating practitioner might find that of comfort and think, “Good. Other people have had a look at this and they are of the same view. I wasn’t sure so I responded in the negative, but now a tribunal is backing that decision.” I would certainly understand that clause 90 could be utilised by someone who feels a bit aggrieved with the tribunal disagreeing with them. The observation is made that the relationship between the practitioner and the patient may have been affected in a negative way. It might be that the patient says, “Okay, I am not feeling too confident about staying with you.” Again, the coordinating practitioner must transfer their role.

**Mr P.A. Katsambanis:** If clause 89 applies, then clause 90 has no real effect; is that correct?

**Mr R.H. Cook:** Yes.

**Mrs A.K. Hayden:** Before the member for Hillarys jumps to his feet, I have a follow-up question. We have just said that the coordinating practitioner must transfer the role to another coordinating practitioner if he refuses to continue after the tribunal has overruled the position. What happens in a regional area where there is only one other coordinating practitioner and that practitioner refuses to take the transfer? Where does that patient end up?
and where does the original coordinating practitioner end up? The bill says that the practitioner must transfer the role. What happens in an area where there may not be another accepting coordinating practitioner willing to take on the transfer?

Mr R.H. COOK: The process is set out in clause 155. The coordinating practitioner has to transfer the role of coordinating practitioner to another medical practitioner who could be coordinating practitioner; it does not have to be a coordinating practitioner. It might be the consulting practitioner who is already involved in the process or has expressed a view that they are prepared to be involved. My friends in the Nationals WA said this poses an element of burden on the health department to put in a regime in which people in regional communities are not unnecessarily disadvantaged. That will be a burden on the department, but it is appropriate.

Clause put and passed.

Clause 91: Constitution and membership of Tribunal —

Mr P.A. KATSAMBANIS: Clause 91 is about the constitution and membership of the tribunal. It gives the terms “judicial member”, “non-judicial member” and “public sector employee”, exactly the same definitions as are included in the State Administrative Tribunal Act 2004. That makes sense. I welcome the Premier to the table in place of the Minister for Health!

Mr M. McGowan: Good evening—happy to be here!

Mr P.A. KATSAMBANIS: I am sure the Premier is! We are too!

Subclause (1) is completely uncontroversial. Subclause (2) indicates that the tribunal, when exercising its review jurisdiction “must be constituted by, or so as to include, a judicial member”. That makes sense. That is uncontroversial. It must be a judicial member. Subclause (2)(b) states —

a person who is a public sector employee may be appointed to be a non-judicial member in respect of matters in the Tribunal’s review jurisdiction.

I have three questions about that. The first question is: what sort of public sector employee is envisaged to be so co-opted onto the tribunal? The second question is: given that it is a “may”, in what circumstances is it envisaged that they be co-opted and in what circumstances is it envisaged that they will not be co-opted and there would be only a judicial member? The third question is: does the drafting of this clause allow for more than one public sector employee to be brought on to constitute the tribunal if the circumstances of the case require the specific expertise of two rather than one public sector employees?

Mr M. McGowan: Clause 91(2)(b) was recommended by the president of the State Administrative Tribunal for insertion into the bill. It modifies the operation of section 117(5) of the State Administrative Tribunal Act 2004 to enable psychiatrists, psychologists and other persons with the relevant skills and training who are public sector employees to be appointed as sessional members to sit on a panel for a hearing. I understand that the president of SAT does this regularly.

Mrs L.M. HARVEY: I seek a little clarification on this clause. Clause 91(1) states —

In this section —

judicial member, non-judicial member and public sector employee have the meanings given in the State Administrative Tribunal Act 2004 section 3(1).

I went to the SAT act to look up the definitions. There is a definition of “judicial member”, which means the president or a deputy president. Will there be a president or deputy president of this tribunal?
Mr M. McGOWAN: A president and deputy president of SAT are already appointed.

Mrs L.M. HARVEY: The definition of “non-judicial member” means a member who is not the president, a deputy president or an ex officio member. Can the Premier give me some examples of who those non-judicial members may be?

Mr M. McGOWAN: I outlined some earlier. It may be a psychiatrist, a psychologist, a lawyer or someone of that nature.

Mrs L.M. HARVEY: I may have missed something. The next definition was “public sector employee”, which under the State Administrative Tribunal Act is a person employed under section 3(1) of the Public Sector Management Act. I went to the Public Sector Management Act, which does not contain a definition of “public sector employee”. There is a definition of “employee”, which means somebody employed in the public sector by or under an employing authority. The definition of the “public sector” means all the agencies and the ministerial offices and the non-SES organisations. We need some advice from the Premier because it is pretty much a catch-all that any public sector employee could be co-opted onto this tribunal. We need to have a bit of an understanding; will it be an employee with regard to this definition of a ministerial officer, for example, who will be co-opted onto this tribunal? Who is it likely to be, which agency are they likely to come from, and what level would it be likely that they would be employed at within those agencies?

Mr M. McGOWAN: The clause is essentially removing any doubt in saying that a public sector employee is able to be allocated or inserted into the tribunal and the person is selected by the president of the State Administrative Tribunal, which is standard.

Mrs L.M. HARVEY: I have an understanding of who could be on the tribunal—the president or the deputy president of the State Administrative Tribunal, a non-judicial member, which could be a psychologist or a psychiatrist operating in private practice or under a public sector award, and it could be other members of the public sector from any agency.

Mr M. McGOWAN: The SAT will make the decision based upon the skills and needs of the matter that is being reviewed. On occasion, it might be a WA police officer or a social worker who can analyse the matters before it.

Dr D.J. HONEY: I assume this would be the case, but to clarify, in these circumstances will the SAT have the opportunity to also seek advice from, for example, an expert panel? If this was a specific medical issue that one consultant or person on the tribunal would not necessarily be able to answer to, could they seek other advice as they see fit and use that as input into its decision?

Mr M. McGOWAN: Yes, they could.

Clause put and passed.

Clause 92: Hearings of Tribunal to be held in private —

Mrs A.K. HAYDEN: This is just a quick question, Premier. Clause 92, “Hearings of Tribunal to be held in private”, states —

(1) Hearings of the Tribunal in respect of a review application must be held in private.

Could the Premier answer why it is necessary to have that in the legislation? The clause continues —

(2) The Tribunal may give directions as to persons who may be present at a hearing in respect of a review application.

Will family members be able to be present at the hearing?

Mr M. McGOWAN: This clause requires tribunal hearings held pursuant to this legislation to be held in private. The tribunal may give directions about who may be present at a hearing. It could be a family member if the SAT president says that is appropriate. Hearings on voluntary assisted dying should not be made public to ensure that the patient is protected and supported as they go through the voluntary assisted dying process, which I think is fairly self-explanatory.

Mrs A.K. HAYDEN: Is it in the Victorian legislation that it must be held in private?

Mr M. McGOWAN: The advice I have is yes. I think it is pretty clear why it should be held in private. I would have thought that was pretty straightforward.

Ms M.M. QUIRK: I suspect the answer is yes. Given the state of the applicant’s health, there may be situations in which the tribunal needs to convene offsite. Will that be possible?

Mr M. McGOWAN: Yes.

Clause put and passed.

Extracted from finalised Hansard
Clause 93: Notice requirements —

Mr P.A. KATSAMBANIS: The tribunal has requirements to give notice to the coordinating practitioner, the consulting practitioner, the administrative practitioner if there is one, the CEO and the board. It strikes me that the notice provision is slightly different from the notice provisions contained in the other parts of the bill that we have gone through already where it is quite prescriptive. In most cases, it is within two days. Why is not a prescriptive period included? What would be considered an appropriate time for the tribunal to give notice, particularly given the point the member for Girrawheen made in her latest contribution when she indicated that we are often dealing with someone who is at the very late stages of life?

Mr M. McGOWAN: The two-day requirement is for the board, which is established under this legislation. It is different because it would be inappropriate to impose such an obligation on a tribunal, which is a judicial body.

Clause put and passed.

Clause 94: Coordinating practitioner to give Tribunal relevant material —

Mr Z.R.F. KIRKUP: Clause 94(b) states —

If the coordinating practitioner is not the decision-maker for the purposes of the State Administrative Tribunal Act 2004, provide to the Tribunal documents and material in the practitioner’s possession …

As part of that process, is it envisaged that the coordinating practitioner would be present for the hearing or will they simply supply all relevant material, but not have to speak to it?

Mr M. McGOWAN: It is a decision for the State Administrative Tribunal whether they call the person.

Mr Z.R.F. KIRKUP: Would the practitioner be compelled to attend?

Mr M. McGOWAN: They can be.

Ms M.M. QUIRK: There are procedures obviously in the State Administrative Tribunal Act, but given there is a presumption of capacity in this legislation, what burden will be placed on SAT when it inquires into those facts? In other words, to understand that the eligibility criteria is met in the context of capacity, what is the burden of proof? Is it similar to, for example, guardianship applications?

Mr M. McGOWAN: The tribunal needs to make a decision based upon the evidence presented by the parties to the proceedings. The State Administrative Tribunal was selected for this role because it has dealt with these kind of matters more broadly since 2004.

Ms M.M. QUIRK: I know that this is a complex issue, because the legislation has not yet commenced operation. There is a presumption that an applicant has capacity. Will that presumption carry through to the SAT, or will the SAT have to do what it does in guardianship applications, for example, and decide that there are cogent and compelling reasons that the person is, in fact, capable?

Mr M. McGOWAN: There is a rebuttable presumption that the individual in question has decision-making capacity. The SAT can presume that the individual has decision-making capacity unless shown otherwise based upon evidence.

Clause put and passed.

Clause 95: Tribunal to give written reasons for decision —

Mr P.A. KATSAMBANIS: Clause 95 is simple. The tribunal needs to give written reasons for its decision—that makes sense. I want to clarify, because, again, timeliness could be a real factor here. Is there capacity for the tribunal to make a verbal decision —

Mr M. McGowan: Yes.

Mr P.A. KATSAMBANIS: — at the time of the hearing or afterwards and then communicate written reasons afterwards? In those cases, how would that work with the notification requirements in the previous clauses that we have already discussed? Will the tribunal be required to communicate both the verbal decision and the written decision? How will it work in those cases?

Mr M. McGOWAN: Yes, there can be an oral decision handed down and followed up with a written decision after that point in time. A written transcript of the part of the proceedings in which the tribunal’s reasons for decision were given orally may constitute written reasons for the purpose of this clause.

Mr P.A. KATSAMBANIS: I point out that even that written transcript might be something that people do not want to wait long for. I am glad the minister has clarified that the tribunal can give oral reasons first. I think that is helpful.

Mrs L.M. HARVEY: Just to clarify, if an oral decision has been made, does it need to be converted into a transcript before it can be enacted or can it be enacted on the basis of what was said? Obviously, a transcript takes time to be produced.

Mr M. McGOWAN: It is based upon the handing down of the decision, so the words of the decision, whether oral or written.
Mr A. KRSTICEVIC: With regard to the decision, the Premier talked about the oral and the written decision. Is there a difference in the level of detail that would be given to the person based on an oral decision as opposed to a written decision? If there is a difference in the detail, what would it be?

Mr M. McGOWAN: It is on a case-by-case basis and the decision of the State Administrative Tribunal. Often the oral decision is transcribed—sometimes immediately, sometimes afterwards—but the decision can be either oral or written, based upon the circumstances.

Mr A. KRSTICEVIC: Is the Premier saying that the written decision would be exactly the same, word-for-word, as the oral decision, or would there be variations in how the information was presented in each case?

Mr M. McGOWAN: In some cases, yes; in other cases, no. All proceedings before the SAT are recorded, so there are transcripts of them. The written decision may well be a transcript of the oral judgement, if you like, or it may be more fulsome. It depends upon the circumstances of the case and its complexity. The presiding officer may well decide on the complexity of what they hand down in writing, based on those circumstances.

Mr A. KRSTICEVIC: The Premier indicated that the written decision may be more fulsome than the oral decision. Can the Premier give me a rationale behind how that would occur? If there is more fulsome information that needs to be given in the written decision, how do we know that the person receiving the oral advice understands completely and exactly what the decision is and the parameters within that decision, if there is ultimately more information going into the written aspect of it?

Mr M. McGOWAN: It is one decision that it makes. Whether it is more extensive in writing than the oral decision or otherwise, it does not change the essence of the decision.

Ms M.M. QUIRK: I know time is of the essence in these matters; I am afraid I was distracted by someone. Is there any reason why there is no time frame within which the SAT has to provide reasons, given the desire for it to be dealt with expeditiously?

Mr M. McGOWAN: Under the State Administrative Tribunal Act, it is a matter for SAT as to when it provides written reasons. Because we have empowered SAT with this responsibility, the SAT act applies.

Mr A. KRSTICEVIC: Clause 95(2)(b) provides that if the coordinating practitioner for the patient is not a party to the proceeding, they also need to get a copy of the written reasons. How soon will it be before they get that advice? I am concerned about the fact that I am not sure what the time frames are. Can the Premier tell me how long it would take? I know the Premier said that SAT has its own procedures, but we know that there are time frames stipulated in this legislation. We just want to make sure that all the information is available to all the people within the stipulated time frames. How will they be given that information?

Mr M. McGOWAN: SAT members will make a determination based upon the circumstances and obviously in these circumstances they would expedite it. They are not silly people; they understand the seriousness of what they are dealing with. They can provide the information in writing either by hand, email or delivery of a letter.

Mr A. KRSTICEVIC: That information can be provided however they see fit. Is there a requirement for them to follow up to make sure that people have received that information? We know that things can get lost in the mail and that emails can get lost through technology. There is no guarantee that people have received the advice. I know that, in the normal course of events, a person is deemed to have received something if it has been mailed to them—for example, an electricity bill or something like that. However, this is not the normal course of events. How will we know that the decision has been conveyed and that they have received that decision?

Mr M. McGOWAN: There are common methods of communication and there is case law around these things. I would expect that, in these circumstances, the parties on all sides would follow up pretty swiftly if they were awaiting the information.

Mr A. KRSTICEVIC: That goes to the heart of the second part of my statement. I know that in the normal course of events, there are conventions that can be relied upon. But we are talking about someone terminating or ending their life. Obviously, it will be the most important decision that someone will ever make in their life; likewise, it will be the most important decision that the coordinating practitioner will be involved in. I do not think that we can say that in the normal course of events, these things just happen and it will work itself out. At the end of the day, communication can be lost or corrupted electronically in some way, shape or form, or it could be lost in translation. We want to make sure that the parties receive the response and the reasons within the required time and that there is no potential for the information to be lost. I want to make sure that we are confident that people will get this information and it will not just be a matter of convention, laws or regulations that will make this happen. There should be some checks and balances in this case.

Mr M. McGOWAN: SAT sits every day and hands down decisions every day, and it communicates those decisions via all sorts of means. The person awaiting the decision would no doubt pick up the phone if an email or a letter had not arrived.

Clause put and passed.
Clause 96: Published decisions or reasons to exclude personal information —

Mr P.A. KATSAMBANIS: Clause 96 provides that if the tribunal publishes a decision or the reasons for its decision, it will depersonalise that decision so that parties to the proceedings, people who appeared before the tribunal, the coordinating practitioner, the consulting practitioner and the administering practitioner are not identified. There is nothing new in that. Tribunals across the nation do that on a pretty regular basis. It is pretty rare for things to slip through in the publication by the tribunal. Clause 96(1) is very good and very simple. It is well understood in tribunal practice. I do not think there is anything controversial in that whatsoever. I also think it is fair. These are very personal proceedings and the identity of the parties ought to remain private in the same way as the identity of parties in the Children’s Court, the Family Court or many other proceedings in our court system remain private. However, subclause (2) provides an exception to that, and that is when the tribunal provides the decision to the parties. The decision it gives to the parties, the board and the CEO will identify all the people. Again, that makes sense because if the tribunal gave a depersonalised decision to the board, the board would not know whom to apply it to. However, what is not included is a sanction against any individual who receives that decision under the tribunal’s powers under clause 96(2) and then chooses to communicate it. Perhaps an aggrieved party will bring an action saying that their friend, parent or partner does not have capacity. What sanction would be available against those people if they chose, erroneously and unfairly, I would say, to make public the decision that person had made in good faith—a decision they deserve to be given the opportunity to make—and in some way brought those people who were party to the proceedings into the public limelight, against the intent of this legislation?

Mr M. McGOWAN: There is an offence provision for exactly that circumstance in clause 106, which we will be at soon, hopefully.

Mrs L.M. HARVEY: Premier, the explanatory memorandum says that clause 95 —

… modifies the operation of sections 75, 77, 78 and 79 of the State Administrative Tribunal Act …

Mr M. McGOWAN: We are dealing with clause 96.

Clause put and passed.

Clause 97: Interim orders —

Ms M.M. QUIRK: Premier, what interim orders are contemplated under this clause?

Mr M. McGOWAN: I thank the member for the question. It is a good question. It is difficult to define, but a couple of examples are an interim order by the tribunal may be an order for more information or an order for a capacity assessment of the individual seeking the decision.

Ms M.M. QUIRK: Thank you very much, Premier. What other circumstances are contemplated under clause 94, which we have passed, in which the coordinating practitioner must give the tribunal relevant material? It does not seem to be an offence if he or she does not do so. I went to the State Administrative Tribunal Act thinking that there may be a relevant offence there. It is not failure to comply with a decision. It is not failure to comply with a summons, because there is no summons issue. I am not sure that it is failing to give evidence as required. It is the opposite of giving false or misleading information; it is not giving any information at all. It might be obstruction, or it could be contempt. If it is contempt, it seems to me that the SAT would probably want to make an order to that coordinating practitioner first to say that it will give them the opportunity to hand over the material before it took the next step of finding contempt.

Mr M. McGOWAN: I think the member’s question is: what if a coordinating practitioner does not provide information in accordance with an order of the State Administrative Tribunal—is that it?

Ms M.M. Quirk: Yes; there does not seem to be any sanction in there.

Mr M. McGOWAN: In my understanding, professional misconduct and other matters are involved in that, and they are also breaching an order of SAT, which may well be an offence under the SAT act.

Mr P.A. KATSAMBANIS: I know that the tribunal has the power to order the production of documents or other important information. It has the power to order people to appear before it, in certain circumstances, by summons or other means. There would not be a need for an interim order in those cases. An interim order is made to prevent something from happening until a final decision is made. As I understand it, under these provisions in part 5, when an application is made, things are stayed; there is no continuation. In those circumstances, I think we are all struggling to come up with reasons why an interim order power would be needed. If the answer is that this provision is in the legislation solely to cover off for completely unintended consequences that we are not quite sure about, I think that is a good thing. However, if something was particularly in the contemplation of the drafters or the people who recommended this methodology, I think it would be worthwhile just having it on the record. As I said, that might not be the case. It might simply be a catch-all just in case. I seek further clarity from the Premier as minister at the table.

Mr M. McGOWAN: The provision was requested by SAT during the consultation process, so we have inserted it at its request. Examples I gave before might include, as the member said, holding proceedings while more
information is being sought, while it refers someone for capacity assessment, or it might want to seek some advice about whether someone is engaging in coercion. It could be any number of matters, but this gives the tribunal extra authority, in effect, to properly assess the matter.

**Mr Z.R.F. KIRKUP**: In some questions that I asked the minister earlier about interim orders and who might be tasked with some investigative powers, such as the police or people like that, if there is a concern, to look into a matter further as part of an interim order, could this clause enable further investigative agencies to look into certain areas of concern as well?

**Mr M. McGowan**: Yes.

**Clause put and passed.**

**Clause 98: Unauthorised administration of prescribed substance** —

Dr D.J. HONEY: I seek the Premier’s indulgence, and some advice from his advisers. In clause 19(4)(b) there is a requirement that if a practitioner is approached by someone who wishes to access the voluntary assisted dying process, and the practitioner refuses, they have to submit a form within two days providing details to the patient and explaining why they did not wish to participate in the process. However, clause 19(4)(b) requires them to provide a form prescribed by the CEO. I understand that there was a penalty for that, but, in this offences part, I could not find a penalty for that, so I am seeking advice from the Premier or his advisers.

**Mr M. McGowan**: It is in clause 107. We will deal with that shortly.

Dr D.J. HONEY: That is failure to give a form to the board, but this offence is failure to give a form to a person seeking access to the process. I appreciate the doctor submitting the form to the board, saying why they do not wish to participate in the process and giving the patient details. This is genuine; it is not a trick question. There is a requirement. The doctor has to give the patient a form —

**Mr M. McGowan**: Clause 10.

**The ACTING SPEAKER (Ms S.E. Winton)**: Member for Cottesloe, do you have a question on clause 98?

Dr D.J. HONEY: I just want some indulgence, please, to look at that. It is simply professional misconduct. I do not know where else to ask this question. Is the Premier saying that that is the only clause that applies if a doctor does not give the patient the form prescribed by the CEO?

**Mr M. McGowan**: That is the area in which there is a consequence for a health practitioner not providing a form.

**Mr Z.R.F. KIRKUP**: I refer to clause 98(a), which states —

A person commits a crime if —

(a) the person administers a prescribed substance to another person; …

I am assuming that, as part of this, some level of understanding has to be reached that the person intended to administer that. I am trying to imagine a scenario in which a person who might be terminally ill asks their spouse to pour a liquid down their throat or something like that. Would that be captured by this clause? It is not inconceivable that that would occur. In that case, would that person be possibly subject to imprisonment for life?

**Mr M. McGowan**: The only two people who will be authorised under the act to administer the substance are the practitioner authorised under the act or the individual themselves. Therefore, this clause would apply to anyone else who did it.

**Mr Z.R.F. KIRKUP**: Thank you, Premier. I am not legally minded, but I assume that it could be a defence that the person did not know that they were providing the prescribed substance or something like that.

**Mr M. McGowan**: That would be the normal defences under the current Criminal Code.

**Mr Z.R.F. KIRKUP**: I appreciate the Premier’s background here. I refer to someone who is under 18 years of age. What would that mean? If a child is seen to be doing it, would they still be bound by the life imprisonment possibility?

**Mr M. McGowan**: The age of criminal responsibility is 10 years old.

**Mr P.A. KATSAMBANIS**: I refer to clause 98. If someone were to administer a prescribed substance to another person without authorisation to do so under this legislation, that would be murder if it led to death, and it would be attempted murder if the administration did not lead to death. That would be the prima facie crime committed. Of course, the mental elements and everything else would need to be made out, but that would be the prima facie case, so why would we need this provision? Why would we not simply rely on what we already have in the Criminal Code?

**Mr M. McGowan**: It is a precautionary provision to ensure that there can be no doubt and is specific to the substance that is provided for the administration of voluntary assisted dying. The bill criminalises conduct that could occur as a result of the bill. These offences apply only to the circumstances relating directly to voluntary

*Extracted from finalised Hansard*
assisted dying. Any action or inaction that does not occur under the bill and does not involve a voluntary assisted dying substance will continue to be governed by existing criminal laws. I think it is to provide clarity in relation to the substance and will ensure that only the individual themselves or the practitioner authorised under the legislation can administer the substance.

Mr P.A. KATSAMBANIS: I understand the theory behind it, but even if that were the case and even if we wanted to create a separate and unique offence, as opposed to the ordinary Criminal Code offences, why would we not incorporate this offence into the Criminal Code, given we are making consequential amendments to other acts? Why would we leave it as a standalone provision in the Voluntary Assisted Dying Bill? For terms of life imprisonment, we would expect the Criminal Code to be the first place one would go. Why would we leave the offence solely in this legislation and not incorporate it into what is meant to be the first port of call for all serious criminal offences in Western Australia? To just round that off, this clause looks at circumstances in which someone has either got their hands on the prescribed substance in a nefarious manner or is perhaps ideologically bent on doing this—the tribunal hearings and everything else happened and they were told not to do it but they did not stop. We are looking at cases right out on the margin anyway, so it is not going to be an everyday or common event. On the other hand, if someone wanted to do ill to someone, I am sure they could probably find a way to obtain and then mix up a whole series of other substances that might not be the prescribed substance but could do the same thing. If they do that and they administer it, they will be subject to the Criminal Code. I do not have a problem with the intent of this clause, but just for the rounding off of our Criminal Code, why are we not putting this offence in there?

Mr M. McGOWAN: To be fair, I think this actually toughens the bill in a way that I would have thought the member would agree with. It makes it absolutely clear that if a person other than the individual who is seeking voluntary assisted dying or an authorised person, who will be a practitioner, administers the substance, they will be subject to the charge under clause 98. That is completely clear. Just so the member knows, a range of offence provisions are contained within the bill that are specific to the circumstances surrounding this bill. We are about to go through a number of them. It just makes it clear. There are other offences outside the Criminal Code for which life imprisonment is the punishment. One that has been brought to my attention is in the Misuse of Drugs Act.

Mr P.A. KATSAMBANIS: As I said, I do not think there is anything intrinsically wrong with having it here; it just strikes me as passing strange. I do not think it toughens the bill. The absence of this provision would not make the bill any weaker, let me put it that way. I think the intent is clear. If someone does not follow the procedure set out in this bill and injects someone with a substance, be it this or another substance, they will not be covered at all—it will be murder or attempted murder. We are not arguing about that. As I said, it is just something that I thought we could clarify and I thank the Premier for his explanation.

Ms M.M. QUIRK: My concerns about this clause go more to the issue of evidence and proving such an offence.

We are looking at a number of scenarios. For example, we are looking at a medical practitioner who is authorised but does not follow clause 58(5) because he has formed the view that the patient does not have capacity, that the patient has been coerced or that the patient does not have an enduring intention. In those circumstances, that will not be readily apparent to anyone who investigates the matter because the death certificate will just say “Died of cancer” and the witness may or may not be competent to give evidence on the fact that this offence was committed. Because the board does not have contemporaneous oversight, I am really at a bit of a loss about how such an offence could be proved. I also want to ask: given that it is under this bill, will the CEO of the Department of Health have some responsibility for investigating?

Mr M. McGOWAN: The police will be authorised to investigate. When the state of mind of the accused is under any doubt or in question and when they do these things, they consider all the surrounding circumstances. Although I appreciate the member’s argument, the same could be said of any prosecution or investigation of any alleged criminal act.

Ms M.M. QUIRK: That is the very argument that certain doctors have been advancing for why we need this legislation. They have been saying that it is not clear, and that they are in jeopardy of legal sanctions or criminal liability because the objective circumstances cannot be inferred, the victim is dead and so on. It is kind of ironic that the Premier has used the very same argument that the proponents of this legislation also use about the same proceeding. I will give the Premier an example. There is a death certificate that says the person has died of cancer. The person has been cremated. On the face of them, the board forms seem to be correctly filled in. Short of having the witness do something absolutely extraordinary, and probably uncorroborated, I am not sure how we would ever successfully find a prosecution for a medical practitioner who has exceeded his authority. I think it would be different under clause 98(a) when someone is not acting under this legislation. But, again, there are some problems there because it is a prescribed substance and that person may choose to use something other than a prescribed substance.

Mr M. McGOWAN: My only answer is that people die every day in all sorts of circumstances and if they are buried or cremated, that obviously influences any sort of investigation into their deaths. This would be no different from those situations that occur every day.

The ACTING SPEAKER: The members—sorry. Member for Hillarys.

Extracted from finalised Hansard
Several members interjected.

**The ACTING SPEAKER:** Members!

Dr D.J. Honey interjected.

Mr P.A. KATSAMBANIS: Slightly—I was wondering what the redistribution had done to me!

The ACTING SPEAKER: I was seeing double!

Mr P.A. KATSAMBANIS: I have only visited the Kimberley a few times. It is a beautiful place. I probably need to visit it more!

The question that the member for Girrawheen asked gives rise to the sort of question we will grapple with in another bill in this Parliament about when events occurred. Again, we are dealing with real externalities. We are dealing with a one-off—I understand that—but it is a potentiality. We are not dealing with when it occurred, but how it occurred. If evidence comes to light afterwards that a person was administered a substance and they died and have been cremated or buried, and it is impossible at that stage to determine what type of substance was used, which offence would people be charged with? If it is impossible to deduce whether the substance used was the prescribed substance, a non-prescribed substance or even a combination of the two, and the accused person was not willing to admit either/or, would they be charged with murder or an offence under clause 98?

Mr M. McGOWAN: It is a decision for the Director of Public Prosecutions looking at all the circumstances. Obviously, the offences under clause 98 and murder are alternative offences and the office of the DPP can pick which one it wishes to charge the individual with.

Mr P.A. KATSAMBANIS: Would it be an offence—a defence, sorry; I am still thrown out by this “Kimberley” reference —

The ACTING SPEAKER: I do my best.

Mr P.A. KATSAMBANIS: That is all right.

Would it be a defence for an accused person if the prosecution could not prove what substance was used? If the accused was charged with murder, they could say that it could not be proven that a prescribed substance was not used, and therefore they should not be charged with murder; they should be charged with an offence under clause 98. Would it be a genuine either/or and it simply would not matter which of the two charges were preferred and all the prosecution would need to prove was that a substance was administered? I am just trying to get clarity on this matter, because we know from experience that these sorts of gaps in the law often result in perverse outcomes, and that is why we have that bill before us in the house. We have not debated it yet, so I am conscious of not foreshadowing debate on it. That is why we have it here; it is because these sorts of gaps or unforeseen circumstances sometimes lead to very perverse outcomes and people avoiding justice when they ought not to avoid it.

Mr P.A. KATSAMBANIS: I regard the Office of the Director of Public Prosecutions and its officers as very professional and knowledgeable about all these matters and they make decisions every day about which offences to charge someone with, particularly when it is a serious offence. The office of the DPP exercises this discretion based upon what gives the best chance of a conviction.

Ms M.M. QUIRK: I have looked at the Victorian legislation and I have looked at clause 98 of this bill, and I see what the issue is. The Victorian legislation is basically limited to those who have a permit to administer and in some way depart from the scope of that permit, but it also has the word “intention”, which is not present in this legislation. It is broader than an authorised medical practitioner, and that is where we are getting into some lack of clarity. Frankly, that is more properly dealt with under the Criminal Code. Any person on the street can give anyone any substance that kills them, which is not a prescribed substance, and is not in any way conduct authorised under this legislation, the authority for which has been exceeded. If clause 98 were limited to people who had authorisation but in some way departed from it, that would be much clearer. Even using the words “knowingly” or “intended to” would, I think, make the clause much clearer. This almost looks like a strict liability offence, which of course it cannot be for a life sentence. I know there is no formal amendment before the house, but I find clause 98 very confusing and I suspect the Director of Public Prosecutions might not be happy with it either.

Mr M. McGOWAN: I think I answered the question to the best of my ability. It provides clarity and the opportunity for prosecution under this legislation with imprisonment for life, which I thought members who do not support the bill would have thought was a good clause.

Ms M.M. QUIRK: With all due respect, Madam Deputy Speaker, I will not flog a dead horse anymore —

The DEPUTY SPEAKER: Thank you.

Ms M.M. QUIRK: — but I will make the comment that for the very reason that it is imprisonment for life—the very reason there is this robust penalty—that means that the standard of proof is incredibly high. For the very reasons that the Premier mentioned, that is why we need a greater level of precision in the drafting.

*Extracted from finalised Hansard*
Mr A. KRSTICEVIC: The clause states that the person administers a prescribed substance to another person. I just want the Premier to explain to me the word “administers”. In what way, shape or form can a person, obviously other than the individual patient, administer the poison to the patient?

Mr M. McGOWAN: It would be injected, poured down their throat or put into their food.

Mr A. KRSTICEVIC: If, for example, a husband and wife are at home and the husband who is terminally ill has the medication and decides that the time has come and says to his wife, “I’d like you to make me that chicken soup that I like so much and I’d like you to put the poison in there. I’d like to eat my chicken soup and pass away”, and she brings the chicken soup to him, puts it on the table and he eats it, is she in any way, shape or form involved in the administration of that poison?

Mr M. McGOWAN: In the case the member gave me, the husband has administered the medication.

Mr A. KRSTICEVIC: Taking that one step further, let us say the husband is too ill to lift the spoon to his mouth and ingest the soup and asks his wife to feed him the soup, and the wife feeds him the soup because he is not well enough, but he is meant to self-administer. Would the wife commit an offence if she feeds her husband and he passes away from that medication?

Mr M. McGOWAN: Yes.

Mr A. KRSTICEVIC: I refer to clause 98(b), which states “the person is not authorised by section 58(5)” if they do not follow those rules. Clause 58(5) refers to decision-making capacity and a range of other things. The administering practitioner is the one who is administering the poison, but family members present at the time of the administration may say to the practitioner, “We do not think they have decision-making capacity at this point” or, “They are not doing this voluntarily and you are coercing them”, or, for whatever reason, some other accusation may be made by the people there. For example, someone’s mother is going through this process but the children may not want the mother to go through this process and may be concerned about what is going on. Will the administering practitioner be in trouble if two or three witnesses said, “Hold on, no, this was not done properly with decision-making capacity” or for some other reason? I ask that because I want to make sure the administering practitioner is safe in doing this if others who happen to be present disagree with that and it is later challenged.

Ms M.M. Quirk: They still need some evidence then.

Mr A. KRSTICEVIC: The evidence would be the witnesses.

Ms M.M. Quirk: The witnesses.

Mr A. KRSTICEVIC: That is right.

Ms M.M. Quirk interjected.

The DEPUTY SPEAKER: One at a time, please, members. The member on his feet has the call.

Mr A. KRSTICEVIC: When there are witnesses, I want to make sure that the administering practitioner would not be scared off because witnesses are there who are challenging this. Is it too late at that point, because the Premier said an individual can change their mind at any time? If an individual can change their mind but their circumstances change and they no longer have decision-making capacity and the witnesses around them think that, would that mean they could be contravening this legislation and end up with a sentence of life imprisonment?

Mr M. McGOWAN: Under clause 58(5) the administering practitioner needs to be satisfied that the patient at the time of administration has decision-making capacity, and is acting voluntarily and without coercion, and that the patient’s request for access to voluntary assisted dying is enduring. That sets out the circumstances. Obviously, there is a range of circumstances surrounding the passing of any individual, but that is what the administering practitioner must be satisfied of.

The DEPUTY SPEAKER: Members, I think a lot of this has already been covered in previous clauses, so I urge you please not to repeat what has been covered.

Mr A. KRSTICEVIC: I am not aware —

The DEPUTY SPEAKER: I am sorry, member, but it will be in Hansard.

Mr A. KRSTICEVIC: This is a first-offence clause.

Mr S.K. L’Estrange: The minister has told us to refer to this section.

Mr A. KRSTICEVIC: That is right, previously.

The DEPUTY SPEAKER: I remember this discussion from earlier when I have been chairing. Go ahead, member, but I ask you not to be repetitious, please.

Mr A. KRSTICEVIC: I am not; I want to know —

The DEPUTY SPEAKER: Go ahead, go ahead.

Extracted from finalised Hansard
Mr A. KRSTICEVIC: There is a penalty for life imprisonment.

The DEPUTY SPEAKER: Go ahead.

Mr A. KRSTICEVIC: I am not aware that we have dealt with offences or life imprisonment or any offences at this point in time.

The DEPUTY SPEAKER: Go ahead.

Mr A. KRSTICEVIC: We did not know it was in previous clauses, unless we referred back, looking forward.

An opposition member interjected.

The DEPUTY SPEAKER: One at a time, thank you.

Mr A. KRSTICEVIC: The administering practitioner is there, and those conditions have been met previously, and there is no question about that. However, three months or six months later, however long it is, because, as we know, medical practitioners get it wrong—we never know; a patient may live for another 12 months or two years—the patient may still have the medication sitting there ready to go. They have not made up their mind yet. They may live longer than six months. If someone is in that situation, and witnesses there say, “We don’t think this person has decision-making capacity at this point in time”, does that carry any credibility? Can the administering practitioner confidently say, “Bad luck, I don’t really care what the five witnesses in the room think. All the boxes have been ticked; I’m administering this medication because the rules have been met, and I’m comfortable with that”, or could they find themselves in trouble if suddenly these five witnesses say, “We’ll take this to court, we’ll charge you with murder, because you have contravened the legislation”, or “We’re going to charge you under this particular offence”? It is quite a simple question. If witnesses in the room at that time have a differing view from the administering practitioner, I want to make sure that the administering practitioner is protected in all cases. That is what this question is about. We do not want them to be challenged afterwards, publicly and/or legally, that they have carried out an illegal activity.

Mr M. McGOWAN: As I said earlier, if the practitioner is not satisfied, they cannot administer. Obviously, the practitioner would no doubt take into account any commentary or the like by other people in making that decision, and whether members of the family, individuals present, or whoever it might be, were acting vexatiously, irrationally, or whatever the case might be. As I think we went through with clause 58(5), in all these circumstances, it is a decision for the practitioner, taking into account the circumstances outlined in that clause.

Mr A. KRSTICEVIC: The Premier says the practitioner would take that into account. I want to know, if there were, say, five witnesses in the room, close family members, saying, “No, we don’t agree with you”, can they try to start action against the practitioner under clause 98, saying, “Actually, no, we disagree with the practitioner”? Let us say, for example, of those five witnesses, two of them are general practitioners, a couple of them are lawyers, and they are sitting there—

Several members interjected.

Mr A. KRSTICEVIC: I hear people think it is a joke. I do not think it is a joke. I think it is quite a serious matter.

MS A. Sanderson: You are not making any sense!

Mr A. KRSTICEVIC: That is okay; the member for Morley can keep intimidating people during this debate, as she has done quite comfortably for a time, trying to assert her authority, but it is not going to get her anywhere, because people know her game.

I just want to know very clearly that if these five people challenge the administering practitioner, the administering practitioner is safe; that challenge has no grounds or merit if the witnesses decide to pursue it. The Premier said, “As long as the administering practitioner is confident.” Who will determine whether they were confident and whether the circumstances were met at the time it was happening? If those other five people decide to pursue it further, what defence does the administering practitioner have at that time, which could be two or three months after the process has been signed off and approved? Obviously, things change over time—within days, let alone months. It is really important to get this on the record so the administering practitioner knows, with confidence, that if they find themselves in that situation—they get challenged in that room and there are four or five witnesses in there—yes, they can administer the medication, and there will be no consequences at all. If these people decide to take legal action, go to court, or do whatever they want to do, the administering practitioner knows, “No, I am protected. I disagree with them; my decision is final, and they cannot challenge me at all.” What defences are there for the administering practitioner?

Mr M. McGOWAN: Those are contained in clause 113, which we have not reached yet. If any individuals have any concerns, they can take the matter to the police. If the police believe there is any sort of case, they can investigate it, and, if they think it is worthy of prosecution, they can take it to the Director of Public Prosecutions.

Mr A. KRSTICEVIC: The Premier has indicated that there is the potential for them to go to the police and ask for an offence to be registered. If, as I said, four or five witnesses were saying, “No, there was no decision-making
capacity at the time”, or there was no acting voluntarily or there was coercion, or whatever the case might happen
to be at that time, and the poor old administering practitioner is on their own on the other side saying, “No, that’s
not what happened”, they would find themselves in a pretty precarious position. Who are the police going to believe—
the five people who said it happened or the one practitioner who is saying something different? Is the Premier
saying that it is now just subject to luck as to whether or not the administering practitioner is charged? I do not
know that that in itself is enough of a safeguard for the administering practitioner. As I said, maybe there are
safeguards that I am not aware of, but I would really like the Premier to tell me that it is not a matter of going to
the police, and gathering evidence, and then the police deciding on the balance of probabilities what five against one
have said and who is guilty and who is innocent. I want to make sure that the administering practitioner is in a safe
position when they do this and will not find themselves reported on in the papers, accused of crimes that they may
or may not have committed, and have to go through that process unnecessarily when there should be safeguards
for them in that situation.

Mr M. McGowan: The patient will have gone through a range of assessments, as we know, prior to reaching
this point, which is a safeguard. There is a range of defences under this legislation, as I outlined before, and under
the Criminal Code. I might just say more broadly that any one of us can allege anything against any other individual
at any point in time and take the matter to the police if we wish to. That happens every day. I could allege something
against the member, if I want, and I could take him to the police, if I want. It would be up to the police and the
authorities then to investigate. If a prosecution were to be launched after I had alleged something against the
member—that he assaulted me, or defamed me, or engaged in criminal assault, or stole from me—it would be
a matter of whether or not there was a prima facie case and whether or not there was a prosecution in the
circumstances. The prosecution would have to prove all the elements of the offence beyond reasonable doubt.

Ms M.M. Quirk: I think part of the confusion is that this clause deals with both medical practitioners who may
have exceeded their authorisation in administering the prescribed substance and other people who are not medical
practitioners or who are outside the scope of this legislation. Perhaps before this legislation goes before the other
place, may I respectfully suggest that some consideration be given to making these offences like a code of conduct
covered by the scope and tenor of this legislation. An ordinary person who does not purport to act under this
legislation and who administers a substance that has the ultimate effect of killing someone could be dealt with in
the normal way under the Criminal Code. The other limiting factor, as I said, is that this creates an offence of
administering only a prescribed substance. If it is a person who is outside the system altogether, there is no
guarantee that what is administered is a prescribed substance. It might have the same effect as a prescribed
substance, but it might be broader. In my respectful submission, there would be less confusion if part 6, “Offences”,
prported to be a code for matters under this legislation, and the more general offence of administering poison
causng death were dealt with in the normal way under the Criminal Code.

Clause put and passed.

Clause 99: Inducing another person to request or access voluntary assisted dying —

Mr P.A. Katsambanis: There is nothing wrong with clause 99, “Inducing another person to request or access voluntary assisted dying”; I think that is a new offence because the legislation is new. Again, it does not make that
much difference whether it is contained in the Criminal Code or in this bill. My first question about this is: why were
the penalties in this clause chosen? The penalty is imprisonment for up to seven years and there is also a summary
conviction penalty of imprisonment for three years and a fine of $36 000. It envisages that it is an either/or offence.
The penalty at the top end is seven years’ imprisonment. Why was that penalty chosen? What similar penalties in
our criminal law were used as a guide for setting this penalty?

Mr M. McGowan: The drafting team met with the Department of Justice to discuss the appropriate penalties.
The drafting team took advice from the Department of Justice and came up with this penalty based upon
section 301 of the Criminal Code, which creates an offence of causing someone to take poison or other noxious
things, and section 304 of the Criminal Code, which creates an offence if a person does any act as a result of which
bodily harm is caused to any person or the life, health or safety of any person is or is likely to be endangered. It is
a similar penalty regime. Sections 301 and 304 of the Criminal Code are similar offences. The team sought the
advice of the Department of Justice, the Western Australia Police Force, the Solicitor-General and the Director of
Public Prosecutions in landing upon this penalty.

Mr P.A. Katsambanis: If an individual induces another person to request or access voluntary assisted dying—
so, the person who accesses the assistance is not acting of their own free will—and that individual is intercepted
prior to the substance being administered to the person, that is all well and good; the induced involuntary death
will be avoided. However, if the inducing is discovered after the inevitable end of the process, and the result is the
involuntary death of the patient, what other crimes can the inducing person, who could be subject to prosecution
under clause 99, be considered for under either this legislation or the criminal law generally?

Mr M. McGowan: The circumstance is covered by clause 100, with imprisonment for life.

Mr P.A. Katsambanis: I do not think it is completely covered by clause 100. It is arguable that clause 100
does not actually apply. Clause 100 would not apply to someone who has the substance administered by an
administering practitioner, so the answer I received was, at the very least, incomplete. I would argue that clause 100 does not apply. The reason my question is relevant is that there is provision in this bill that indicates that a death under the provisions of this bill is not a suicide. If someone induces another person to undertake this process, the actual death under the process is not suicide. We cannot blame the practitioners involved; we cannot blame anybody if the coercion is not caught—that is, the pernicious coercion that I spoke about in the second reading debate and have also spoken about in my other contributions. Perhaps the question that needs to be asked is: was consideration given to a separate and distinct penalty for when the inducing of a person actually leads to their death, as opposed to simply an inducement that was caught prior to the ultimate demise of the affected party?

Mr M. McGOWAN: The Criminal Code also applies here. Section 273 of the Criminal Code states that any person who commits an act or makes any omission that hastens the death of another person who at the time has a disorder or disease arising from another cause is deemed to have killed that other person. When that act or omission to cause death or injury results in death, the offence of murder or manslaughter will apply, and the penalty is life imprisonment.

Mr P.A. KATSAMBANIS: Premier, since clause 98 includes a provision that, effectively, substitutes the murder and manslaughter provisions, why was consideration not given to incorporating further clauses—a clause 99(3) and (4), as the case may be, or a clause 99A—in which the penalty is higher for someone who commits a crime, as spelt out in clause 99(2), and that crime leads to the death of the person. I think that we are half pregnant here; we are creating some specific crimes and then leaving gaps where others might or might not be covered by the Criminal Code. Perhaps it is, again, something that could be contemplated between the houses. I am not being obstructionist in any way. I am trying to make this legislation as coherent and functioning as possible.

Mr M. McGOWAN: It is up to any prosecution, in relation to these matters, to choose which offence and which act best applies. Sometimes they will choose the Criminal Code, but the Criminal Code does cover the field.

Mr P.A. KATSAMBANIS: I accept that the Criminal Code may cover the field. I am just concerned that the provisions here are incomplete and do not cover the field. That theme has emerged throughout this entire consideration in detail. I accept that the government has delivered this bill as a magnum opus, and as a sermon that best applies. Sometimes they will choose the Criminal Code, but the Criminal Code does cover the field.

Ms M.M. QUIRK: This question probably relates to all these offence provisions. I am concerned that written material may be needed to found a prosecution case. I am wondering whether there are any constraints on either the CEO or the board in providing information needed for the purposes of the prosecution.

Mr M. McGOWAN: Police will be able to investigate these matters, and use their ordinary powers to seek whatever material they can under their existing powers.

Ms M.M. QUIRK: Throughout this consideration in detail, there have been issues about patient privacy, and documents and the way they are handled. The Premier is giving us assurances that police will have no problems sourcing them, or their being volunteered by the board or the CEO.

Mr M. McGowan: Yes.

Clause put and passed.

Clause 100: Inducing self-administration of prescribed substance —

Mr Z.R.F. KIRKUP: In relation to inducing the self-administration of a prescribed substance, I am assuming that means trying to corral or force someone to take it. Is that the Premier’s definition of the term?

Mr M. McGOWAN: It means to try to coerce, corral or persuade. There may well be a common law definition. I will just see if we can find it, but I am confident that the courts understand the meaning of the word “induce”.

Mr Z.R.F. KIRKUP: Are we waiting on that information to come back?

Mr M. McGowan: We are seeing whether we can find it.

Mr Z.R.F. KIRKUP: Thank you.

Mr M. McGowan: It is leading someone to do something through strong persuasion and coercion.

Mr P.A. KATSAMBANIS: I have a couple of questions about this. Following on from the member for Dawesville’s question, where would force come into this? If a person forces another person to administer a prescribed substance, would that be coercion? Would that be inducing? Where would that fall into it?

Mr M. McGowan: It would be covered by clause 98, or coercion under clause 100.
Mr P.A. KATSAMBANIS: I do not know about clause 98, because that deals with the person of ill intent administering the substance.

The DEPUTY SPEAKER: I think the Premier may have meant clause 99.

Mr M. McGowan: I meant clause 98.

The DEPUTY SPEAKER: Clause 98? It is not mentioned there.

Mr P.A. KATSAMBANIS: It deals with administering the substance. Forcing someone to take it is not administration. I hope that coercion or inducement would include simply forcing them. I am trying to see why some language was chosen and not other language. Again, this is being left up to common law interpretation when the questions are too hard to answer. We are replacing either existing provisions of the Criminal Code or existing common law provisions with statutory provisions when we have already thought about it and done it. It seems as though these things are being made up as we go along. We are dealing with an extraordinarily serious subject matter, perhaps the most serious subject matter that has ever been considered by this Parliament, save for maybe capital punishment, which I think falls into exactly the same category. Others may have different views. It is one of the most serious subject matters that we have ever dealt with. Unfortunately, the common law is used when it suits us and we override the common law when that suits us. It is really disappointing that legislation that ought to be as watertight as possible in this subject area seems to be not watertight at all.

I will move on with my other question about clause 100. It is a question about the limits of this provision.

Clause 100 states —

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

I want to clarify something and I hope the answer is yes: does the self-administration of a prescribed substance include circumstances in which the individual who will take the substance has procured it under the provisions of this bill? They have the substance. It has come to them and for some reason or other they have decided either they do not want to take it or they are not going to take it right now, but someone induces them to take it. Does this clause cover that circumstance?

Mr M. McGowan: Yes.

Mr P.A. KATSAMBANIS: Great. Does it also cover the circumstance in which another person—not the patient, but the person who wants to cause harm—somehow or other comes into possession of the prescribed substance and forces that to be taken? The patient, if you like, has not come into the possession of the substance because they went through the process; this other person has somehow or other acquired it and convinced the other person to take it. Does it cover that circumstance as well?

Mr M. McGowan: If another individual, the agent or contact person gets the substance and tries to force or coerce the individual to take it, that would be captured by clause 100.

Mr P.A. KATSAMBANIS: I am not asking about the agent. Let us say that a little bit of this substance slips through the cracks. I will use the example of dishonesty. A person who wants someone else to pass away grabs this medication, walks up to them and says, “Here you are. This is medication that I have googled on the internet. I think this medication is going to make you better”, and the person takes it. It is the prescribed substance; it has just fallen through the cracks somehow. Will this be the penalty that is used? I hope it is. I hope that is covered by clause 100. It is the exact circumstances that one would want a provision like this to cover. I want some clarity around that.

Mr M. McGowan: It is covered by clause 100.

Mr P.A. KATSAMBANIS: Thank you.

Ms M.M. QUIRK: I have taken the opportunity to look at the equivalent section in the Victorian legislation. I think it is much more precise in its drafting, which means that the kind of confusion that the member forHillarys is experiencing is basically eliminated. Section 86 of the Victorian legislation says —

A person must not, by dishonesty or undue influence, induce another person to self-administer a voluntary assisted dying substance dispensed in accordance with a voluntary-assisted dying substance dispensing act.

It is clear that it is limited to the scope of the act, whereas clause 100 talks about a person who induces another person to self-administer a prescribed substance. It does not necessarily need to be someone who has acquired the prescribed substance and it may well be in circumstances that are outside the scope of this legislation. Sorry; I am tired, so I am not being very sensible. However, there are material differences between section 86 of the Victorian act and this bill. It would be my submission that the Victorian act is a lot more precise because it uses the words “dispensed in accordance with a self-administration permit”. That makes it clear that it comes under the tenure of the legislation and is not just a general prohibition.

Extracted from finalised Hansard
Mr M. McGOWAN: Section 86 of the Victorian act is far weaker than this clause. The punishment under clause 100 is imprisonment for life; the punishment under section 86 of the Victorian act is imprisonment for a maximum of five years.

MS M.M. QUIRK: With respect, Premier, it can be as heavy a penalty as one likes, but if a prosecution is not actually secured, it makes no difference. What I am contending is not about the penalty but about the wording, which contextualises it within the scheme under this very bill.

Clause put and passed.

Clause 101: False or misleading information —

Mr Z.R.F. KIRKUP: Clause 101(1) could conceivably capture the consulting, coordinating or administering practitioner. I imagine that would apply to them equally.

Mr M. McGOWAN: Yes.

Mr Z.R.F. KIRKUP: Clause 101(2)(b) provides for a person who might provide a statement that —

omits anything without which the statement or information is, to a person’s knowledge, misleading in a material particular.

What burden is required to prove that that exists? I suspect that as per the answers already provided there would be some precedent elsewhere that there has to be a stated intent or desire to mislead; is that right? I am not making much sense; similar to the member for Girrawheen—tired.

Mr M. McGOWAN: Any element of an offence is required to be proven beyond reasonable doubt.

Mr P.A. KATSAMBANIS: Why is the term “in a material particular” included in clause 101(2)(a) and (b)? Why is it not limited to any statement or information that a person knows is false or misleading? Why is the extra requirement that it be a “material particular” included, given that if something is proven to be false and misleading, that will be a matter for debate in any litigation? Why limit it to only material particulars, because then we will need a finding on what is material and immaterial?

Mr M. McGOWAN: It is to ensure that anything covered by this clause is not trivial or inconsequential; it is something of a material particular, which is not immaterial or inconsequential.

Ms M.M. QUIRK: I can give an example. If one of the forms were submitted and a practitioner, for example, were aware that the person had not resided in Western Australia for the preceding 12 months, that would be a material particular.

Mr M. McGOWAN: It would be a material particular.

Clause put and passed.

Clause 102: Advertising Schedule 4 or 8 poison as voluntary assisted dying substance —

Mr Z.R.F. KIRKUP: I have a few quick questions on this clause. I understand the intent of the clause; the Deputy Premier has spoken about it at length. I have a query about the definition of “advertise”. I appreciate that in the traditional sense a newspaper or whatever would be captured by this, but what would happen if this information were provided online?

Mr M. McGOWAN: An online advertisement is still captured by this.

Mr Z.R.F. KIRKUP: I appreciate that, but what if it finds its way online not through an advertisement? If a person expresses the contents of a schedule 4 or schedule 8 substance in a non-advertisement form, will that be captured?

Mr M. McGOWAN: There are further clauses restricting the publication of information such as clauses 105 and 106.

Mr Z.R.F. KIRKUP: I appreciate that. I will save those questions for that part. Let us say that the advertisement is accessed by a person in Western Australia, and let us use as an example the advertisement online that the Premier just spoke about. It is published by someone outside the jurisdiction but accessed by someone within the jurisdiction. Is that still an offence; and, if so, how would it be prosecuted if the advertisement were displayed on a website hosted in a different state or overseas?

Mr M. McGOWAN: Someone who sees an advertisement has not committed an offence; it is the person doing the advertising who commits the offence.

Mr Z.R.F. KIRKUP: I appreciate that. The person commits the offence in another jurisdiction; they provide the advertising. If someone is in Queensland or overseas, for example, and they provide information saying what exists—there are a lot of websites on this sort of stuff and I imagine some people might want to display it for whatever reason—is it still an offence in that case? That is all.
Mr M. McGOWAN: It is about the advertising in Western Australia, but when prosecuting someone in another jurisdiction, there is always an issue of whether that person can be accessed by whatever means, such as extradition, either interstate or overseas.

Mr P.A. KATSAMBANIS: Just to follow up the point of the member for Dawesville about advertising, particularly online, an advertisement has a particular form, and we spent a bit of time earlier this year talking about what constitutes an advertisement or publication in relation to ticket scalping. It is a rather complex area when online circumstances are overlaid, because people do not necessarily need to advertise. They could promote something on their Facebook page; they could put something up there. I ask simply for completeness. I support the intention of this bill with clause 102. I do not want people promoting schedule 4 or 8 poisons in any way, particularly as voluntary assisted dying substances; that is the last thing we want. Even this bill wants that very, very highly regulated. Why was it not contemplated that the words be expanded, so instead of the bill just saying “advertising”, it perhaps could say “advertises, promotes or in any other way represents a schedule 4 or schedule 8 poison as a voluntary assisted dying substance” simply to cover all those question marks about whether a post on Instagram is advertising or simply a statement or a representation. Again, the drafting here could have been better, to give better protection than currently exists and to avoid the whole thing of letting the courts decide whether or not it is an advertisement. It could be made very, very clear that any claim made in public, whether an advertisement or not, would be captured by this clause.

Mr M. McGOWAN: Advertising involves publication, so it is pretty clear what the word means.

Ms M.M. QUIRK: What is the mischief of clause 102? What is the rationale for having that in the bill?

Mr M. McGowan: It would not be prudent to allow the public to know which schedule 4 and 8 poisons may be used for voluntary assisted dying as this may encourage persons who are not subject to a voluntary assisted dying process to stockpile their supply for the purpose of suicide or assisted suicide outside the protections contained within the voluntary assisted dying legislation.

Mr P.A. KATSAMBANIS: In the Premier’s answer to my question about why the terminology was not extended, the Premier said that advertising involves publication, so we are okay. I accept that advertising will involve publication. Advertising is one subset of publication, but publication is much broader than advertising and that was the point that I was making: although advertising may involve publication, publication may not necessarily involve advertising and that is the missing link in this clause to make the protection as watertight as possible. I want to emphasise that although the Premier’s answer might have been technically correct, it does not cover the failing of this clause.

Mr M. McGOWAN: Advertising means to publicise information about a thing or to make a fact known.

Ms M.M. QUIRK: This clause is about someone saying, “We have phenylene available for those who want to end it all.” Would that be a correct assessment of the mischief of that clause, Premier?

Mr M. McGowan: I am sorry, I did not hear the question.

Ms M.M. QUIRK: This clause is about someone saying that they have in their possession certain drugs and are not naming those drugs. That is the rationale behind the clause. If the person does not use the drugs but says the names of the drugs, and says, “I have access to schedule 4 or schedule 8 poisons for the purpose of administration under the act”, would that fall foul of this offence? Does the Premier understand what I am saying or do I need to rephrase it?

Mr M. McGowan: I do not understand, I am afraid.

Ms M.M. QUIRK: Someone advertises that they are in a position to administer schedule 4 or schedule 8 poisons. They do not name them but they say, “I am in a position to lay my hands on this stuff and can administer it to you.” I am not suggesting that the drugs are illegally obtained, but the mere fact that they advertise that they can acquire them for the purposes of administration, would that be covered by this clause?

Mr M. McGowan: I think the wording of the clause is very clear and covers the circumstance that the member alluded to.

Ms M.M. QUIRK: The intention is that a person commits a crime if they name a schedule 4 or 8 poison as a voluntary assisted dying substance. That is the mischief that the clause is trying to address. It is the naming of the drug, so then people go out and acquire it somewhere else and do their own thing.

Mr M. McGowan: They do not have to name the particular drug, although that would be covered by the clause. All they have to do is say that it is a schedule 4 or schedule 8 poison, or both, to be captured by the clause.

Mr Z.R.F. KIRKUP: Can the Premier imagine that a Google search or something like that might fall within this clause? As such, could it be conceived that Google, for example, listing the information or providing the information publicly could be captured by this? If I search it, for example, and try to find a schedule 4 or schedule 8 poison and link it as a voluntary assisted dying substance, could Google Australia be conceivably captured by this? The

Extracted from finalised Hansard
Deputy Premier made the point that we do not want to name it because it could conceivably increase the price or something like that. Obviously, on an online environment it is very hard to do that. Is there an ability to stop the publication of it and to what extent?

Mr M. McGOWAN: I think the member is asking who would be doing the advertising. Clearly, whoever runs Facebook, Twitter or Google would not be guilty of an offence; the person who did the advertising would be guilty of the offence.

The DEPUTY SPEAKER: I understand there is an agreement to take a 15-minute break.

Mr A. KRSTIC: I know the focus is on schedule 4 and schedule 8 poisons for voluntary assisted dying. What if someone advertises it as a poison available for voluntary assisted dying? They are not saying schedule 4 or schedule 8 but are advertising it as a poison that is appropriate for voluntary assisted dying. How would that be caught, if at all?

Mr M. McGOWAN: It would be a specific offence under the Medicines and Poisons Regulations 2016.

Clause put and passed.

Sitting suspended from 10.06 to 10.20 pm

New clause 102A —

Ms M.M. QUIRK: I move —

Page 67, after line 24 — To insert the following new clause —

102A. Publishing statements about accessing voluntary assisted dying

(1) In this section—

*publish* has the meaning given in the *Civil Liability Act 2002* section 16.

(2) A medical practitioner, or a person acting for a medical practitioner, must not publish, or cause to be published, a statement that may reasonably be thought to be intended or likely to encourage or induce a person —

(a) to make a request to a medical practitioner for access to voluntary assisted dying; or

(b) to use the services of a medical practitioner in order to make a request for access to voluntary assisted dying.

Penalty for this subsection: a fine of $10 000.

(3) A medical practitioner does not contravene subsection (2) only because —

(a) of a statement made to a person —

(i) who is receiving ongoing health services from the medical practitioner; or

(ii) at a health facility as defined in section 160(1) where the medical practitioner carries out health services;

or

(b) the medical practitioner gives a patient information under this Act, including under section 19(4)(b) or (5)(b); or

(c) of a statement made on the medical practitioner’s website that is limited to statements about —

(i) the operation of this Act and a person’s right to access voluntary assisted dying; and

(ii) the conditions under which the medical practitioner is prepared to do anything under this Act as a medical practitioner.

(4) A person acting for a medical practitioner does not contravene subsection (2) only because of a statement made —

(a) to a person —

(i) who is receiving ongoing health services from the medical practitioner; or

(ii) at a health facility as defined in section 160(1) where the medical practitioner carries out health services;

or

Extracted from finalised Hansard
In the previous clause, we dealt with the advertising of poisons, but we have not dealt with medical practitioners advertising for services for people to access voluntary assisted dying. This is on all fours with section 16 of the Civil Liability Act, which limits and restricts lawyers from advertising for personal injury claims. I think it is self-explanatory in that regard. We think this new clause is very important, because some practices will set themselves up as voluntary assisted dying centres. That has all sorts of ramifications with the independence that has been sought. Also, I think that patients need to have independent medical practitioners. It is all part of a continuum, but if it is good enough for lawyers to be restricted in acting for clients who are pursuing personal injury claims, we think that it is more than appropriate in these circumstances.

Mr P.A. KATSAMBANIS: I rise to support proposed new clause 102A. As the member for Girrawheen has outlined, it is pretty similar to some of the prohibitions that other professions have in relation to some of their advertising. It does not stop medical practitioners from providing advice or even letting people know about their rights under this legislation, but it covers off the concern in some sections of the public—a concern I share, I must say—that there may be one or two people who want to set up a business based around voluntary assisted dying. That would shift the goalposts from a procedure that is available to people at the end of life to something that is directly marketed to people as something that they ought to consider more generally. I think the proposed new clause is well drafted and well calibrated, particularly subclause (4) which offers some defences or indicates when people do not contravene the prohibition against publishing statements; that is very comprehensive. They can still make statements to someone who is receiving ongoing health services from a medical practitioner or a health facility, and a medical practitioner can make statements around the operation of this legislation, the person’s right to access voluntary assisted dying, and the conditions under which the medical practitioner is prepared to do anything under this legislation as a medical practitioner. Again, it does not limit any of that. Practitioners can continue to do that. Because there are question marks about how close the two medical practitioners might be to each other, particularly in a business sense, this sort of prohibition is necessary. I think it is offered in good faith, and I hope the government accepts it in good faith because it adds an extra layer of protection and is a safeguard. The government likes to use the term “safeguard”, and I think this is a very appropriate safeguard for the restriction of those rather rare individuals—we know they exist—who might want to treat this sort of regime as a massive business opportunity rather than as a health option, one other choice, as it is portrayed by the proponents of the legislation. That is why I support this proposed new clause. I think it is very reasonable and I hope the house gives it fair consideration.

Mr R.H. COOK: I certainly understand the sentiment behind this proposed new clause. It is important that we have a set of guidelines or driving protocols for professional conduct standards about the way in which medical practitioners conduct themselves, particularly with regard to this legislation. From that point of view, I certainly commend the member for her choice of words. I will say that I do not believe it is necessary for the reason that the conduct of medical practitioners is suitably regulated under the Health Practitioner Regulation National Law (WA) Act 2010. That is the law that we rely upon for both this legislation and other legal frameworks around the conduct and activities of medical practitioners. Two sections within that act are pertinent. Section 39 provides for the development of regulations, codes and guidelines, particularly with regard to the advertising of a regulated health service by health practitioners. Section 41 provides for approved registration standards, codes or guidelines in disciplinary proceedings.

Although I understand the sentiment with which the member has moved this proposed new clause, I do not believe it is necessary because these activities are already regulated for the purposes of the conduct of medical practitioners. I note the comments of the member forHillarys about commerciality, but that is a theme that we have visited before.

Ms M.M. QUIRK: I knew it was a somewhat quixotic endeavour. Is the minister aware that certainly overseas specialised clinics that promote themselves as being solely for voluntary assisted dying have been set up? To regulate conduct by way of professional codes or ethical guidelines is not good enough for lawyers in the case of the Civil Liability Act, so I am probably leading with my chin in asking whether the minister is saying that lawyers need more constraints and restrictions on them by way of enforceable legislation than do doctors. The Civil Liability Act is principally there so that ambulance-chasing lawyers behave themselves. Is the minister telling the chamber that he would not contemplate that the ethical standards of anyone in the medical profession would not be similarly compromised?

Mr R.H. COOK: No, member; I am simply saying that we have very effective regulation of our medical workforce through the Health Practitioner Regulation National Law.
Division

New clause put and a division taken, the Acting Speaker (Ms J.M. Freeman) casting her vote with the noes, with the following result —

Ayes (12)
Mrs L.M. Harvey Mr Z.R.F. Kirkup Dr D.J. Honey Mr R.S. Love Dr M.D. Nahan Mr P.A. Katsambanis Mr S.K. L'Estrange Ms L. Mettam (Teller)

Noes (36)
Ms L.L. Baker Mr T.J. Healy Mr Y. Mubarakai Ms R. Saffioti Dr A.D. Buti Mr D.J. Kelly Mr K. O'Donnell Mr J.J. Shaw Mr J.N. Carey Mr F.M. Logan Mrs L.M. O'Malley Mr D.A. Templeman Mrs R.M.J. Clarke Mr M. McGowan Mr P. Papalia Mr C.J. Tallentire Mr M. Folkard Mr D.R. Michael Mr D.T. Punch Mr R.R. Whiteby Ms J.M. Freeman Mr K.J.J. Michel Ms C.M. Rowe Mr B.S. Wyatt Ms M.J. Davies Ms S.F. McGurk Mr P.J. Rundle Ms A. Sanderson (Teller)

New clause thus negatived.

Clause 103: Cancellation of document presented as prescription —

Mr Z.R.F. KIRKUP: Thank you very much, Acting Speaker. As always, your efficiency is appreciated.

At subclause (2) under “Cancellation of document presented as prescription”, is there a time frame within which the physical cancellation must occur? I note, again, we usually would have written the word “immediately” but that language has been constrained. I am keen to understand why the supplier must cancel the document by marking it, and if they do not, obviously there is a term of imprisonment for up to 12 months. Is there a specific time frame around that? Imagine a situation in which the supplier has not cancelled the substance and they get caught and then they say, “I was going to cancel it, but I just didn’t get around to it” or something like that. There is no specific time frame in which to do that. I am keen to understand what that might look like.

Mr R.H. COOK: Member, in that scenario, if the supplier said, “I was going to cancel it. I saw that. Yes, I realised I should have cancelled it, but I haven’t done it six months later”, that would not be adequate. It is at the point the decision is made that they will cancel the substance that we would expect them to proceed forthwith.

Mr P.A. KATSAMBANIS: I note that the CEO needs to be informed of the cancellation, but under this clause there is no need to inform the board. Is there a reason why the board will not be informed given that it would be given notice of the prescription in the ordinary course of events?

Mr R.H. COOK: Member, I am advised that the board will be able to see the cancellation through the portal arrangements, so it is not necessary. Also, in the context of the management of medications and poisons and the prescriptions thereof, it is appropriate that that is oversighted by the CEO in terms of that chain of command.

Clause put and passed.

Clause 104: Contact person to give unused or remaining substance to authorised disposer —

Mr P.A. KATSAMBANIS: This clause creates penalties for the contact person not returning the prescribed substance to an authorised disposer. When the contact person is appointed, they will be given some information that will include a list of “musts”. Will that information on the approved form include a step-by-step guide of their obligations under clause 104 and the penalties if they do not comply? The last thing we want is someone to inadvertently fall foul of this because they simply were not informed of their obligations.

Mr R.H. COOK: Yes, and that is precisely the intent of clause 148, which we will come to in due course—sooner rather than later, I hope! Clause 148 deals with the information that the board needs to send to a contact person so that they are aware of their obligations under the act.

Ms M.M. QUIRK: The minister is, of course, correct. We need to look at clauses 67, 104 and 148 together. Clause 67 provides that a contact person may refuse to continue in that role. I think we canvassed with the Attorney General last night the situation in which the contact person has been given their instructions, duties and role, and they were sent out in some prescribed form. The contact person may well have consented on the basis that they were just supplying the phone number or point of contact, and English may be their second language. There does not seem to be any requirement to ensure that the role is adequately understood by the contact person, and that may well make them liable to imprisonment for 12 months. I have to say that we did not get a satisfactory answer; in fact, we got a misleading answer from the Attorney General last night. I would like to clarify whether consideration has been given to how a communication is given to a contact person whose second language may be English.
Mr R.H. COOK: As the member knows, this was discussed extensively last night, so I do not mean to go further into it. Obviously, it is appropriate that the information is in a form that the contact person understands, and that the contact person can be reasonably expected to understand their obligations under the legislation. From that perspective, we discussed the occasions on which the chief executive officer, through the implementation phase, would be required to make sure that the laws are managed in a way that acknowledges people from different cultural backgrounds. Again, clause 148(b) outlines the support services available to assist the contact person to comply with the requirements referred to in paragraph (a). It contemplates the fact that support would be provided to the contact person so that they can fulfil their role.

Mr Z.R.F. KIRKUP: Under clause 104(1), the substance has to be provided back within 14 days. That entirely has merit. What happens if an aberration occurs? I am thinking in particular of a remote community or regional area where it is very difficult for that to come back from. I am hoping that there would be some leniency or some ability for that to be looked at as an extreme circumstance that would not automatically be prosecuted. Would that be the case? What would that require? Who would be in charge of that? Would the CEO be initiating it?

Mr R.H. COOK: The CEO is the authorised officer in relation to simple offences, so, obviously, they would take that into account in the context of a remote community or something of that nature.

Mr Z.R.F. KIRKUP: In the event that a matter might be referred by the board, if the board sees it as a concern, would the mechanism then be that the board would refer it to the CEO? I am imagining a situation in which, because of the bureaucratic situation that might exist, the board might immediately trigger it to the police, for example, rather than the CEO. What is the definition there in terms of simple offences? Is it 12 months’ imprisonment?

Mr R.H. COOK: Ordinarily, in the first instance, the Voluntary Assisted Dying Board would notify the CEO if it became aware of any irregularities, but it may alert the police if it had a view about that. As always, the police will investigate with the powers they have under the Medicines and Poisons Act or something of that nature, and would undoubtedly liaise with the chief executive officer, who has overall responsibility for that act, to see whether they should investigate further or the matter is in hand and the CEO is exercising his or her authority under the simple offence provisions.

Mr Z.R.F. KIRKUP: I refer to subclause (1). If a person has revoked their self-administration decision, the contact person has to give the prescribed substance to the authorised disposer. Why is the patient or the agent, who was previously charged with retrieving the substance, not required to give it to the disposer—unless I have misread that?

Mr R.H. Cook: The patient has died.

Mr Z.R.F. KIRKUP: No, subclause (1) is not in the event that the patient has died. Subclause (2) covers that.

Mr R.H. COOK: There is nothing to stop the patient from retrieving the substance. The agent, under this bill, is simply the person who retrieves the medication from the authorised supplier. The contact person, as we have discussed extensively, is responsible for the voluntary assisted dying substance under the act and, ultimately, must bear the burden of responsibility to give it to the authorised disposer. There is nothing to stop the patient from doing it, but as I have reminded the member for Darling Range on a number of occasions, these people are at the end of their lives, so chances are that they are not very mobile.

Mr Z.R.F. KIRKUP: I appreciate that, minister.

Referring to subclause (1), I imagine that the self-administration decision will be made and the patient might be at the very early stage rather than the end stage and will make a decision to revoke their self-administration decision. I refer to subclause (2). The way in which the legislation is drafted suggests that once a patient dies, the contact person must return the substance within 14 days. I can imagine a situation, possibly, that would occur in which the patient is, on the balance of probabilities, going to die within six months, so they go through the process and the contact person is appointed and everyone is ready to go, but the decision is not yet made that the person wants to take the substance. They might not have contact with the contact person. A good example is that I have not spoken to my mother for about six weeks.

Mr T.J. Healy: Call your mother!

Mr Z.R.F. KIRKUP: Thank you very much!

I can imagine a situation in which the contact person might not be in regular contact with the patient, especially over a number of months.

Several members interjected.

The ACTING SPEAKER: Members!

Mr T.J. Healy: I’ll call her!

Mr Z.R.F. KIRKUP: Thank you very much, member for Southern River. I am sure she would appreciate your call!
Why is it 14 days from death? I can imagine a situation in which the patient may have passed on without having taken the substance, but the contact person might not be aware of it and in three weeks they call them or they realise that something has happened and that the patient has passed away, but they have received no notification of it. That person may possibly be automatically charged with an act that may see them be imprisoned for 12 months.

Mr R.H. COOK: Notwithstanding the frequency with which the member for Dawesville contacts his mother, he may be judged in this chamber but he is not held to account by the laws of the land. In this particular case, a contact person will in fact have obligations and legally binding responsibilities under the legislation. They are expected to keep in regular contact with the patient. Regardless of whether that patient leaves us now or in three or six months’ time or whatever, the contact person basically will have responsibility for the voluntary assisted dying substance.

Mr Z.R.F. KIRKUP: I would like Hansard to note that the member for South Perth just noted that I would not be his contact person, based on my lack of frequency of contact with my mother by the sounds of it!

I appreciate that there are obligations; I had not thought about that.

Mr P.A. Katsambanis: Also, you are likely to outlive him.

Mr Z.R.F. KIRKUP: I might.

I appreciate that obligations are part of the burden of becoming a contact person. That makes perfect sense; I appreciate the minister’s clarification.

With respect to subclause (3), there is reference to any prescribed substance that the contact person knows is unused. What happens if the person does not know if there is an unused portion? I do not know what circumstances might exist, but perhaps the substance is prepared and then locked away or hidden because the patient might not want the substance to be out in public or in whatever setting in which they are doing this, so they put it away somewhere and it is very difficult to find. Of course, the contact person now has 14 days in which they must try to track it down. I appreciate the minister’s response to my previous question about having regular contact and engagement, but in the event that they cannot identify or locate it, which I could imagine may happen at some point in time, will they possibly be liable to be charged or imprisoned? Is there any option to try to stop that occurring in the first instance?

Mr R.H. COOK: This subclause is essentially there, I guess, to protect the contact person if they could not reasonably know about the unused portion. As the member said, it may be at the bottom of the syringe, at the back of a cupboard or something like that. It is essentially allowing for that fact.

The ACTING SPEAKER (Ms J.M. Freeman): The question is that clause 104 stand as printed. All those in favour say aye.

Ms M.M. QUIRK: Madam Acting Speaker.

The ACTING SPEAKER: Oh; member for Girrawheen.

Ms M.M. QUIRK: You groaned.

The ACTING SPEAKER: Who groaned?

Ms M.M. QUIRK: I thought you did, Madam Acting Speaker; I apologise.

We could have a scenario in which a prescribed substance for self-administration is with the patient and he or she dies, either without having to have that prescribed substance or having had only a portion thereof. How do we keep track of that? I know that it is only small quantities in the larger scheme of things, but what is to stop the contact person from maybe pocketing half or two-thirds of the substance and returning a third and saying, “Oh, well; this is all the patient needed to take before they shuffled off this mortal coil.” That is what I am asking. How do we prevent the contact person from retaining the drugs or misleading authorities about how much was used?

Mr R.H. COOK: This is precisely why we have penalties under the legislation for the misuse of either these substances or other substances. A contact person or anyone who is spending time with the patient might come in contact with any number of medications, which would be available to the patient and other people in the patient’s house. I am reminded of the commentary of the Leader of the Opposition last night when she discussed her circumstances. She was amazed at the amount of different sorts of drugs, some very powerful, that were essentially left over after the event. There are very strict laws under the Medicines and Poisons Act and the Misuse of Drugs Act, and the contact person is subject to extra responsibilities, which are detailed in clause 104.

Ms M.M. QUIRK: Presumably, if a contact person returns a portion of the drugs, but not all of them, will they still be liable for possession of whatever part of the substance they decided to retain?

Mr R.H. COOK: Yes.

Mr Z.R.F. KIRKUP: I note that all the penalties prescribed in this clause are 12 months’ imprisonment. Is there any prospect that that will be relaxed or varied, or is it a fixed point in time? Is it a minimum sentence of 12 months’ imprisonment or is that the maximum? I am keen to gain some understanding about that because I imagine it would vary according to the circumstances.

Extracted from finalised Hansard
Mr R.H. COOK: That is the maximum penalty. In the context of prosecution and sentencing, there may be variations on that theme.

Clause put and passed.

Clause 105: Recording, use or disclosure of information —

Dr D.J. HONEY: Subclause (1) states —

A person must not, directly or indirectly, record, use or disclose …

I take it that “record” means writing down. Will that include doctors’ notes? To pre-empt where I am heading with this, I would have thought that a doctor would always be able to record all the details of any medical issue that they have been involved with, including this. Given that under this bill someone can raise concerns up to two years later, surely it would be important that a doctor is able to record all the details, including a person’s name and all the details of their involvement in the voluntary assisted dying process. Could the minister please clarify that? Does it apply to doctors’ notes or not?

Mr R.H. COOK: I draw the member’s attention to subclause (2), which sets out things to which subclause (1) does not apply in the recording, use or disclosure of information—that is, paragraphs (a) to (f).

Dr D.J. HONEY: I looked at them but I did not know whether any of them would apply to a doctor’s notes. Would the minister be able to clarify for me which of those paragraphs in subclause (2) cover a doctor being able to take notes, including the details of a person who is subject to the process?

Mr R.H. COOK: I think doctors’ notes would be captured in subclause (2)(a) or (2)(b) in terms of requirements under the act.

Dr D.J. HONEY: I am not labouring this point for any other reason than I want it to be clear that a doctor will be absolutely protected when they take appropriate notes, including a person’s name. Could the minister confirm that with his advisers? It may be that he has already done that, but I would like real confirmation of that.

Mr R.H. COOK: I can provide that clarity. The doctor would obviously record, use or disclose the information for the purposes of performing a function under this legislation, which is outlined in subclause (2)(a). That would absolutely capture that set of activities.

Mr Z.R.F. KIRKUP: Previously, I asked the Premier a question about advertising the schedule 4 and schedule 8 poisons and how that might be displayed online versus advertising information. When the Premier answered that question, he pointed to clause 105 and information that is published in relation to schedule 4 or 8 poisons being covered under this clause as well. I am trying to imagine a circumstance in which the information is not advertised, but the information is published in some way. Will this clause still cover that, if a person provides that information?

Mr R.H. COOK: Yes, I am advised that it will.

Mr Z.R.F. KIRKUP: Thank you, minister. I note that subclause (1) states that a person must not, directly or indirectly, record, use or disclose information, which I think the minister just covered. Does it have to be obtained because the person has a function at any time under the legislation? My reading of that is that they have to have previously been a practitioner, a patient, a contact person or something like that. Will that cover the person who has had no role to play in the process thus far but they are still providing information online? I was getting quite concerned in the sense that the merits of clause 102 in relation to advertising are perfectly sensible. I was worried that captured only people who advertised versus information that has been put out there. My concern is that if the information is put out there under clause 105(1), it will only bind people who have been previously involved in the process. If someone is independent of that or never been part of it, will they be subject to the penalty, and necessarily penalised if they publish information that is related to it?

Mr R.H. COOK: The only way someone would get information about the schedule 4 or schedule 8 drugs used in the voluntary assisted dying substance would be if they had a role to play in the context of the voluntary assisted dying regime, the act or otherwise. Nothing will stop someone from doing their own research overseas or something like that and creating their own pool of information that they draw upon. But in that instance, we say that they do not have any authority or verification that they are the substances involved. For the purposes of what the member is saying, the only way someone would obtain that information would be if they had a role under the act.

Mr Z.R.F. KIRKUP: Thank you very much, minister. I want to provide some context for the position I am coming from. I do not want the details of the substance out there. The member for Morley and, I think, the minister have spoken about other jurisdictions publishing information and the price going through the roof. That is not what we are trying to achieve here in terms of equitable access. I was worried that if a person provides information in relation to the substance in particular but does not advertise it but comes across the information and has no function—a family member, for example—they will not necessarily be a person with a function under the legislation; they would be related. I would consider “function” in the definition to be a role in terms of patient and contact person. They are functions. I am not trying to deliberately go in a cycle here, but I am worried about what
I think is captured under the advertising clause, which has merit and is something I support. I am worried that this clause does not capture that person. If they are not advertising it but are related in some third party fashion, that information could seriously get out there, but from my understanding of how the clause stands, there is no penalty.

Mr R.H. COOK: Regarding the scenario the member described with the family member standing around and so on, someone might say, “This is the stuff” and they could take it away to a lab and analyse it, I suppose. Remember that the details of what is in the voluntary assisted dying substance is not written on the pack, and things of that nature. I am trying to foresee a situation in which it could happen; I simply cannot, other than whether that information is disclosed in a way that is unlawful by someone who is involved in that. I think that clarifies that.

Clause put and passed.

 Clause 106: Publication of personal information concerning proceeding before Tribunal —

Mr Z.R.F. KIRKUP: Clause 106(1) states, in part —

\begin{quote}
**publish** means to disseminate to the public or a section of the public by any means, including the following —

\begin{itemize}
\item a website, an online facility or other electronic means.
\end{itemize}
\end{quote}

I assume that that was incorporated to cover things such as mobile applications or something like that. Is that the reason that that definition has been included?

Mr R.H. COOK: Yes.

Mr Z.R.F. KIRKUP: In relation to a website or something like that that might be hosted outside Western Australia, what capacity do we have to stop that from occurring in the first instance?

Mr R.H. COOK: Our Criminal Code extends to the borders of Western Australia.

Clause put and passed.

 Clause 107: Failure to give form to Board —

Mr P.A. KATSAMBANIS: Clause 107 is headed “Failure to give form to Board” and states —

\begin{quote}
A person who contravenes a provision of this Act listed in the Table commits an offence.

Penalty: a fine of $10 000.
\end{quote}

The table lists a series of about 18 different forms or different sections under which forms need to be provided to the board. My question is a relatively simple one—simply procedural. The penalty is a fine of $10 000. Is there any intention that a modified penalty may be introduced that may be dealt with by infringement notice rather than prosecution, or is it intended that every breach of failure to provide a form would lead to prosecution under this legislation?

Mr R.H. COOK: As the member observed, this is about a failure to provide particular forms to the board, which will incur a maximum fine of $10 000 for a registered health practitioner. It will apply in the same way as the sentencing and fines act in the way that maximum penalty is applied. The CEO will initiate the investigation of these offences.

Mr P.A. KATSAMBANIS: I understand that, but I am just asking whether the CEO at this stage intends to issue a monetary penalty rather than prosecute in the way that the modified fines regime works in Western Australia. All I am seeking to clarify is whether there is a current intention around that.

Mr R.H. COOK: No, member, there is no current intention, but these are obviously very early stages.

Mr Z.R.F. KIRKUP: The accountability mechanism of the form and the role that it will play with the board is quite significant in the relationship the board will have in monitoring the legislation—possibly referring it to the State Administrative Tribunal and the like. I think $10 000 is not an insignificant penalty, but why have we not settled on something a bit larger than that? The whole way through this legislation, the form is central. The provision of quite a number of those forms to the board is central to the oversight, and I am interested about why we did not go with a more significant penalty.

Mr R.H. COOK: It is because this is ultimately about the failure to lodge the forms, not necessarily what is in the forms. It does not mean the activity has not taken place, but this is simply the act of passing the information to the Voluntary Assisted Dying Board. It is a very important governance process that takes place, so it is important that there is a penalty for not lodging those forms. There are obviously the other aspects of the activities that the forms describe and that is captured elsewhere.

Mr Z.R.F. KIRKUP: I could be wrong, but on my count there are probably seven or eight forms. The process is relatively straightforward for the first request. From when the coordinating practitioner coordinates the first assessment to the final request and the administration decision, I can see seven forms, but I could be wrong about the process. They are all reasonably important gates to get through. The board is required to provide a permit or something like that, which we understand, and the board is there to monitor the functions. There is a penalty of $70 000 in total for not returning those seven forms, and if some are entirely missed in the process, that is all. What
will be achieved by the outcome if this is successful is quite significant. A fine of $10,000 seems slightly small compared with the rest of the penalties in the bill. I was genuinely very surprised when I was going through the bill and I got to page 70, as I had seen a lot of very strong penalties, and all of a sudden there was a penalty of just 10 grand for the failure to return the form. It is important for us as parliamentarians and for the board to function; it is central to the ability of the board to function.

Mr R.H. COOK: I can go to the list, if the member likes, but there are significantly more than seven forms.

Mr Z.R.F. Kirkup: But in terms of the process.

Mr R.H. COOK: In the context of the way this would be operate, a portal system would be used. A person would not be able to go to the next form unless they had lodged the previous form. It is also consistent with the relevant penalties in the Victorian legislation. This is about making sure that we have a good pathway of information going to the board at any point in time, and it is important that the penalty reflects that, although many, many forms need to be lodged at any particular point in the process. The member described it as a gateway, and I think that is a good way to describe it. If someone did not lodge one form and then they lodged a form two stages down the process, the board would say, “Hang on, sunshine, you have missed a stage here.” The way things will work in actuality is that a person will not be able to move through the portal unless they do so sequentially, but, in any event, the board would be able to raise red flags very quickly.

Mr Z.R.F. KIRKUP: I appreciate that, minister. We are having this conversation about there being a portal, and because of that the mechanism makes a lot more sense. I hope that the clinical expert panel develops this, because it makes a lot more sense to me in terms of following the journey. I envisaged this scenario while going through the legislation. I know 18 forms are prescribed, but when I was talking about the seven, it was as if there was a clear journey. People do not realise that there is further contact, administration decisions and all that sort of stuff in the 18 forms captured by this clause. I think the portal makes perfect sense and I appreciate the minister’s clarification.

The ACTING SPEAKER: I take that as a comment, member.

Ms M.M. QUIRK: As the minister explained, it is contemplated that the CEO will set up a portal and these forms will be transmitted electronically. Is that the case?

Mr R.H. COOK: Potentially, yes. There is lots of nodding around the room. I think it would be envisaged that it would be on the basis of an online arrangement, yes.

Ms M.M. QUIRK: That probably obviates the concerns I had about receipt.

Mr R.H. Cook: Yes.

Ms M.M. QUIRK: Given that answer, I am intrigued. Clause 21(1), for example, states —

Within 2 business days after deciding to accept or refuse the first request, the medical practitioner must complete the approved form … and give a copy of it to the Board.

That kind of language would not be used if a person was entering the form electronically. I am wondering whether that is a term of art or whether it is just drafting that contemplates that hard copies may be sent. What is the story there? Obviously, it is relevant, as it is one of the contraventions listed in clause 107.

Mr R.H. COOK: Yes. In a modern health system, I think we envisaged that it would be an electronic transmission. I guess we use language like “a copy of” because, ultimately, there may be a situation in which, if something is down, or some other circumstance, there would need to be a physical copy. But in the modern context, we would expect all this to be undertaken online.

Clause put and passed.

Clause 108 put and passed.

Dr D.J. Honey: Can we slow down, please?

The ACTING SPEAKER (Ms J.M. Freeman): No. You have been sitting here. If you have a problem with the Chair, move a dissent.

Clause 109: Court to notify CEO of conviction of offence under Act —

Mr Z.R.F. KIRKUP: I am keen to understand, when the court convicts a person of an offence as is described in clause 109, does the minister imagine that other notification processes would occur outside that? I realise that a lot of the legislation we have before us is the bare minimum, as the minister described it; he hoped that there might be more. Does the minister imagine that he would be informed of that on a regular basis? Does he think that Parliament would be informed of that on a regular basis? I realise that it might be captured in the annual reports, which, of course, occur annually. Ultimately, the minister will be in charge of the operation of the act. Does the minister think that it would be important to make sure that he was made aware of these convictions?

Extracted from finalised Hansard
Mr R.H. COOK: This minister would expect to be told. Obviously, that is up to the chief executive officer and the minister in terms of their relationship. This clause requires a court to send the CEO notice of a conviction and the penalty imposed when the court convicts a person of an offence under the act. It is important for the CEO of the Department of Health to be kept abreast of convictions pursuant to the Voluntary Assisted Dying Act, particularly as the CEO has investigation and enforcement functions under the act. Furthermore, even when a person is found not to be guilty of an offence under the act, they may be subject to disciplinary proceedings, professional misconduct or unprofessional conduct.

Mr Z.R.F. KIRKUP: I thank the minister. The member for Hillarys and I were talking while the minister was conferring with his advisers, and the member for Hillarys provided a not dissimilar response in respect of where we are going with that. There is nothing to prohibit the minister from having that relationship and having that line of sight into what occurs. Just by way of some context for my concern about this, I was quite surprised that, aside from the annual report, the Parliament would not be more involved in this legislation. I look at other serious acts like the terrorism act, the CCC act or something like that under which there are consistent regular—quarterly—notifications to the Parliament of very simple data. We would expect the Parliament to be made aware very quickly of offences, not on a real-time basis, but in terms of reporting. Is there any reason the minister has not considered, apart from annual reports, enshrining more regular updates on things like offences? That is something that, as legislators, we would have expected more comfort on. I am keen to understand why that has not been pursued by the minister.

Mr R.H. COOK: It does not preclude those activities taking place. Ultimately, it comes down to the court about whether the information is publicly available in relation to the conduct of court proceedings. But there is nothing to stop the minister of the day publishing information more frequently. Obviously, it is appropriate that the annual report—which we all rely upon—provides that once-a-year information, but there would be nothing to stop Parliament from requesting that information or a minister publishing it more frequently.

Mr Z.R.F. KIRKUP: I appreciate that, minister. My concerns particularly related to clause 105 with regard to the disclosure information. That exempts the court from providing information but does not necessarily exempt the Parliament from providing information that is acquired as part of the function of the legislation. I appreciate that the minister has not effectively given an undertaking, but we can at least ask questions on it. I appreciate the assurances, I suppose, of the minister that nothing would preclude that from occurring.

Ms M.M. QUIRK: I am a little puzzled about the need for this clause. I would have anticipated that the chief executive officer would, for example, need to supply documentation for the purpose of evidence for court proceedings. I am having difficulty contemplating a prosecution being launched without the CEO having at least been informed, because he or she would need to provide information and relevant material that would form part of the prosecution.

Mr R.H. COOK: The member is quite right. It would be an unusual situation, but it might be, for instance, that the investigation was instigated by the police, not the chief executive officer. But one would imagine that if they are activities undertaken under this legislation, there would probably be a request from police at some point in time. I am pleased that it is here just to make sure that we close the loop.

Ms M.M. QUIRK: Lastly on this, I gather “CEO” includes the CEO or his delegate?

Mr R.H. COOK: Yes.

Clause put and passed.

Clause 110: Who may commence proceedings for simple offence —

Mr P.A. KATSAMBANIS: Clause 110 is headed “Who may commence proceedings for simple offence”. Can the minister define at the outset what is a simple offence?

Mr R.H. COOK: I am happy to provide the information. The member will probably be familiar with it. I am informed that a simple offence is defined in the Criminal Code. They are offences such as not lodging a form, which has a fine of up to $10 000. From that perspective, it is those types of offences. Simple offences are defined in the Criminal Code.

Mr P.A. KATSAMBANIS: This raises a number of issues, one of which I raised with the Premier when he was at the table and we were dealing with the penalty provisions. Why were some of these offences not simply incorporated into the Criminal Code? The Premier indicated that that was not under consideration by the government, and that is fair enough. The second and more important issue is that there are a number of definitions throughout the bill. Clause 5 in division 3 of part 1 has a number of definitions that refer to other acts. For instance, “health service” has the meaning given in section 7 of the Health Services Act 2016 and “medicine” has the meaning given in section 3 of the Medicines and Poisons Act 2014. I would imagine that if we were to use a definition drawn from the Criminal Code, a definition of simple offence that refers to the Criminal Code would have been included on page 8 of the bill between the definitions of “self-administration” and “supply”. Otherwise, everyone is scratching around. These offences are not included in the Criminal Code. If we wanted to refer to

Extracted from finalised Hansard
a term that is defined in the Criminal Code, good drafting practice would have included a definition. I know that we have passed that clause, but I ask the minister whether he would give consideration to either providing a definition in this clause or, at least before the bill goes to the other house, giving consideration to defining “simple offence” in clause 5, “Terms used”.

Mr R.H. COOK: I am not a lawyer, but I am informed that the concept of a simple offence is quite a familiar one in drafting legislation. This clause is about those sorts of offences that would be appropriate for the CEO to commence proceedings for, as opposed to, for instance, the DPP or WA police. It is consistent with the Medicines and Poisons Act, under which the CEO or the delegate is primarily the decision-maker for prosecutions, and the medicines and poisons regulations branch would conduct investigative work and then make a prosecution recommendation to the CEO or delegate. From that perspective, it is consistent with current laws that work within this context. I appreciate that the member might have a different view about the drafting style or arrangements, but we think it is perfectly appropriate.

Mr P.A. KATSAMBANIS: It is not simply the drafting style. The drafting style leads to interpretation of the legislation. This legislation contains a series of offences. They are quite contained; it is not as though there are thousands of them. Part 6 has the offences. Can the minister indicate to the house for the record, for the public and for everyone who will use this legislation which of those offences are to be deemed to be simple offences and which are not?

Mr R.H. COOK: Member, it is for any of those offences that do not involve imprisonment, such as board forms and things of that nature. I am happy to come back tomorrow morning with a complete list to clarify that for the member. I am further advised that under clause 98, “Unauthorised administration of prescribed substance”, a person commits a crime if the person administers a prescribed substance to another person. When the offence is described as a crime, it is not a simple offence in that context.

Mr P.A. KATSAMBANIS: What is it then? Is it when the offence is described as a crime, or when the offence does not attract a penalty of imprisonment? If it is the latter, the only one I can see in these offences is in clause 107, which would have been just as simple.

Mr R.H. Cook: By way of interjection, it is the former, not the latter.

Mr P.A. KATSAMBANIS: It is the former.

Mr R.H. Cook: It’s those offences not described as crimes.

Mr P.A. KATSAMBANIS: It is those offences not described as crimes. There are a few of those that are not described as crimes but still attract a penalty of imprisonment. I am happy for the minister to come back, as he indicated, tomorrow morning, or at some stage tomorrow, and give me an exhaustive list and then I will carry on with my other questioning around this.

If the prosecution is going to lie with the CEO or someone authorised by the CEO, is it the intention that a prosecution unit will be set up within the Department of Health, or is the CEO likely to authorise the Director of Public Prosecutions, or police prosecutors for that matter, to be the authorised prosecutors under this clause? What is the intention for how it will work in practice?

Mr R.H. COOK: I do not know whether the intention of the chief executive officer is to have a specific unit. But, obviously, the chief executive officer already has obligations under the Medicines and Poisons Act, the Misuse of Drugs Act and the Public Health Act. For instance, the medicines and poisons regulation branch conducts investigative work and then makes a prosecution recommendation to the CEO or the CEO’s delegate. That is in accordance with section 122 of the Medicines and Poisons Act. Other positions delegated under section 102 of the Medicines and Poisons Act include the Chief Health Officer, the deputy Chief Health Officer and the Chief Pharmacist. After an investigation, the CEO of Health may authorise the WA Police Force or the Director of Public Prosecutions to commence a prosecution for a simple offence, but the department already has significant infrastructure to manage these things. It could be that within those regulatory units, it has a unit specifically set up for this, but that is a decision for the CEO.

Mr P.A. KATSAMBANIS: Perhaps the minister might seek some advice, if he can, between now and tomorrow on that as well. As the minister described, he is the Minister for Health and he has a lot more understanding of the way the department is structured. But, as I understand it, those prosecutorial units the minister mentioned are effectively standalone units that deal with issues they are already tasked with, so the people under the Medicines and Poisons Act deal with medicines and poisons and the people under the Public Health Act deal with public health. Will this job require a new unit or will one of the existing units be tasked with doing this job?

Mr R.H. COOK: There would not necessarily be a dedicated unit across the act. Obviously, this bill involves heavy interaction with the Medicines and Poisons Act, so obviously there would be crew in there associated with that. Other areas are to do with the conduct of medical practitioners and so forth. The CEO may wish to set up a dedicated unit, but I suspect that that person would simply bring teams together out of the specific units that have expertise in those areas.

Extracted from finalised Hansard
Mr R.H. COOK: The member is quite correct. They do use different language, but that does not mean that they are not consistent. I did not catch the final question that the member asked.

Ms M.M. QUIRK: I am still not sure of the rationale behind the CEO’s signing off on a prosecution before it is commenced.

Mr R.H. COOK: I am advised that these are lower order offences in this bill, so it is appropriate for the CEO to be the investigator, rather than some different authority, such as the police or the Director of Public Prosecutions.

Ms M.M. QUIRK: There is no problem, administratively, with the CEO understanding and being made fully aware of what is proposed to be done in the way of prosecution action. The problem I have with this clause is that it then becomes an element that the prosecution must go along with a bit of paper saying that there is this approval. Although that is easily done, it is also sometimes forgotten. I understand why it would be administrative practice that the CEO needs to be made aware of all prosecutions and administratively approve of them, but I do not understand why this formal provision needs to be in the bill.

Mr R.H. COOK: It is not an extraordinary clause. It is similar to clauses used in other aspects of simple offence legislation within the government. The CEO is the best person to commence prosecutions. It is good that we have it defined around the CEO so there is no confusion about who has responsibility and carriage of these things. It is just to maintain clarity about who to go to to get these things happening.

Mrs A.K. HAYDEN: I want to follow on from the comments of the member for Hillarys about simple offences. The minister has said that he is going to table the simple offences. That is great because, unlike him, I am not aware of the simple offences list and we have not been able to get it from the minister this evening. I appreciate that the minister will make that available tomorrow. Can the minister also indicate which clauses in the bill the CEO has jurisdiction over to prosecute? Again, it is not outlined in the legislation, so someone who is going back over this legislation down the track can flick through and see which are relevant and not relevant. The legislation has it in all the other clauses so readers can make that available tomorrow. Can the minister also indicate which clauses in the bill the CEO has jurisdiction over to prosecute?

Ms M.M. QUIRK: I am advised that these are lower order offences in this bill, so it is appropriate for the CEO to be the investigator, rather than some different authority, such as the police or the Director of Public Prosecutions.

Ms M.M. QUIRK: This clause makes clear that a prosecution for a simple offence under this Act can only be commenced by the CEO or by a person authorised by the CEO to do so.

This clause is consistent with section 122 of the Medicines and Poisons Act 2014 (WA).

This is what the minister has already told us. However, section 122 of the Medicines and Poisons Act does not refer to simple offences. I suspect that that may well be because all the offences under that act are simple offences, but it says that a prosecution for a simple offence under this act may only be commenced by the CEO or person authorised by the CEO. Clause 110 of this bill and section 122 of the Medicines and Poisons Act, although they are consistent, do not use similar wording. I also want to know what the rationale is for the CEO having to authorise this prosecution.

Mr R.H. COOK: The member is quite correct. They do use different language, but that does not mean that they are not consistent. I did not catch the final question that the member asked.

Ms M.M. QUIRK: I am still not sure of the rationale behind the CEO’s signing off on a prosecution before it is commenced.

Mr R.H. COOK: I am advised that these are lower order offences in this bill, so it is appropriate for the CEO to be the investigator, rather than some different authority, such as the police or the Director of Public Prosecutions.

Ms M.M. QUIRK: There is no problem, administratively, with the CEO understanding and being made fully aware of what is proposed to be done in the way of prosecution action. The problem I have with this clause is that it then becomes an element that the prosecution must go along with a bit of paper saying that there is this approval. Although that is easily done, it is also sometimes forgotten. I understand why it would be administrative practice that the CEO needs to be made aware of all prosecutions and administratively approve of them, but I do not understand why this formal provision needs to be in the bill.

Mr R.H. COOK: It is not an extraordinary clause. It is similar to clauses used in other aspects of simple offence legislation within the government. The CEO is the best person to commence prosecutions. It is good that we have it defined around the CEO so there is no confusion about who has responsibility and carriage of these things. It is just to maintain clarity about who to go to to get these things happening.

Mrs A.K. HAYDEN: I want to follow on from the comments of the member for Hillarys about simple offences. The minister has said that he is going to table the simple offences. That is great because, unlike him, I am not aware of the simple offences list and we have not been able to get it from the minister this evening. I appreciate that the minister will make that available tomorrow. Can the minister also indicate which clauses in the bill the CEO has jurisdiction over to pursue this? Again, it is not outlined in the legislation, so someone who is going back over this legislation down the track can flick through and see which are relevant and not relevant. The legislation has it in all the other clauses so readers can flick back and forth to the clauses that they are relevant to. It would be appreciated if that could be included as well.

Mr R.H. COOK: Yes. Just to clarify the member’s request, I assume she wants those simple offences that the CEO will be responsible for—not all the things that the CEO will be responsible for—

Mrs A.K. Hayden: No, the simple offences.

Mr R.H. COOK: — and the clauses in which they occur.

Mrs A.K. HAYDEN: I think the minister answered this in reply to the member for Girrawheen. I am sorry if I did not hear it correctly, but can anyone other than the CEO or someone the CEO authorises prosecute any simple offences? The CEO can and if he or she authorises a person, they can. Is there anyone other than that who can prosecute these?

Mr R.H. COOK: As I explained to the member for Girrawheen, the CEO is the go-to person to begin the investigation. The CEO will be able to authorise the Western Australia Police Force or the Director of Public Prosecutions to commence prosecutions for a simple offence. As I said, the lower order offences under the act would not ordinarily pique the interest of the Western Australia Police Force. They are offences that are not described as crimes, so it is appropriate that the CEO will have carriage of those offences.

Mrs L.M. HARVEY: I seek further clarification from the minister, because that is not what the clause states. It states—

A prosecution for a simple offence under this Act can only be commenced by the CEO or by a person authorised by the CEO to do so.

The clause states that it will not be just the CEO who can commence prosecutions for a simple offence. It can also be a person who the CEO may authorise. We would like to understand who might those individuals be.

Mr R.H. COOK: It will not surprise the member to hear that the Chief Health Officer, the Deputy Chief Health Officer or the Chief Pharmacist are likely go-to people. The chief executive officer may authorise the Western Australia Police Force or the DPP to commence a prosecution.

Mr Z.R.F. KIRKUP: From the minister’s own awareness, are there any other circumstances in which the CEO can initiate investigations or prosecutions at the moment? I realise that for health practitioners, the Australian Health Practitioner Regulation Agency can do that. I am keen to understand whether there are similar simple offences for which the CEO can initiate.
Mr R.H. COOK: Yes, member; under the Medicines and Poisons Act and the health act. The member would be surprised what gets captured under the health act—everything from the storage of food through to sewage and all manner of activities.

Clause put and passed.

Clause 111: Time limit for prosecution of simple offence —

Mrs A.K. HAYDEN: This is a very quick one, minister. I will ask two questions in one so that we do not need to keep getting up and down. Firstly, why is a time limit included? Can the minister explain why there is a time limit in the bill for a prosecution to commence within two years after the day on which the offence is alleged to have been committed? Secondly, subclause (2)(b) states —

The prosecution notice need not contain particulars of the day on which the offence is alleged to have been committed.

I am finding that to be a bit of a conflict. Can the minister tell me, firstly, why there is a time limit of two years; and, secondly, why, under subclause (2)(b), no day is required to be put on the prosecution notice?

Mr R.H. COOK: This clause sets out the time limit for the prosecution of a simple offence. The prosecution must commence within two years after the day on which the offence was committed or on which the evidence of the alleged offence first came to the attention of a person authorised under clause 110, who is otherwise known as the CEO. To answer the member’s question, the period of two years is consistent with the Medicines and Poisons Act. The time limit relates to when the alleged offence first came to the attention of the person and not necessarily to when the offence took place.

Mrs A.K. HAYDEN: What if it does not come to their attention until two years and one day after the offence? Are they able to prosecute that or is it just two years regardless? Again, there are two different lines there.

Mr R.H. COOK: It is self-evident. If it is two years and one day after the alleged offence came to their attention, they cannot be prosecuted.

Clause put and passed.

Clause 112: Protection for persons assisting access to voluntary assisted dying or present when substance administered —

Mr Z.R.F. KIRKUP: Can the minister give me some guidance of how paragraph (a) might reconcile with previous offences relating to inducement or coercion? This obviously is about someone who has acted in good faith. It states —

in good faith, assists another person to request access to, or access, voluntary assisted dying in accordance with this Act; …

The bill includes clauses to stop coercion and things like that. Is this just a protection clause for somebody who is trying their best as part of the functioning of the legislation?

Mr R.H. COOK: This clause provides a protection from criminal liability. This clause applies to a person who in good faith assists or facilitates any other person to access the voluntary assisted dying process in accordance with this bill. This clause also applies to persons who are present at the time of the administration of the prescribed substance. The patient’s families, friends or carers support the patient during the voluntary assisted dying process and should be free to do so in accordance with this bill.

Mr Z.R.F. KIRKUP: Thank you, minister. I refer to paragraph (b), which is about a person being present when self-administration occurs. I am trying to understand situations in which this clause might be applicable. There could be a whole number of people in the room. If the legislation is not followed, will this still provide them with protection from criminal liability? If a patient goes about the process in a manner that is contrary to the bill as it stands at the moment, or the practitioner goes about it in a manner that is contrary to the bill, the people who are present are not expected to understand the full content of the legislation simply by virtue of the fact that they are there. They are not expected to understand it, and the bill will provide them with the necessary protection from any legal issues. Further to that, they could not be defined therefore as an accessory after the fact or anything like that; is that correct? I seek the minister’s satisfaction.

Mr R.H. COOK: Yes, that is the precise intent and effect.

Clause put and passed.

Clause 113: Protection for persons acting in accordance with Act —

Mr Z.R.F. KIRKUP: I am keen to understand how the provisions in clause 113(3) will be ascertained. What will happen if the whole way through there are persistent issues with a practitioner, for example? How will we ascertain whether “the doing of the thing” is not regarded as a breach of professional ethics and things like that? When I was going through this clause, I did not quite understand this. Maybe that is because I do not understand the intricacies of professional misconduct for health practitioners. I am keen for the minister to provide more clarification on subclause (3) if possible.

Extracted from finalised Hansard
Mr R.H. COOK: This is to provide general protection from criminal liability under the Voluntary Assisted Dying Act—civil liability and professional liability. The proposed section protects a person who in good faith does a thing in accordance with the Voluntary Assisted Dying Act, or believes on reasonable grounds that the thing is done in accordance with the Voluntary Assisted Dying Act.

Mrs A.K. HAYDEN: Can the minister maybe give an example of what the “thing” would be—just one?

Mr R.H. COOK: Given the strict process in the bill and the various points to check compliance, it will be difficult for a medical practitioner to deviate from the bill without a purposeful act, thus noncompliance in error is likely to apply only when there has been a minor administrative error, such as in completing forms and things of that nature. It is simply to protect someone in the event that they, as I said, believe on reasonable grounds that the thing they are doing is in accordance with the Voluntary Assisted Dying Act.

Clause put and passed.

Clause 114: Protection for certain persons who do not administer lifesaving treatment —

Mr P.A. KATSAMBANIS: Clause 114 provides protection for a range of people who are defined as registered health practitioners, or ambulance officers or some other person who has a duty to administer lifesaving treatment to another person. The protection is provided when those people do not provide lifesaving treatment because they are under the impression that the person does not want that treatment. At the outset I want to, firstly, canvass the minister that that would then have to do what they ordinarily do and provide that treatment. Is that right?

Mr P.A. KATSAMBANIS: Clause 114 provides protection for a range of people who are defined as registered health practitioners, or ambulance officers or some other person who has a duty to administer lifesaving treatment to another person. The protection is provided when those people do not provide lifesaving treatment because they are under the impression that the person does not want that treatment. At the outset I want to, firstly, canvass the minister that that would then have to do what they ordinarily do and provide that treatment. Is that right?

Mr R.H. COOK: Yes, that is spot on. If a patient changes their mind and requests life-sustaining measures, health practitioners or ambulance officers would be required to provide life-sustaining treatment as able. It is a tricky situation, is it not, but obviously it is an important clause to make sure that we protect these officers.

Mr P.A. KATSAMBANIS: This protection is around not administering lifesaving treatment, and it covers both criminal and civil protection as well as anything considered to be a breach of ethics, standards or professional misconduct and the like, and that is good. That is as it should be. However, I want to countenance an opposite scenario.

Mr R.H. COOK: This essentially protects a group of people who have a sworn duty to protect and provide lifesaving treatment. In the event that they come across a circumstance in which they would not reasonably know or be aware that the person is acting within the voluntary assisted dying legislation and they administer lifesaving treatment on this person—I think we are visualising a pretty bizarre scenario there, but let us just go with it for the moment—they would be protected because they are already protected under their own jurisdictions to administer lifesaving treatment, regardless of whether that person has separately sought to access voluntary assisted dying. The intent of this clause is to protect those persons from doing something that they otherwise would be professionally bound, and in some contexts legally bound, as a member of that profession, to undertake. It simply makes sure that they do not get prosecuted in that context because they are protected by the voluntary assisted dying legislation.

Mr P.A. KATSAMBANIS: I am not necessarily sure whether we are dealing with totally bizarre circumstances, because as we know from other jurisdictions that have self-administration, there are circumstances in which people self-administer enough substance to render themselves unconscious, but not quite enough to get to the point at

Extracted from finalised Hansard
which the substance kills them, and after some time they come back to consciousness. It does happen, so it is possible that someone could find a person who is unconscious and not dead in those sorts of scenarios. Irrespective, I take it from the minister’s answer that the protection in the case that I outlined, the opposite to what clause 114 provides for, would come from the general protection of a person who has a duty to provide lifesaving treatment to another person. They would rely on that, whether it is a common law or some statutory protection. Does the minister believe that that duty exists anyway, so he did not need to provide any separate coverage of it in this legislation? Am I putting words in the minister’s mouth or is that basically correct?

Mr R.H. COOK: No, that is absolutely correct. The member referred to subclause (1) of this clause. These are people who are registered health practitioners, ambulance officers or anyone else who has a duty to administer lifesaving treatment to another person. It is about protecting them from having to carry out that duty in this context.

Mr Z.R.F. KIRKUP: We are not there yet but I might take the opportunity to wish the member for Churchlands a happy birthday. We are not yet in the next day; we will wait a minute.

The SPEAKER: I think you should withdraw!

Mr Z.R.F. KIRKUP: I will not!

Minister, subclause (1)(c) states that a protected person means —

a person (other than a person referred to in paragraph (a) or (b)) who has a duty to administer lifesaving treatment to another person.

Is there some other broader definition of occupations that might fall under this paragraph that the minister can provide some information on? I am imagining someone like a surf lifesaver, for example. Would they be captured under the legislation? When I raised this clause in the town hall meetings I did in my district, people were quite pleased that this particular clause is there. They were worried if they were an ambulance officer or someone like that—but in this case it was about their grandchildren—who performed lifesaving functions, otherwise are there other definitions of different occupations that the minister could provide us more information on who would not be covered as a registered health practitioner, are not an ambulance officer but might otherwise provide lifesaving treatment?

Mr R.H. COOK: It is the type of person the member is talking about: a surf lifesaver, a first aid officer, a firefighter, potentially a State Emergency Service officer—anyone who is required to provide assistance in certain circumstances that define their duties.

Mr Z.R.F. KIRKUP: Subclause (2)(b) states —

the protected person believes on reasonable grounds that the other person is dying after self-administering or being administered a prescribed substance in accordance with this Act.

Taking away when a practitioner has done that administration, which is quite obvious, how would that be arrived at as a very quick decision-making process? I am conscious that it might cause myriad possibilities whereby people could suggest that the reason they did not administer lifesaving treatment might be because they thought someone was reasonably accessing the medication or substance. I am sure it has been thought through. I am just keen to understand what that might look like.

Mr R.H. COOK: Family members would say, “No, it is okay, this person is accessing voluntary assisted dying under the act. Here is a form; here is a doctor who says it.” There are any number of circumstances in which after a person asks why they did not provide lifesaving treatment to the patient they would say, “They were surrounded by family and friends, all of who claimed this person was doing it as consistent with the Voluntary Assisted Dying Act”.

Then it would be pretty unfair to prosecute that person for not then having done it, given that all those people standing around would give them reasonable grounds to believe that the person was dying after self-administration.

Mr Z.R.F. KIRKUP: Just in case I was not particularly clear, this was just in relation to the self-administration option. I am conscious that if someone was not necessarily performing their function, they could simply claim that they thought the person was accessing the VAD substance. It might not be in the circumstances the minister described when they are surrounded by friends or family. That was it. I appreciate the minister has probably looked at that.

Mr J.E. McGrath interjected.

The SPEAKER: Put your shoes on please, member for South Perth.

Mr Z.R.F. KIRKUP: I could smell that.

There was some capacity for that which I was concerned about that the member for South Perth just described and the minister probably did not hear.

Clause put and passed.

Debate adjourned, on motion by Mr D.A. Templeman (Leader of the House).

Extracted from finalised Hansard
Resumed from 18 September.

Clause 115: Board established —
Debate was adjourned after clause 114 had been agreed to.

Mr P.A. KATSAMBANIS: This clause is in part 9, which establishes the Voluntary Assisted Dying Board. I just want to give the minister an opportunity to put on the record what the role of the board is intended to be and why it was seen as necessary to establish the board in order for this legislation to work.

Mr R.H. COOK: I will decline that opportunity; we have discussed the board and its monitoring and oversight role at length. One of the recommendations of the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying was that an oversight body should be established to carry out certain functions in relation to voluntary assisted dying.

Clause put and passed.

Clause 116: Status —

Mrs A.K. HAYDEN: Clause 116 states —

The Board is an agent of the Crown and has the status, immunities and privileges of the Crown.

Can the minister explain what status, immunities and privileges of the crown are held by the board?

Mr R.H. COOK: All bodies that are established by statute have this provision.

Clause put and passed.

Clause 117: Functions of Board —

Mr Z.R.F. KIRKUP: Clause 117 makes provision for the functions of the board, and clause 117(b) states, in part —

to provide to the Minister or the CEO, on its own initiative or on request, advice, information and reports on matters relating to the operation of this Act …

We talked last night about a more regular update to the Parliament, more broadly speaking. I realise that there is an annual report. I pointed to a number of other flagship pieces of legislation on which there are quarterly updates to the Parliament. I realise that in this case, the legislation will grant to the board its own initiative to provide reports and information, and the initiative is bound only to the minister or the CEO, or delegates thereof. Why is it that we have not included the Parliament as well, as part of that initiative, to ensure that they can provide some sort of exposure to us, as legislators, to see how the legislation is travelling?

Mr R.H. COOK: The member is quite right; we did canvass this at length last night. As I said, this is obviously the minimum requirement. The board is absolutely capable of providing subsequent reports—clause 117(b) will provide it with the capacity to do so. Parliament can request information of the board, and in relation to the operation of the legislation, the board will have to provide an annual report, as all operating boards do. The board will have an advisory function, such as the annual report to the CEO, but in addition to that, it will also provide advice and recommendations on voluntary assisted dying—related policy, legislation and strategic directions to the minister and the Parliament.

Mr Z.R.F. KIRKUP: I appreciate that, minister. Just to confirm, because it is not enabled in this part of the legislation: could the board take it upon itself to provide information directly to the Parliament, if it so chose, or would that still have to come via the minister?

Mr R.H. COOK: Yes, it would be via the minister.

Mr P.A. KATSAMBANIS: In comparing the functions that will be given to the board in Western Australia with the functions given to the board in the Victorian Voluntary Assisted Dying Act 2017, the Victorian board was given a power to review the exercise of any function or power under the act. Why has that function not been included as one of the functions of the Western Australian board under clause 117?

Mr R.H. COOK: The member is referring to the investigatory power; is that correct?
Mr P.A. KATSAMBANIS: I am referring to a review power. It can review the exercise of any function or power under this legislation. There is a difference between investigation and review. It is a well-known difference. A review gives the power to basically look at how the legislation is functioning and then make recommendations to the minister, the CEO or anybody else about the overall functioning of the legislation. That is very clear in the Victorian legislation. I just wondered why it was not included in the functions and powers of this board.

Mr R.H. COOK: I draw the member’s attention to paragraph (b), which states that the functions of the board include “any recommendations for the improvement of voluntary assisted dying”.

Mr P.A. KATSAMBANIS: So the minister would argue that that does exactly the same.

Mr R.H. Cook: That is correct. That would be my contention.

Mr P.A. KATSAMBANIS: I will take that on board; thank you.

The Victorian legislation also includes a function to promote continuous improvement in the quality and safety of voluntary assisted dying by those who exercise any function or power under the act. That whole sense of continuous improvement indicates an ongoing brief to that board that it monitor what is happening, stay actively involved and act as, I guess, a repository of knowledge about this whole area. Is that covered under the Western Australian legislation, because I do not see it directly reflected in the bill? Obviously, there are nuances in drafting language, so I am seeking an idea of where that would fit in under our legislation.

Mr R.H. COOK: Under paragraph (a), the board is to monitor the operation of the legislation and, under paragraph (b), it is to make any recommendations, including for the improvement of voluntary assisted dying. I observe that the ancillary functions of the board are to promote compliance with the requirements of the legislation by the provision of information and advice to the CEO of the health department about voluntary assisted dying matters, to promote continuous improvement in the quality and safety of voluntary assisted dying by the provision of information and advice to the CEO of the health department about VAD matters, and to consult and engage with the community and professional groups as part of its research function.

Dr D.J. HONEY: Do we have an estimate of the likely cost of the board itself? I appreciate that there will be staff and the like. We had a generic cost of the whole process, but do we have something that relates specifically to the cost of the board itself?

Mr R.H. COOK: No, we do not at this point. Obviously, any board will be subject to oversight by the Public Sector Commissioner and the Public Sector Management Act. From that perspective, the commissioner provides advice about the appropriate management and remuneration of any board. At this point, we do not have that line of sight. It requires the Public Sector Commissioner to form a view about the level of obligation of board members, the time that they would be required to be involved and their individual responsibilities. That will be determined at a later date.

Dr D.J. HONEY: The other area I want to explore a little is public engagement. I do not wish to deviate too far, but we had a lot of discussion during debate on the Infrastructure Western Australia Bill about the extent to which that body would engage separately in community discussion outside of government. Does the minister think that that public engagement is likely to also include the board separately engaging in discussion or promotion and those sorts of activities, or does he think that that will be limited very much to a political function, if you like, through the minister?

Mr R.H. COOK: I would not characterise it as political, but the proper management and functioning of the law would certainly be a function of the CEO. From that perspective, it would be the responsibility of the CEO to undertake the functions that the member speaks about. Obviously, the CEO will be informed by research, analysis and data collection that the board will undertake.

Mrs A.K. HAYDEN: Mr Acting Speaker, I seek some clarification and maybe some direction and willingness from the minister. I note that there is an amendment on the notice paper to be put forward after this clause is debated, but that member is not in the chamber. She may have been delayed by the traffic, as were quite a few members today. Is there any avenue to return to that amendment? Under standing order 180, clauses may be postponed, so I just want to make sure that the member is not penalised because of a tragic accident that occurred on the freeway this morning and she is unable to move her amendment on the notice paper. I ask for some direction if I may.

The ACTING SPEAKER (Mr I.C. Blayney): I will seek someone to move the amendment on behalf of the member for Girrawheen, but we will deal with clause 117 first. If the member would like to move it on her behalf, that would be fine.

Mrs A.K. HAYDEN: Under standing order 180, is there a provision for the member who has advised of an amendment to go back to it?

The ACTING SPEAKER: Apparently not, because it is not a clause; it is an amendment. But it can be moved by somebody else on her behalf. I am told that the member for Girrawheen is aware of that.
Mr P.A. KATSAMBANIS: Still on clause 117, “Functions of Board”, under paragraph (c), the board has the power to refer to a series of persons or bodies any matter in relation to voluntary assisted dying that is relevant to the functions of the person or body. Paragraph (c) provides that it is a function to refer a matter to the State Coroner appointed under the Coroners Act 1996. We had some debate—I am not sure whether the minister was at the table; I think it might have been the Attorney General at the time—about the point that this area would not ordinarily be subject to coronial investigation; it would not need to go to the coroner. What things would trigger a referral from the board to the State Coroner in these circumstances under the bill? It appears from previous consideration that the coroner will have very little or nothing to do with this regime.

Mr R.H. COOK: I can understand why it raises the member’s curiosity but not his anxiety. The member will understand that if the Voluntary Assisted Dying Board has any concerns about an incident or a series of events, it will draw it to the coroner’s attention. The member will also notice that the board can refer matters to a range of other agencies and individuals, including the police. It is not an automatic referral, but it is intended to ensure that the board has the power to elevate those matters if it has concerns.

Mr Z.R.F. KIRKUP: I have a couple of questions about clause 117(c). The member for Hillarys has covered a number of questions as well. I am particularly interested in paragraph (c)(v), which reads —

the chief executive officer of the department of the Public Service principally assisting in the administration of the Prisons Act 1981;

As the corrections portfolio is currently structured, would that be the Department of Justice and the Commissioner of Corrective Services, and why is that referral power there?

Mr R.H. COOK: I am informed that prisoners will not be excluded from the provisions of the Voluntary Assisted Dying Act; however, prisoners are held in care, so any issue involving prisons obviously has to include the director general—the chief executive officer is the generic term—of prisons. It is important that the board has the capacity to refer. If there is a death of any nature in custody, that is subject to oversight by the coroner as well.

Mr Z.R.F. KIRKUP: The first part of my question was about the director general of the Department of Justice or the Commissioner of Corrective Services. By the minister’s answer, I would assume it would be the director general of Justice.

Mr R.H. Cook: That’s right.

Mr Z.R.F. KIRKUP: Under paragraph (c), matters can be referred to seven different areas. I am trying to understand where the Health and Disability Services Complaints Office or the Australian Health Practitioner Regulation Agency would fit in. I appreciate that police would look at their own line of inquiry, as would the Registrar of Birth, Deaths and Marriages and the State Coroner. How would the minister see the interplay between HADSCO and AHPRA? The CEO has his own functions as well, that he can look into. I appreciate that a lot of areas can be referred, under the referral powers of the board, but I want to make sure that we do not create a situation in which there are so many people responsible that no-one is responsible—that so many different avenues can be pursued as part of the referral by the board that the matter gets lost. I am keen to understand the difference between those two, for example.

Mr R.H. COOK: It depends on the nature of what the board is investigating, and the way it manifests itself. It may not be an issue of life and death; it may simply be a disputation between a member of the public or a patient and their doctor, in which case those issues might ordinarily be better handled by HADSCO, which is responsible for mediating an agreeable outcome between a patient and their medical practitioner. It may be a more serious matter, in which case the board may form a view that another agency would be more appropriate. It may be considered of a criminal nature, in which case it can go even further. This provision is simply to make sure that a range of options is available to the board. HADSCO has a pretty prescriptive role. It is not an arbitrator, by the way; it is simply a mediating service between the patient and the medical practitioner. There would be circumstances in which it is more appropriate to handle the matter at that level, to get a good outcome. In other circumstances, the board may form a view that the matter needs to be elevated to the chief executive officer or, as I said, if it is a more serious nature, to police.

Mr Z.R.F. KIRKUP: AHPRA, for example, deals with the licensing of practitioners, so I imagine the interplay there would be—not to verbal the minister—that HADSCO would be for that minor mediating level between the patient and practitioner, whereas AHPRA goes to the regulation of possible misconduct by that practitioner. Would that be a correct assertion?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: I appreciate that. If I can just go back for a moment to the issue of prisons. Obviously, the director general is charged with the care of all prisoners. I think every referral body so far makes total sense, but to me it seems a bit unusual that the director general of prisons would be involved. He has charge of all prisoners, but this relationship is between the practitioner and an individual patient, regardless of the setting. In a criminal

Extracted from finalised Hansard
situation it would be police, if there is a coronial investigation. Is this reflected in other jurisdictions? Is there interplay; that is, does the prisons CEO in Victoria, say, have the same level of insight? To be perfectly frank, I cannot understand why prisons have been included in the first place. I realise that the director general is in charge of the prisoners, but I would argue that the relationship is largely between the patient and the practitioner.

Mr R.H. COOK: I am advised that it is necessary in Western Australia to advise the chief executive officer who is the administrator of the corrections portfolio—presently the director general of the Department of Justice—when a prisoner serving a long-term sentence or a continuing detention order has been given final approval for voluntary assisted dying. It would be unlikely, for instance, to take place in a prison setting; they would most likely be transferred to a hospital. It is important that there is capacity to refer and communicate. It goes to the CEO of Justice, because that is the relationship with the CEO of Health and other sections of the public sector, rather than going down the chain of command, if you like. It is essentially an opportunity to make sure that there is good communication.

Mr Z.R.F. KIRKUP: I will move to clause 117(d) and (e), which read —

(d) to conduct analysis of, and research in relation to, information given to the Board under this Act;
(e) to collect, use and disclose information given to the Board under this Act for the purposes of performing its functions;

I presume this is the capability to provide for statistical information to be collated and disseminated. Is that correct?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: This is not just for the annual report. Could this also go to universities or other areas of medical research that might be looking into it?

Mr R.H. COOK: Absolutely. The member for Nedlands spoke about the role of the Education and Health Standing Committee. It might be undertaking a review or some analysis of these issues. It would go to the board to collect the data that it needs to inform its decisions and analysis.

Mr Z.R.F. KIRKUP: I move to paragraph (f), and that is all I have under clause 117. Referring to any other function given to the board under this legislation, if it passes, there is a review clause. When we reach the review point, will the board play a relatively central role as part of that review? I notice that, as part of the implementation, the clinical expert panel will create this whole process. The board then carries the legislation through for the monitoring of its performance. Would that be delegated to the board under paragraph (f)?

Mr R.H. COOK: That would be an example of what the board will be doing. Under the review clause, the agency considers a range of technical and substantive changes that it thinks need to be taken on board in a review of the act, and the government makes a decision about those that it wants to proceed with. The member can understand that the board, whose responsibility under paragraphs (a) and (b) is to monitor and make any recommendations for improvement, would be central to that discussion.

Mr Z.R.F. KIRKUP: This clause outlines the functions of the board, more broadly speaking, and there is nothing in this clause that prohibits board members from being asked to appear before a parliamentary committee hearing or to answer parliamentary questions that have been submitted to the Minister for Health. I imagine that the board has a level of accountability to the Parliament and nothing in these functions prohibits that from occurring; is that right?

Mr R.H. COOK: No. The board will absolutely be required to undertake those sorts of roles. Obviously, it will be prevented from disclosing personal information, but it will be subject to the whole suite of other acts that manage the public sector, such as the Public Sector Management Act and other parts of legislation that it will need to be aware of.

Mr Z.R.F. KIRKUP: I appreciate that. One thing that I am slightly concerned about is freedom of information and how “personal information” will be classed. Unless an applicant seeks their own information in an FOI application, personal information is often exempt. Because this is an intimate and private journey and procedure between a practitioner and patient, I wonder whether any FOI application will be caught under paragraph (c)(i)? In any case, that is something to be aware of. I was slightly concerned about how this would interfere with the provisions of the Freedom of Information Act 1992 and the subclause and schedule exemptions, but I appreciate that the board is still subject to other parliamentary oversight mechanisms.

Dr M.D. NAHAN: I refer to clause 117(a), which is to “monitor the operation of this Act”. This is a very important role for the board. I will go through some scenarios. One of my concerns is that a number of regulators will oversee the people who are involved in this, particularly the practitioners; it is their board, and then we will have this. For instance, what will happen if SAT knocks back a case that involves a practitioner who repeatedly approves voluntary assisted dying and various processes? I am sure that SAT will have the power to inform the board of that and the board will have the power under paragraph (a) to monitor and identify that. What power will the board have to act on that if it finds that there has been sloppy behaviour or behaviour that is not illegal but because it is a decision of the practitioner it gets knocked back too often? What will happen if we see recurring behaviour of certain participants in the process?
Mr R.H. COOK: There may be reasons for the scenario that the member refers to. A practitioner may not have fulfilled their role as a practitioner under the national regulations law, in which case the board, potentially, would refer that to the Australian Health Practitioner Regulation Agency. Indeed, an individual, including a medical practitioner’s colleague, could be concerned and refer it to AHPRA. The board could form the view that a particular proportion, or a number, have been overturned and refer that to the CEO, and say, “You need to have a look at the way the operation of the coordinating practitioners is going because we are now seeing an emerging pattern.” It could be that a more serious breach of the voluntary assisted dying laws has emerged, in which case the board would refer that directly to the police. That should give the member an idea of the severity of the reasons to overturn decisions—I think the language is “set aside” the severity of that analysis.

Dr M.D. NAHAN: I am concerned about people such as Philip Nitschke who want to take the process in a direction that is not intended in this legislation. Those types of people do what they want. He is no longer a doctor and he can no longer operate, but those people exist. The board will have sufficient powers to monitor the decision-making of the VAD process and concentrate on it to identify both specific people and general trends. Will the board report these trends? Will it be required to report these trends to the minister or to the public in an annual report of some nature?

Mr R.H. COOK: Yes to all those questions—at least to the minister and, obviously, to the Parliament via the annual report. All that sort of analysis should be presented and made public.

Mrs A.K. HAYDEN: I want to go back to the line of questioning that the member for Cottesloe started on the cost of the board. The minister said that he has not yet determined that. Has the board been benchmarked against anything, such as the Victorian board? The board would know what it is paying the board members. Board members and support staff will need to be paid, but the minister said that he does not have a figure for that. Obviously the Victorian board would have worked that out, so will the minister use that benchmark?

Mr R.H. COOK: No.

Mrs A.K. HAYDEN: Can the minister let us know whether board members will be paid and how much that will cost? When legislation is drafted that involves a cost, I am sure the Treasurer would want to know what the cost will be to the state budget. As was determined earlier, the state government will be covering the bill for the cost of the substance and the administration of the substance, so there will obviously be a cost to the state budget. There will also be a board. I assume that board members and support staff will be paid, so that is another cost to the state budget. Was there a Treasury submission or did this go through the Expenditure Review Committee when the legislation was drafted?

Mr R.H. COOK: The government is captured by the Parliament. If Parliament passes laws, the government is required to provide funding for the functioning of those laws. If this legislation passes Parliament, the government will set the task of understanding the costs associated with it and move forward in that manner.

Mrs A.K. HAYDEN: Did this legislation go through Treasury? Was a Treasury submission provided before this legislation was brought to Parliament?

Mr R.H. COOK: I am informed that Treasury was consulted.

Mrs A.K. HAYDEN: Is the minister able to advise what Treasury was consulted about? Is there an estimated cost? If the minister consulted Treasury, there must have been a cost relevant to that. Is the minister able to share the Treasury submission or the conversations that were had with Treasury, and the cost?

Mr R.H. COOK: I have already answered that question. We are not doing the costings at this stage. We will see whether the law is passed. When any legislation is drawn up, it is appropriate that good consultation occurs right across government. However, at this stage, we have not gone into any analysis on the likely costs. Obviously, people have an understanding in the back of their minds in general terms about how much the obligations associated with any board are, such as whatever obligations they have under the Public Sector Management Act. At this stage, we have not undertaken any analysis of the overall costs. We are still waiting for Parliament to craft the legislation. Once Parliament has crafted the legislation, that will inform the government about the nature of the associated costs.

Dr M.D. NAHAN: Does the board have the powers to get involved—defined generally—in specific cases? If patient X starts the process, does the board have the power to act in the decision-making in specific cases?

Mr R.H. COOK: Obviously, if a matter that is considered to be of a criminal or dangerous nature is brought to the attention of any board member or by support staff to the board, they, like anyone, have a responsibility to refer it immediately to the appropriate authorities. Ordinarily, the board has a monitoring function, and in that sense it is about understanding the patterns or the nature of the way the legislation is operating, but clearly if they see something of a serious nature, they would act.

Dr M.D. NAHAN: I understand that the role of the board is to oversee and monitor the legislation, bed it down initially and then undertake an analysis of trends, but it also provides a collection point for information and assessment. It might have to have an operational rather than just an oversight role, and I think that might be important. Can the board bring a case to the tribunal?

Extracted from finalised Hansard
Mr R.H. COOK: The board has combinations of functions, and one of them is regulatory and referable. Under the regulatory function, it will monitor each individual case of voluntary assisted dying from the request stage to the completion stage so that each voluntary assisted dying case has proper oversight from start to finish. It will monitor the overall pattern of voluntary assisted dying deaths, maintain a database of all relevant statistics, conduct analysis and research, and monitor the exercise of any function or power under the legislation. In addition, it has a referral power, so it would not go to the State Administrative Tribunal; it would refer something directly to the chief executive officer or, as I said, in particularly severe cases, it would refer it to the police. In the context of what the member is saying about the SAT and the board wanting to intervene in a case, it would not do it in that matter; it would do it via the CEO of the Department of Health.

Mrs A.K. HAYDEN: I want to try to finish off my questioning on the cost. I know that the minister says he does not have the figure, but I would like to understand whether he has an estimate of cost but just does not want to share it prior to the passing of the legislation.

Mr R.H. COOK: This is the nature of government. The government waits to discover the nature of the legislation and then it would be subject to the normal Expenditure Review Committee processes. I think the member made reference to the Victorian board. The Victorian board is different from ours, so there would not be a comparative analysis. In the back of people’s minds they might consider how senior this board is and that might provide them with a sense of how big it is. In the implementation phase, which is 18 months after the legislation might pass, it would be the responsibility of government to understand the nature of those costs, the number of staff that would be associated with it and things of that nature. This is simply the nature of government. We will wait to see what the legislation looks like and then the government will set to the task of understanding the costs associated with implementation. I assure the member that I am not seeking to keep anything from her. If it would expedite moving through clause 117, I would obviously provide the information. I assure the member that I am not trying to hide any information about that. It is just too early in the piece.

Ms M.M. QUIRK: I apologise for being late, minister, so if this question has already been asked and answered, do not hesitate to let me know. Under section 93 of the Victorian legislation, which relates to its board, there is, I think, a material difference in that one of the functions of the board is to provide reports to its houses of Parliament on the operations of the act and any recommendations for the improvement of voluntary assisted dying, whereas in the bill before us, the board is to provide information or advice to the minister or the CEO of its own initiative or on request. If this has not already been asked, I want to know why there is a difference. After the debate over the last couple of weeks, the minister will be well aware that there is significant interest in this matter, and I wonder why there is not direct reporting to Parliament.

Mr R.H. COOK: As the member would expect, and as she predicted, we have spent a bit of time on the reporting and accountability functions of the board. It is our intention that the sorts of issues that the member canvassed just then in relation to making sure the public is informed of the functions and oversight of the legislation would be included in the annual reporting.

Ms M.M. QUIRK: Matters may come up throughout the course of the year that might require more urgent attention by Parliament, and it seems to me that a conscious decision has been made to change the reporting basis in Western Australia from what is present in Victoria. I am really trying to drill down and find out what the basis of that decision was and why Parliament, which has some interest in the matter, is not able to have reports from time to time at the initiative of the board.

Mr R.H. COOK: The member made the observation that the Victorian board can report to Parliament, as will the Western Australian board via the annual report. There is no intention to stifle, and, as we have already discussed extensively this morning, there is ample opportunity for the Parliament to cross-examine the board at any point in time, and obviously through the committee process in particular.

Ms M.M. QUIRK: I have a last question on this, and it is probably a segue to the amendment I intend to move. Not having this mechanism is, again, a lack of real-time reporting, just as the board itself receiving information is not a real-time monitor. The minister used the word “oversight”, but in fact the board will really just a repository to make sure that the forms are filled in—there will be no clear oversight. I will not pursue the matter, because this is picked up in the amendment I intend to move.

Mrs L.M. HARVEY: Following the member for Girrawheen’s inquiry, under the section on the functions of the board in the Victorian legislation, there are a couple of other facets, one of which is —

> to promote compliance with the requirements of this Act by the provision of information in respect of voluntary assisted dying to registered health practitioners and members of the community;

Other stated functions are —

> to promote continuous improvement in the quality and safety of voluntary assisted dying to those who exercise any function or power under this Act;

...
to consult and engage with any of the following persons and groups in relation to voluntary assisted dying —

(i) the Victorian community;
(ii) relevant groups or organisations
(iii) government departments and agencies;
(iv) registered health practitioners who provide voluntary assisted dying services;

I thought those functions would be important and useful for the board to assist it to proactively monitor the operation of the legislation, and to have a culture and, indeed, a purpose of continuous improvement, continuing consultation and continuing engagement with the community. I am curious to know why that was excluded from the functions and powers of the board in our legislation.

Mr R.H. COOK: It was not. Those functions are all functions of the board under clause 117(a) and (b). In that respect, we may have used language that is different from the Victorian legislation, but essentially the function is the same. The board has all the capabilities it needs for monitoring, researching and providing advice on the improvement of the voluntary assisted dying process. From that perspective, paragraphs (a) and (b) capture all the things the member described in relation to the functions of the board.

Mrs L.M. HARVEY: I accept that the minister says that clause 117(b) is a catch-all for all those functions, but the functions of the board are somewhat less specific than the functions of the board under the Victorian legislation. I suggest to the minister that our colleagues in the other place may well look to further define the functions of the board to make them more specific so that it is clear to the board that there is an expectation that there is a culture of continuous improvement. It is a function of the board to continually improve the legislation. It is a function of the board and indeed a requirement to continue with consultation. I seek the minister’s advice on whether he would be amenable to amendments such as those if they were made in the other place. Would they be accepted by the minister should the legislation come back to this place amended in that manner?

Mr R.H. COOK: That would depend on the amendment.

Dr M.D. NAHAN: In debating this bill, we have highlighted a range of trends based on research that was done around the world on other legislation. Victoria’s legislation is new so there is not much to do. I am sure that in framing this bill the government used research from other jurisdictions. The minister often talks about Oregon, but Canada is relevant too now. How does a layman or a parliamentarian such as me, who has an interest in finding out certain types of trends, input that to the board to see whether it can monitor it? I will give some examples. The nature of pain: is it existential pain? The Canadians have done research on this—I have read some data—and it is a relevant point. Another factor depends appropriately on a tight relationship between doctor and patient. That has been historically the case, but increasingly, particularly with the bulk-billing trends, that does not exist. The patient is known to the doctor largely from a database rather than through a personal relationship. If there are issues for people soon after the legislation comes in, how are we to inform the board other than through the minister, I suppose, that we think those things should be monitored and reported on to the public or to the other processes?

Mr R.H. COOK: The board is capable of responding to any sort of request in that context. Just to cap off on the comment the member made, the board would be more likely to talk about suffering than pain, but I understand what the member says: there is an issue there that someone wants to dig into. Ultimately, if it is a member of the public, they would be treated one way; if it is a university academic undertaking a study under the guidance of the university and the ethical processes, there might be a different approach. However, there is no reason the board cannot respond to community concerns about a range of issues and report back on those. Just like any other government board, the board would have an outward-facing profile as well as an inward-facing profile. There would be advice to government, but also expert advice to the community as well.

Clause put and passed.

New clause 117A —

Ms M.M. QUIRK: I move —

Page 77, after line 18 — To insert the following new clause —

117A. Notice of no objection

(1) This section applies if a patient makes an administration decision.

(2) The coordinating practitioner for the patient must apply within two days to the Board for a notice (a notice of no objection) under this section for the administration decision.

(3) The Board must give the coordinating practitioner a notice of no objection unless the Board considers there is a problem with what has occurred, including, for example —

(a) the patient has not acted voluntarily and without coercion; or
(b) the patient has been subject to abuse; or

Extracted from finalised Hansard
(c) the patient has not been given adequate support in coming to the decision to access voluntary assisted dying; or

(d) a provision of this Act has not been complied with.

(4) If the Board refuses to give the coordinating practitioner a notice of no objection under subsection (3), the Board must give the coordinating practitioner a notice stating its refusal.

We have talked about this previously during the consideration in detail stage and I have foreshadowed it. This is basically to ensure that the monitoring and oversight of the board is in fact in real time. It effectively issues a notice of no objection to the process proceeding, given the information that has been mandated and needs to be provided to the board along the way. It is almost de facto to what happens in Victoria. As I have already talked at length on this issue, I will just say that this amendment clears up what I believe is an ambiguity in the role of the board and, in particular, the level of scrutiny and oversight.

Mr P.A. KATSAMBANIS: As the member for Girrawheen said in moving this amendment, the issues have been well canvassed. This would be a significant improvement to both the legislation and the regime that is being introduced to monitor voluntary assisted dying. For the reasons I have outlined previously at the consideration in detail stage, I support this amendment.

Division

New clause put and a division taken, the Deputy Speaker (Ms L.L. Baker) casting her vote with the noes, with the following result —

Ayes (7)
Dr D.J. Honey Mr A. Krsticicic Mr P.A. Katsambanis Mr S.K. L’Estrange Dr M.D. Nahan Ms M.M. Quirk Mrs A.K. Hayden (Teller)

Noes (41)
Ms L.L. Baker Mr M. Hughes Mr K. O’Donnell Mr J.M.C. Stojkovski Dr A.D. Buti Mr D.J. Kelly Mr P. Papalia Mr C.J. Tallentire Mrs R.M.J. Clarke Mr W.R. Mammon Mr S.J. Price Mr D.A. Templeman Mr R.H. Cook Mr M. McGowan Mr D.T. Punch Mr R.R. Whitty Ms M.J. Davies Mr J.E. McGrath Mr J.R. Quigley Ms S.E. Winton Mr M.J. Folkard Ms L. Mettam Ms C.M. Rowe Mr B.S. Wyatt Mr A. Saffioti Mr T.J. Healy Mr Y. Mubarakai Ms J.J. Shaw

New clause thus negatived.

Clause 118 put and passed.

Clause 119: Delegation by Board —

Mr P.A. KATSAMBANIS: This clause will enable the board to delegate any power or duty of the board to either a member of the board or a committee that has been established under the board. I understand this is a relatively standard clause. However, under what circumstances would the board choose to delegate a power or a duty?

Mr R.H. COOK: The member is absolutely spot on. This is a simple standard clause. The delegation by the board is important, because it will enable continuation of service, particularly in circumstances in which the board may be administratively bound by the matters or needs to direct a particular duty to a member or to a committee that has the necessarily skill to address it.

Clause put and passed.

Clause 120: Staff and services —

Mr P.A. KATSAMBANIS: I am trying to get some clarity. This clause relates to staff and services. In debate on a previous clause, a similar question was asked about what the staffing will look like. My question is probably slightly different. I think the minister has already answered that the Department of Health is looking into that and is not quite sure what the staffing will look like, but some support services will need to be provided. Is it envisaged that the staff and services required for this regime and provided for under this clause will be provided under the existing resources that are allocated to the Department of Health, or will a separate budget appropriation be required to provide for the administration of this bill; and, if so, what will be the monetary amount on an annual basis, or will there be an establishment cost and an ongoing cost after that?

Mr R.H. COOK: As I am sure the member would suspect, this will be resolved in the implementation phase.

Extracted from finalised Hansard
Mr P.A. KATSAMBANIS: If we will find out about that at some further time, how will the public be informed about that? Will the minister report to the house, and will there be a potential budget allocation that we can look at, or will we simply need to divine that through the myriad ways of extracting information from the executive government?

Mr R.H. COOK: I am sure the member will cross-examine me within an inch of my life in estimates —

Mr P.A. Katsambanis: — which is the proper forum for examining the budget proposed by the government. In addition, there are questions on notice. There is a range of range of mechanisms, as the member would be aware, to make sure there is necessary oversight of the proper functioning of the Department of Health.

Clause put and passed.

Clause 121: Assistance —

Ms M.M. QUIRK: Clause 121 states —

(1) The Board, with the Approval of the Minister, may co-opt any person with special knowledge or skills to assist the Board in a particular matter.

(2) A person who has been co-opted to assist the Board may attend meetings of the Board and participate in its deliberations but cannot vote at a meeting of the Board.

I understand that the board will be serviced by members of the Department of Health, and that it will operate in a manner consistent with, say, the surrogacy board, which I think exists. Does the minister contemplate that there might be a need to co-opt under clause 121 if only a couple of staff have been allocated to servicing the board?

Mr R.H. COOK: I am advised that it is important that the board have access to the appropriate skills and expertise necessary to thoroughly review and monitor general and specific matters relating to voluntary assisted dying. This clause will ensure that even if there is insufficient expertise on the board for a particular matter or case, the board may bring in a person with the appropriate skill set to attain or analyse that information.

Ms M.M. QUIRK: It is contemplated that the staff who, effectively, provide executive support to the board, may be required under clause 121 to facilitate that co-option. I am asking: how many staff are contemplated being appointed under clause 120?

Mr R.H. COOK: Given that I think the member had some line of inquiry under clause 120 but missed the call for it, I will quickly respond. In my response, member for Darling Range and member for Hillarys, I repeat: we do not have line of sight into the necessary requirements for the board. That will depend upon the final package of legislation if it is passed. We will come to these issues in implementation. Clearly, the chief executive officer must provide all the support and resources reasonably necessary to enable the board to perform its functions.

Clause put and passed.

Clause 122: Minister may give directions —

Mr Z.R.F. KIRKUP: Will the directions referred to in clause 122(1) be published, as are other directions when the minister instructs an agency?

Mr R.H. COOK: I am advised that it is important that the text of any direction given must be included in the annual report. This will ensure transparency of any minister’s direction. I add that the written directions clause does not enable the minister to give the board an unlawful direction. For example, any direction by a minister or other official to the board to hide or alter information other than that enabled under the bill, such as de-identification of persons involved in the voluntary assisted dying process, would constitute unlawful activity.

Dr M.D. NAHAN: I refer to clause 122(2), which provides that the minister cannot make a direction about the performance of a function in relation to a particular person or matter. I think I understand why it is “particular person” although I will raise that later. Why “matter”? A public interest issue might arise in a certain case that needs ministerial leadership or at least for the minister to be informed. Can the minister tell me what “matter” means and in what circumstances the board can inform the minister about a case that has valid public interest?

Mr R.H. COOK: This clause provides that the minister may give written directions to the Voluntary Assisted Dying Board on the performance of its functions, either generally or on a particular matter. The board must abide by these directions. However, the minister cannot direct the board in the performance of its functions concerning a particular person or a particular application or proceeding. If a patient is moving through the review process, the minister cannot write to the board and say that they want the board to intervene on a specific matter or a specific person. That is not the intent of this clause.

Ms M.M. QUIRK: Directions given by the minister to the Road Safety Council, for example, are tabled. Although the minister says those directions will be in the annual report, this is another example in which there is lack of topicality and, in real time, it is another mechanism of scrutiny by the Parliament that is effectively rendered

Extracted from finalised Hansard
ineffective because it may be up to 11 and a half months before the Parliament is made aware that a direction has been made. Was it contemplated to include a provision such as that covering directions to the Road Safety Council; and, if not, why not?

Mr R.H. COOK: I think the member is elevating what is simply a mechanistic clause to the level of skulduggery or subterfuge. This is simply an opportunity to make sure the government of the day has the potential to seek advice or provide a direction to the board in a manner that is consistent with usual government practice. It is not, as I said, an opportunity to interfere in a matter, but it is competent for legislation to contemplate a situation in which the minister would give the board a direction. It is consistent with, I would have thought, much of the common practice of government.

Clause put and passed.

Clause 123: Minister to have access to information

Mrs L.M. HARVEY: Clause 123(2) provides that the minister is entitled to have information in the possession of the board, but subclause (3) puts a caveat on it as follows —

…the Minister is not entitled to have personal information about a person unless the person has consented to the disclosure of the information.

I can understand a patient not having their identifying information disclosed to the minister. However, it appears to me to be a catch-all. Presumably, the minister can have access, for example, to the personal details of doctors involved in voluntary assisted dying—the practitioners and contact persons—without having to seek their permission for disclosure. Can the minister clarify that? I would have thought that the minister should not necessarily face a hurdle in finding out the personal details of a collection of doctors involved in making decisions about access to voluntary assisted dying. But I understand why protection is needed for patients. Can the minister clarify that?

Mr R.H. COOK: The intent here is for the minister to be able to request information from the board and that the board must comply with the request. However, the minister is not permitted access to information in a form that discloses the identity of the person involved in a voluntary assisted dying application or proceeding. The relevant language in this, member, is to have regard to the personal information about a person. It would not prevent the board from disclosing professional information about a medical practitioner or someone else involved in the process. It is the personal nature of the information. In my work as Minister for Health, I am entitled to a range of information but I am not entitled to patient records and things of that nature. I am allowed to receive a summary specifically relating to a person but I am not allowed to receive the person’s personal information. It is to make sure that we protect those personal issues.

Mrs L.M. HARVEY: It would seem to me that it might have been more prudent, since the minister is not entitled to have personal information about a patient, unless the patient has consented to the disclosure of information. If a minister is carrying out due diligence, they would probably want to have readily available, without any hurdles, a list from the board of all the coordinating practitioners, consulting practitioners and other decision-makers in the voluntary assisted dying process. Because this clause is broad and refers only to a person, it seems to me that coordinating and consulting practitioners would be able to use it to not have their personal details disclosed to the minister. I see that as a loophole, if you like, for the minister not to be able to gain access to the details of the practitioners engaging in this process.

Mr R.H. COOK: It is not a loophole. It is not intended that the board would provide information of this nature to the minister. It may be, in the normal course of events, that the chief executive officer—with the oversight that the chief executive officer has over the entire system—from time to time provides briefings to the minister to allow the minister to discharge their duty, but it is not the responsibility of the board in this particular instance. I understand the point the Leader of the Opposition is making. This is more about protecting the patient than a particular doctor, especially if that doctor is seen to be acting improperly. The proper mechanism for that would be to seek that information through the chief executive officer, with the oversight the chief executive officer has over the workforce. This is really to protect those people who do not come to the process as a professional but simply as a member of the public. I understand the point that the Leader of the Opposition is making, and I think it is a good one, but this is really about clarifying that it is not the role of the board to disclose information on the individual process to the minister. That would ordinarily be the responsibility, if considered necessary, of the chief executive officer, but not the board in this case.

Dr M.D. NAHAN: Just two minor things. Clause 123(3) refers to “unless the person has consented”. What happens if the person has died? If the person has passed away, who is the guardian of that information on behalf of the person who has passed away?

Mr R.H. COOK: Clearly, they will not be getting the consent from the individual. I understand that the administrator of their estate has a role to play in that regard, but I am not familiar with the responsibilities of someone who is the administrator of an estate. I am informed that they potentially could provide permission for that information to be disclosed.

Dr M.D. NAHAN: That would maybe be an interesting thing for the member for Hillarys to talk about, because it could potentially —
Sometimes there is a need to have someone with financial knowledge, legal knowledge or medical knowledge.

stipulate the types of skills, qualifications or experience that at least some members of the board ought to have.

Dr M.D. NAHAN: Okay!

Another issue is: are there any restrictions on the minister passing on the information he or she gets from the board? Sometimes ministers tend to do that, you know.

Mr P.A. KATSAMBANIS: I’m not going to talk about it today, but you can if you want!

Dr M.D. NAHAN: Okay!

Mr R.H. COOK: Absolutely, member. There is absolutely a requirement on the minister to not disclose that information. The member is right: from time to time, a minister does pass on information, and they get into trouble.

Mrs L.M. HARVEY: I think the member for Riverton has a valid point. If a patient is deceased, they obviously cannot give permission for their details to be disclosed. Does the minister envisage, as part of this process, that there may well be on one of the many forms that are lodged with the Voluntary Assisted Dying Board an informed consent to allow disclosure of details in the interests of research et cetera? If the patient agrees to that as part of the process, it could certainly help with research efforts into voluntary assisted dying and who accesses it et cetera.

Mr R.H. COOK: That is a great point. I refer the Leader of the Opposition to clause 150, which I am just now becoming familiar with. As I think I have answered to the member for Dawesville on a number of occasions, the legislation sets out the information that must be in the forms, but it is not restrictive. Under clause 150(b), the board may, on request, disclose information obtained in the performance of its functions to a person or body for the purposes of education or research. That is something that we are grappling with at the moment. There is one school of thought that anyone who sets foot inside a public hospital to receive services should, almost by default, give consent for their de-identified information to be used for medical research for the good. I have some sympathy with that view. The law does not allow for that sort of thing, but I think it is a really interesting point that the Leader of the Opposition makes. We could envisage a situation in which a person who is ahead of the game, or even in the middle of the game, could say, “I’m happy, for the purposes of education, research and the betterment of humankind, for this information to be disclosed.” That is a really important point and I think there will be more discussion about that right across the health sector.

Clause 124: Membership of Board —

Mrs L.M. HARVEY: The board will consist of five members appointed by the minister. I seek some details from the minister about what sort of skill set would be sought in the people who are to make up the board. What sort of background would they need to have? Who are the sorts of people that we are looking for to sit on the board, and how will they be appointed? Will there be an expression of interest process? Will it be a transparent process of application for people to become members of the board? I just seek some information about how the minister is going to find these people, who they are, what their skill sets will be, and how they apply.

Mr R.H. COOK: This clause provides for five members of the board, as appointed by the Minister for Health. The bill gives the minister discretion to appoint people with the appropriate skill and expertise to carry out the functions of the board under the bill. It is intended that it will be a working board and not simply be composed of figureheads. In appointing members of the board, the minister will endeavour to ensure that the board is composed of individuals who have special knowledge and experience in the areas that they will be required to deal with under this legislation — for example, a medical practitioner, a legal practitioner and a community representative. Western Australian health service boards are appointed by the Minister for Health. These boards reflect the skills and experience required to provide clinical and organisational governance and oversight across the health system, and there is no reason to apply a different approach to the Voluntary Assisted Dying Board.

As the Leader of the Opposition knows, I am responsible for appointing members to the boards of health service providers and myriad other boards across the health sector. I receive advice from the Department of Health about those whom the department considers competent to carry out those tasks, making sure that we have the appropriate blend of skills and experience. This board will be no different. Currently, the mechanism for people putting their name forward is a government portal called OnBoardWA. People provide their details for the sorts of boards that they are interested in serving on. There is no specific stipulation in that process because it is expected to follow the usual pattern of appointments to boards. I am advised that an ex-Chief Justice of the Supreme Court has been appointed as chair of the Voluntary Assisted Dying Review Board in Victoria. That is the sort of status and insight for this information to be disclosed. That is a really important point and I think there will be more discussion about that right across the health sector.

Mr P.A. KATSAMBANIS: I do not have any question that the minister or any other minister —

The DEPUTY SPEAKER: Perhaps you should sit down then, member, if you have no questions!

Mr P.A. KATSAMBANIS: I do not have any question about the minister choosing appropriate people; it is just interesting that the acts that establish a number of boards, including some that the minister is responsible for, stipulate the types of skills, qualifications or experience that at least some members of the board ought to have. Sometimes there is a need to have someone with financial knowledge, legal knowledge or medical knowledge.
Why was it not considered necessary that there be some stipulation in the establishing act of at least some of the core range of skills that ought to be covered—I would submit that things like having an understanding of psychiatric issues or palliative care issues would be extremely important—just to give some clarity about the type of people who will be eligible for appointment?

**Mr R.H. COOK:** As the member knows, the role of boards in government is an evolving or emerging phenomenon. When the Western Australian Health Promotion Foundation board was set up, it had to have one person from this entity, one person from that entity, two from there and so on. It was a very prescriptive and clunky mechanism.

**Mrs L.M. Harvey:** And irritating!

**Mr R.H. COOK:** Well observed, Leader of the Opposition! Roll forward to when the previous government revamped that legislation and it did away with all that, because that is not the modern nature. Also, when Hon Kim Hames brought in changes to the health act to put together the health service providers boards, a similar mechanism to this was adopted. It simply follows the pattern of modern legislation.

Clause put and passed.

Clause 125 put and passed.

Clause 126: Term of office —

**Mr Z.R.F. KIRKUP:** I understand that the term of office will not exceed three years. In my experience of appointment terms, that seems to be a relatively short term. I know that they will be eligible for a reappointment process. Is there any reason why three years was chosen and not a longer term, given the importance of the board?

**Mr R.H. COOK:** There is no great science behind it. Three years is considered an appropriate term of office, particularly as we will get an opportunity to see how they perform their functions in their first three years; and, at the end of that time, they would be reappointed or a replacement would be sought.

**Mr Z.R.F. KIRKUP:** I have two further questions. Will the board appointment process go to the Governor in Executive Council for their concurrence or ultimate agreement; and, if not, why not? Is there any reason why three years was chosen and not a longer term, given the importance of the board?

**Mr R.H. COOK:** The answer to the member’s first question is yes. The answer to his second is that reappointment will be determined by the Minister for Health based on the performance of the board member and, indeed, the needs of the board. We would not put a time limit on it. For instance, I am preparing to reappoint Professor Con Michael as chair of the Western Australian Board of the Medical Board of Australia, and Lord knows that he has been there for a lot longer than two or three terms. It is really about the performance of the board member.

**Dr D.J. HONEY:** Was any consideration given to staggering the appointments? I have looked at other bills in this place under which boards have been appointed and it has been stated that the appointments will be staggered so that there is not a complete generational change at the end of the three-year term.

**Mr R.H. COOK:** Yes, we would ordinarily expect them to be staggered. The member will note that the term is not to exceed three years. Ordinarily, we will appoint half for some of the time and half for the full time and make sure that there is that rolling consistency of knowledge and experience.

Clause put and passed.

Clause 127: Casual vacancies —

**Mr Z.R.F. KIRKUP:** Subclause (1) states —

In this section —

misconduct includes conduct that renders the member unfit to hold office as a member even though the conduct does not relate to a duty of the office.

I assume that that is misconduct as defined in the Public Sector Management Act or the Australian Crime Commission Act; would that be right?

**Mr R.H. COOK:** It is not inconsistent with those, but misconduct in this context is specifically defined in clause 127. The member is right; it is not limited to this legislation. It would apply to their responsibilities under the Public Sector Management Act and any other statutes that they would have responsibility under as a member of a government board.

**Mr Z.R.F. KIRKUP:** Given that it will be at the minister’s discretion, I expect that that would largely be determined by how the minister of the day perceives misconduct might be construed under instructions or policies issued by the government of the day. If my reading of this clause is correct, misconduct will be determined by the minister; is that a fair assessment?

**Mr R.H. COOK:** Ultimately, the authority for removal rests with the minister, but that would ordinarily be on the advice of the chief executive officer and, more specifically, the Public Sector Commissioner, who has oversight of the conduct of all boards.

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: Effectively, it will be no different from any of the obligations of other boards and their relationship with the Public Sector Commission.

Mr R.H. Cook: Yes

Mr Z.R.F. KIRKUP: Subclause (2)(b) refers to an individual who becomes bankrupt or insolvent. How will that be monitored in a practical sense? There will obviously be an obligation on the individual to inform whom—the minister? I would not expect the minister to be actively aware of the financial affairs of his board members at every point in time. How does the minister anticipate this being monitored—again, under normal public sector functions?

Mr R.H. COOK: Clause 127 is not unique to this legislation. This is a standard requirement for boards and board members. Ultimately, as I said, the Public Sector Commissioner has oversight of the conduct of boards and there are responsibilities for board members to report on matters pertinent to their capacity to perform their duties.

The DEPUTY SPEAKER: Go ahead, Dawesville.

Mr Z.R.F. KIRKUP: Thank you very much, Maylands! In relation to subclause (4)(a) —

The DEPUTY SPEAKER: I do not know that that is in the parliamentary spirit, but I will let you get away with it!

Mr Z.R.F. KIRKUP: Do you cease to be the member for Maylands when you are in the chair?

The DEPUTY SPEAKER: Not really. It is hard to wipe it out completely.

Mr Z.R.F. KIRKUP: I refer to clause 127(4)(a) and (b), which refer to neglect of duty, and misconduct or incompetence. I assume that these terms have been included to ensure that the minister has as wide a range of options as possible to get rid of a board member. Would that be correct?

Mr R.H. COOK: Yes.

Mr Z.R.F. KIRKUP: Subclause (4)(d) refers to missing three consecutive meetings as a ground for removal. Does that negate any leave that could be applied for by a board member?

Mr R.H. COOK: I think it states absence without leave.

Mr Z.R.F. KIRKUP: Yes; sorry. Under paragraph (d), how long can the member be on leave for? Is it just up to the satisfaction of the minister, in that case?

Mr R.H. COOK: These are standard clauses relating to the conduct of a government board. There is nothing unique and exciting about this.

Mr Z.R.F. Kirkup interjected.

Mr R.H. COOK: Fair enough; I understand the member is exercising his curiosity. If a board member has to take extended leave, ordinarily they would seek leave from the chair. If it is an unusual circumstance, the chair might seek guidance from the Public Sector Commissioner or, indeed, provide notice to the minister. These things are managed within the confines of that process.

Mrs L.M. HARVEY: Clause 127(3) states —

A member may at any time resign from office by written notice given to the Minister.

There is an opportunity, I guess, by way of discussion, if the minister is not happy with a member of the board, and the board member does not fit with the provisions of subclause (4), which are really about neglect, incompetence or incapacity, or simply not performing their duties. Having been a minister and having inherited some boards, I know that there are occasional personality clashes with individuals on boards that may make the relationship unworkable, and a particularly recalcitrant member of a board may not want to assist the minister by resigning. I am wondering whether any consideration was given to including an option for the minister to remove a member of the board as they see fit, if you like, to ensure that the minister can have a good working relationship with members of the board.

Mr R.H. COOK: As the member knows, the relationship between any board member and the minister can often be a matter of some complexity. If a board member is doing a good job as a board member, and discharging their responsibilities, and the minister finds that person a bit objectionable, I guess we place a restriction on the minister’s powers for good reason. This clause exists simply because the minister appoints the board members, and board members must resign to the minister. I remember receiving a letter from my father once saying, “Dear minister, I hereby resign from the Mental Health Review Tribunal.” From that perspective, it simply provides clarity about how the member would execute that task. There are limitations, I guess, on what ministers can do, but the member knows the ways and means of the Public Sector Commissioner and a good board chair. These processes are often nuanced, and this is obviously the bog-standard approach to the powers and constructs of a board.

Clause put and passed.

Clause 128 put and passed.
Clause 129: Alternate members —

Ms M.M. QUIRK: Minister, the grammar police have arrived. I note that the heading of this clause refers to alternate members. I gather from the sense of the clause that what is in fact meant is alternative members. For the purposes of Hansard, this is often a mistake, but “alternate” means to happen or exist one after the other repeatedly, whereas “alternative” means a substitute. I have not actually drafted an amendment, the minister will be very pleased to know, but this may well be something that needs to be looked at in the other place. Although it is in the clause itself, the heading is almost an editorial decision by parliamentary counsel. Can I confirm that what the minister actually means is “substitute”?

Mr R.H. COOK: The member is quite right. This clause is to allow a member to step in. I am provided with robust advice that “alternate” is the correct term to use. I am happy to go away and do some research on that, but I am pretty confident that this is consistent wording and practice in Western Australia.

Ms M.M. QUIRK: It is certainly used by Main Roads, and I forgive it, because I have surmised that there is not enough room on signs for “alternative” as opposed to “alternate”, but in this case we are not swapping backwards and forwards, we are putting somebody else in to replace them. I will provide for the minister’s advisers a copy of a paper titled “44 Common Confusions to Annoy the Grammar Police”, which may assist.

Clause put and passed.

Clauses 130 and 131 put and passed.

Clause 132: Quorum —

Mrs L.M. HARVEY: I seek clarification from the minister. This clause states —

A quorum for a meeting of the Board is 3 members of the Board.

But further on in this division there is a provision that if members disclose a personal interest, they need to excuse themselves, and they may be declared ineligible to participate in meetings under clause 141. Then, under clause 142, if a member is disqualified under clause 140 in relation to a matter, the quorum is actually two members. I seek a bit of clarification on this matter. It seems to me that, if there are five members of a board, it would be a highly unusual circumstance for three members to be unable to vote on a matter. I query why we have this option to allow a meeting to convene with only two members present, as a quorum.

Mr R.H. COOK: I am advised that this covers a highly exceptional circumstance that would be very rare indeed. It is simply a standard mechanism to make sure that the board can continue to function. For instance, I think the Environmental Protection Authority dealt with some issues some years ago with respect to Rio Tinto. Because of the nature of Rio Tinto, a number of the members of the board had to excuse themselves, and they got very thin on the ground. This is simply a mechanism that would allow the board to continue to undertake its function and make sure that it does not become paralysed.

Mrs L.M. HARVEY: Therein lies the issue that I would like to raise: when a number of members are disqualified or unable to vote, would it not seem more appropriate, rather than reducing the quorum from three to two, to substitute a member of the board for the purposes of the board’s deliberations? Would that not head off issues that could arise, similar to those matters that arose in that Environmental Protection Authority decision, which ended up being made by, I think, a committee of one?

Mr R.H. COOK: This is a common and standard approach to maintain the functions of the board. The member would understand that this would arise when a board of three members is dealing with matters, as it usually would, and a board member has a conflict of interest. That member would step out—that is so the board would not lose its quorum. I understand the point the member makes, but this is stuff that government boards and governments generally seek to avoid. It is simply there to make sure that the circumstance in which a board cannot function does not arise, because there are three members sitting in a room deliberating, and one has to excuse themselves. It is there to make sure that the board can continue to function. I accept the premise of the member’s argument—it is not the best approach and in terms of competent management of government we would seek to avoid it ordinarily.

Clause put and passed.

Clauses 133 to 135 put and passed.

Clause 136: Holding meetings remotely —

Mrs L.M. HARVEY: Clause 136 relates to the composition of the board. Does the minister envisage that there will be regionally based members on the board who will be able to participate in meetings via video link or via whatever other way that modern technology allows?

Mr R.H. COOK: Absolutely; we could also envisage a situation in which a board member is in Sydney for the day. This will not stop them from participating in a board meeting.

Clause put and passed.

Extracted from finalised Hansard
Clause 137 put and passed.

Clause 138: Minutes —

Mr Z.R.F. KIRKUP: The minister would appreciate that I would not ask questions that could be dealt with in a normal setting, but I want to satisfy myself about the publication of minutes. Does the minister anticipate that the minutes will be published and made publicly available? Does that usually happen in other circumstances?

Mr R.H. COOK: No; the minutes would ordinarily not be made available as they are by other boards. I wonder whether they will be subject to FOI—I am not sure. If they were, personal information would not be publishable. But, as the member says, this is what occurs in the normal course of a board’s life.

Ms M.M. QUIRK: The issue about disclosing the minute relates to patient privacy and this will be part of the implementation phase. I accept that the minister may not be able to answer this question at this stage, but is it likely that instead of using names, some sort of convention such as numerical identification will be used? Will that be problematic given that a patient’s name will appear on all the paperwork?

Mr R.H. COOK: The member is right: this stuff will be worked out administratively. I think it would be more likely that if the minutes of a meeting were FOI-ed, the information would be redacted rather than relying on a numerical or some other de-identification system.

Clause put and passed.

Clause 139: Disclosure of material personal interest —

Mrs A.K. HAYDEN: Clause 139(1) states that a member of the board who has a material personal interest has to declare that beforehand, and if they do not, there is a penalty of up to $10,000. Can the minister explain what a “material personal interest” is?

Mr R.H. COOK: Again, this is a standard provision for WA boards. A material personal interest is one that is personal to the member and not to the general public, nor an interest of another person. The interest must be material—that is, not trivial.

Ms M.M. QUIRK: It appears that so long as a person declares an interest, they will not be precluded from sitting on the board. The example I can think of is maybe a medical practitioner who is in a practice with a partner who in fact is a coordinating medical practitioner, or what have you, or is in a practice that promotes their services in this regard. As I said, the important thing is disclosure, rather than prohibiting that person from sitting on the board. That is certainly the minister’s understanding. There may be some interest above and beyond the interests of a normal member of the public, but a person is not precluded from sitting on the board so long as disclosure is made.

Mr R.H. COOK: The matters relating to disclosure of material personal interest are further expanded in clauses 140 and 141. Again, these are unremarkable clauses that deal with the usual processes of a government board. I also stress that a board member is subject to all the provisions of the Public Sector Management Act and other obligations under good governance.

Mrs A.K. HAYDEN: I note that when the minister sometimes gives his answer, he reads them out, which is fine; I understand that there is a lot of detail to get across. But the fact is I am asking a question about a material personal interest because there is a fine attached to it if that is not disclosed. I do not appreciate the minister being dismissive and suggesting that we should know that because it is common knowledge. It may be common knowledge to the minister, but, as I said, the minister is reading out his answers, so it cannot be that common. I point out that this is a debate for the whole Western Australian community so that they can understand what everything means. When we have asked some questions, we have got some eyeball rolls, suggesting that they are silly questions. But I want examples from the minister about what a material personal interest is.

Ms A. Sanderson interjected.

Mrs A.K. HAYDEN: See—getting eyeball rolls from backbench members is not helpful. This is a debate so that the person on the street in Western Australia can read this and understand it at any time. They should not be expected to know about the standard roles of board members and the like. All I ask for is a little bit of flexibility. We are nearly finished, members.

The DEPUTY SPEAKER: Member, just pop the question you want.

Mrs A.K. HAYDEN: As we go into further clauses, could the minister at the table, and not the backbench, give an answer and provide an example of what a board member will be able or unable to vote on?

Mr R.H. COOK: Member, I would not worry about the eyeball rolling that goes on around the place. There are much worse things that take place in the Parliament—’tis the nature of the Legislative Assembly. We need to make sure that we are immune to those sorts of things. I am saying that these clauses are unremarkable in that they are the standard provisions that relate to a board member. A material interest, for instance, may be related to a person under a matter of consideration.

Extracted from finalised Hansard
That would be a material interest. The board might be considering a financial transaction that the person has some relation to. That would be a material interest. From that perspective, the conventions and rules around these things are well known in the context of the Public Sector Management Act. When someone becomes a member of the government board, they get their induction and it is made sure they are made aware of their obligations under the legislation.

Clause put and passed.

Clauses 140 and 141 put and passed.

Clause 142: Quorum where s. 140 applies —

Dr D.J. HONEY: I was just looking at the quorum. I was concerned that a quorum is two people. I would have thought that it would be prudent to make the quorum at least a majority of the board. I understand that there are five members on the board, but with a quorum of only two, matters may be considered, passed and acted on when not even a majority of the members of the board is present at the meeting. I wonder whether the minister could tell me why the number required to make a quorum is so low and why at least a majority of the board should not be required to make or vote on a decision, and not two people. Why would that minimum quorum not be three people?

Mr R.H. COOK: As they say in the classics, there are no prizes for second, and I am afraid the Leader of the Opposition has already beaten the member to the punch on this issue. I apologise if the member was not here when we discussed clause 132, but there was a fairly extensive discussion about those special circumstances in relation to this. To summarise the discussion, this is essentially for when there are three people in the room and for a particular matter a member has to excuse themselves. It is just so the board can continue to operate for the purposes of that matter. Obviously, in the ordinary matter of events the board would be managed in such a way that this does not occur, but this is simply a stopgap measure to make sure the board could continue to deliberate.

Clause put and passed.

Clause 143: Minister may declare s. 140 and 142 inapplicable —

Ms M.M. QUIRK: I do not know whether this is a standard clause or not. It seems quite strange to me. It states that the minister may declare sections 140 and 142 inapplicable. That relates to voting by an interested member and a quorum when there is voting by the member. The explanatory memorandum says —

This clause enables the Minister to declare, in writing, that either or both clause 140 (voting by interested member) and clause 142 (quorum where section 140 applies) do not apply to a specified matter, generally or in voting on particular resolutions. The declaration must be laid before each House of Parliament within 14 sitting days after it was made.

I have a couple of questions. The first is: can the minister explain why this clause is necessary? The second is: why is it considered appropriate to table such a declaration in each house of Parliament when for other matters that we have asked to be tabled in Parliament it was not considered appropriate to do so?

Mr R.H. COOK: My understanding is that this is a standard clause and is consistent with WA practice and administrative necessity. The reason the minister’s declaration must be laid before each House of Parliament within 14 days is that the minister has come to a view that perhaps a potential material interest is not a material interest, but it is appropriate that there is some transparency about that. It is consistent with WA practice and is essential to good governance.

Ms M.M. QUIRK: I understand that this might be a standard clause for a busy board that meets frequently. I know this will be considered in the implementation phase, but how often is it contemplated that the board will meet? Is this really necessary? Is it not possible to undertake these meetings more on phone lines so that a quorum could be insured without problematical members needing to participate? I think it is an interesting clause, given that we may be talking about half a dozen, if that, meetings a year, if that, the predictions of the number of people who will avail themselves of voluntary assisted dying are accurate.

Mr R.H. COOK: Again, this is standard architecture for legislation that contemplates a board to oversee its functions. On the question of how often it would meet, I refer the member to clause 131, which says “must be held at times and places determined by the Board”. It is to be discovered to what extent the board will meet to discharge its duties. As the member says, these matters would be resolved in the implementation phase. Having these provisions in the legislation is the standard architecture we expect in this sort of legislation overseen by a board in order to make sure it can discharge its functions.

Clause put and passed.

Clause 144: Establishment of committees —

Mr Z.R.F. KIRKUP: I refer to subclause (1). This might be a regular thing, and if so, I appreciate that is the case and apologise in advance. What other committees would be established to assist the board? Does the minister have an understanding of what that might look like so that he can provide me a bit more exposure of what that would usually mean?

Extracted from finalised Hansard
Mr R.H. COOK: Yes, again, it is standard for a government board to have the authority to establish committees. For instance, the health service provider boards have a risk and audit committee, which is a standard element of the work they do. This simply makes sure the board has the authority to undertake these tasks.

Mrs L.M. HARVEY: Further to this, subclause (3)(b) says that the board may appoint any members of the board or other persons as it thinks fit to be members of a committee. Presumably, members of a committee would be entitled to remuneration. I seek clarification from the minister whether a board member appointed to a committee would be doubly remunerated.

Mr R.H. COOK: No, they certainly cannot double dip. Remuneration is covered under clause 130, which essentially states that I would act on the recommendation of the Public Sector Commissioner on remuneration of all board members. One example is that a person cannot be paid to be a public servant and paid to be a board member at the same time. Those sorts of issues would apply. They are again administrative matters.

Mrs A.K. HAYDEN: Under clause 144(3), does the minister have oversight of or input into the appointment of any members of the board or other persons?

Mr R.H. COOK: No, member.

Mr P.A. KATSAMBANIS: Clause 116 confers a status on the board that it is an agent of the Crown and has the status, immunities and privileges of the Crown. Will the committees have exactly the same status, immunities and privileges under this clause?

Mr R.H. COOK: I have received some comprehensive advice on this question—no.

Clause put and passed.

Clause 145: Directions to committee —

Mr Z.R.F. KIRKUP: Will the directions that the board gives to a committee be published in any way? If not, could that be accessed through the FOI process or parliamentary questions?

Mr R.H. COOK: It would not ordinarily be reported to the Parliament. It is essentially the internal functions of the board that we are considering here. The directions would form part of the minutes, so technically one could FOI the minutes. This clause is essentially to make sure that the committee is a beast of the board and that the board maintains control of the functions of the committee at all times.

Mr Z.R.F. KIRKUP: Given the directions from the board to the committee, would the board have to report the establishment of those committees in its annual report? I am conscious that a situation might exist across the health system, as I have found, where all types of boards and functions might be established that we do not know about until we delve quite deeply into it. Is there a way for the board to publish that it has created different committees to look at certain areas? If so, what mechanism would that take?

Mr R.H. COOK: That would be a function of its annual report. It certainly would report that sort of information in its annual report.

Mr Z.R.F. KIRKUP: The minister mentioned the risk and audit committee, for example. Could it be envisaged that if a particular issue were found with the monitoring of the act, the board would establish a committee specifically to look at that particular function? I imagine that would not be case specific but specific to a particular function or area of the act; is that correct?

Mr R.H. COOK: That is entirely a matter for the board. It might want to inquire into a particular issue and so it will send the committee off to have a look at that matter.

Mr P.A. KATSAMBANIS: Under clause 145, the board can give directions to the committee. Can the minister utilise the power under clause 122 to give directions to the committee if it is effectively a beast of the board? Could the minister issue similar directions utilising the powers in clause 122?

Mr R.H. COOK: It is not intended that that is the case, although technically, as the member observed, the minister can make a direction to the board. The board would then potentially execute that through the committee. The committee is a function of the board. From that perspective, the chain of command is through the board rather than directly between the minister and the committee.

Mr P.A. KATSAMBANIS: That helpfully answered my next question: could any minister direct the board and then pass it on to the committee?

Mrs A.K. HAYDEN: I apologise if the minister included this in his answer; I may have missed it: does the minister have any oversight of this?

Mr R.H. COOK: Only through the board, member. This is a subcommittee of the board as such. Going back, for instance, to the risk and audit committees of the health service provider boards, I do not have a relationship with those subcommittees; I have a relationship with the board through the chair.
Mrs A.K. HAYDEN: Just to clarify: if they give directions to the committee, is there no need for them to advise the minister of those directions? Will the minister just read it in the annual report?

Mr R.H. COOK: Yes.

Clause put and passed.

Clause 146 put and passed.

Clause 147: Remuneration of committee members —

Mr Z.R.F. KIRKUP: I presume this clause relates to the remuneration of committee members rather than board members. Can the minister give me an example of other committee members, a comparative board, to which this would apply? I imagine that a number in Health would be equivalent. I am keen to understand how much they would be paid or what that function looks like. I appreciate that that information might be difficult to provide on the fly. Perhaps the minister could provide an understanding of that later.

Mr R.H. COOK: Yes, I certainly cannot tell the member what they will be paid. Ultimately, that is something that is done on the recommendation of the Public Sector Commissioner, who takes a range of issues into account in terms of the nature of the committee, what it is advising on, and the status—for want of a better description—as in the skills and experience of the people who will be on that committee. I envisage that the board might want to have a committee that has a clinical aspect to it; for instance, to advise the board from time to time in relation to those things. That could potentially be one of those things. Ultimately, these matters are decided by the Public Sector Commissioner, who makes a determination on the appropriate remuneration. I remind members of my earlier comment that public servants do not get remunerated on a board anyway.

Mr Z.R.F. KIRKUP: I appreciate that the recommendation comes from the PSC to the minister; is that right?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: There is no requirement for a committee member in this case. They are not appointed through Executive Council or anything like that; they are just a sub-function of the board; is that right?

Mr R.H. Cook: Yes.

Mr P.A. KATSAMBANIS: I seek the minister’s view of how this might operate in practice. There will be committee members and there will be a determination. Usually a different annual fee is payable to a chairperson and a deputy chairperson to reflect their roles. Permanent members or members appointed get a different fee again. Often committee members end up getting sessional fees.

Mr R.H. Cook: Yes, that is right.

Mr P.A. KATSAMBANIS: If there were a situation in which a member or members of the board were sitting on the committee who were already paid their annual fee, and sessional members were entitled to a fee, would the board member sitting on the committee ordinarily also be entitled to the sitting fee or sessional fee in addition to the board fee payment, or would it be expected that they sit on those committees without additional payment?

Mr R.H. COOK: I addressed this in answer to an earlier question from the Leader of the Opposition—no, people cannot double dip. To clarify, if a board member receives a standard remuneration, they cannot then pick up a sessional fee on top of that. These things are decided by the Public Sector Commission and are done in a way that limits the capacity of a member to be inappropriately remunerated.

Mr P.A. KATSAMBANIS: I was asking only for clarification. I am not sure whether it is appropriate or inappropriate. I can imagine circumstances in which it might actually be appropriate when board members are recompensed an annual fee on the understanding that they will need to spend X amount of time as board members. If they are co-opted to other committees, that may be additional time. I was seeking clarification on that. I am not wedded to one side or the other.

Mr R.H. COOK: It is all about the Public Sector Commissioner and the way in which, in this case, she manages these things.

Clause put and passed.

Clause 148: Board to send information to contact person for patient —

Mr Z.R.F. KIRKUP: The preamble to clause 148 states that the board must send information to the contact person for the patient. Will there be a prescribed format for how that information will need to be sent? I know it sounds a bit ridiculous, but I am conscious of the distance and the nature of what we are trying to achieve. Will the information need to be provided in a prescribed manner?

Mr R.H. COOK: No, there is not a prescribed manner, but obviously it would depend on the circumstances of the person to whom the information is sent. I refer to the issues raised by the member for Girrawheen about the person’s cultural background and things like that. There might be different forms in which that information would be held.

Extracted from finalised Hansard
Mr Z.R.F. KIRKUP: I appreciate that, minister. We have spoken a lot about the role of the portal, particularly in the entering of information and the recording and monitoring of that information through the board. Does the minister imagine that in this case, the contact person might also have some involvement with the portal? Is that a possibility? Given that the patient will have to send the information to the contact person, will the contact person also have the ability to interact with the portal, or will it have to be done by email or phone? How will the contact person be provided with the information?

Mr R.H. COOK: No, I would not think that the contact person would have interaction with the portal. The onus will be on the board to ensure that the information is received by the contact person. Therefore, from that point of view, we could not make reference to the portal and assume that the contact person had accessed it. We would need to make sure that the information was received by the contact person in that context. I guess that the contact person in that respect would be supported in the role they play, whereas a coordinating practitioner, for instance, would have received the mandatory training and would have a level of expertise and would themselves be accessing the service. Therefore, from that point of view, the portal would be supporting that person to undertake their role. This is about making sure the contact person has the information in their hot little hands and is supported in the process.

Mr Z.R.F. KIRKUP: I appreciate that, minister. The reason I am interested in clause 148 is that it provides that the board needs to satisfy itself that the contact person has been made aware of their responsibilities. Last night, we had a conversation about the possibility that the contact person was not aware that the patient was deceased, for example, because they had not been in regular contact. I imagine that this clause will enable the board to ensure that the contact person is expressly aware of their obligations. I appreciate that the contact person may not be involved with the portal. My only reflection on the portal is that it could provide an acknowledgment that the contact person had read and accepted—like terms and conditions—each particular element. If the board were to just provide the contact person with a range of material, there would not necessarily be any way in which it could satisfy itself that that had been done, depending on the way in which the information had been sent, which is the reason that I asked whether the contact person could be involved. Perhaps during the implementation phase of this bill, the clinical expert panel could look at whether it would be possible to provide a portal that the contact person could look at. That could be quite relevant. The information could easily be translated, according to the person’s linguistic background, and, if the person was in a remote setting, it could be sent through the internet. Similarly, it would enable the board to satisfy itself that the checks were in place and that the contact person had identified that they had read and understood their obligations and things like that. As the minister rightly pointed out, this clause places a lot of obligations on the contact person. The contact person will also have an obligation to be aware of the disposal site. Therefore, it might also be relevant to look at providing a portal into which the contact person’s address could be inputted and they could be directed to the nearest disposal site. We are trying to remove any friction points. Therefore, it might be worth the expert clinical panel looking at a portal as part of the transition phase.

The ACTING SPEAKER (Ms J.M. Freeman): I will take that as a comment.

Mr S.K. L’ESTRANGE: The minister will recall that during the debate on clauses 64 to 66, he made the point that the contact person will not need to be present when the patient decides to self-administer, for example. I assume that the board might not know whether that is the case. What information will the board provide to the contact person?

Mr R.H. COOK: Clause 148 provides that the board must, within two business days after receiving a copy of a contact person appointment form for the patient, send information to the contact person that explains the requirements under clause 104, and make sure that they understand their role and the information as set out in paragraph (b). It also outlines the support services that would assist the contact person to comply with the requirements of the bill. This is about ensuring that when the contact person is appointed, they are provided with a list of approved disposers, as the minister for Dawesville observed. Furthermore, this information would be publicly available, so they would be able to refer back to it. It is simply about making sure that the intent of the law is that the board supports the contact person in understanding their role and carrying out that role.

Mr S.K. L’ESTRANGE: The minister referred to clause 104. We know that the contact person will be required to give any unused or remaining substance to an authorised disposer within 14 days after the day on which the patient has died. In the debate on clauses 66 and 67, the minister highlighted that the contact person will not need to be there at the time the patient dies. Will the board provide information to the contact person about how to gain access to the premises, which will obviously involve legal aspects, and about how to collect any unused or remaining prescribed substance? Will there be any instruction on how that might occur?

Mr R.H. COOK: This will obviously be subject to extensive focus in the implementation phase. The member would understand that the board would provide information to the contact person to say, “Speak to the patient about the circumstances in which they are going to self-administer; and, if you are not going to be around at the time, make sure that you have made arrangements so that you can carry out your functions with regard to any unused portions of the voluntary assisted dying substance.” It is about assisting the contact person to anticipate what they will need to do to successfully carry out their functions. It reflects the point raised by the member for Dawesville.
about how we will know whether the contact person has all the information they need. Under clause 65(1)(e), the contact person will be required to make a statement to the effect that they understand their role so that everyone will be satisfied that the information has been communicated appropriately.

Mr S.K. L’ESTRANGE: Clause 65(1)(e) is important. One of the concerns that we raised during the debate on that clause is that the only qualification for the contact person is that they be 18 years of age or over. Let us say the board has made the statement under clause 65(1)(e) that the contact person understands their role. However, if during the course of preparing for the patient’s death the board came to the conclusion, or the opinion, whatever it might be, that the contact person was not competent or capable of understanding their role properly in this circumstance and to carry out their functions, could the board relieve that contact person of their duties?

Mr R.H. COOK: Ordinarily, we would anticipate that the board might raise concerns with the coordinating practitioner about whether the contact person is capable of carrying out these functions. If the contact person is an adult and has made a declaration to that effect, that is their right. Of course, the board is there to make sure, within its powers, that the law functions properly, so it would undertake whatever activities it felt necessary to satisfy itself in that circumstance.

Mr S.K. L’ESTRANGE: I think we are getting to the point of considering a situation in which the board is of the opinion that some of the key authorised activities of the contact person might be at risk. For example, we know that under clause 66(1), the contact person is authorised to receive the prescribed substance, supply the prescribed substance and give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer. It is a pretty serious role. Even after talking to the coordinating practitioner or the patient themselves, the board may say, “We think this contact person is a key person for you; they need to be present and involved with you but they simply do not understand.” The contact person might not have a good grasp of English, for example. There might be an issue around reading the instructions about the process. If the board determines they are not in a fit state to carry out the role, can the board step in and say, “We’re happy for this contact person to stay with you, but you need to consider appointing a new contact person who will be able to fulfil these duties properly”?

Mr R.H. COOK: We are starting to dig into the minutiae of this process. Under clause 148, the board will have the responsibility to make sure the contact person understands their roles and responsibilities. The requirement for the board to follow up with the contact person and remind them to return the substance in time is another safeguard in the bill to ensure that a voluntary assisted dying substance is used only for the patient for whom it is prescribed. We could contemplate any range of situations. From that perspective, we assume that an adult who makes a declaration in the context of this has the appropriate capacity to carry out their functions. They will have made a declaration to that effect and have been contacted. The board could ordinarily contact the coordinating practitioner and make suggestions about the way it operates. I think we have the necessary safeguards there. Obviously, a range of things could or might take place, but, ultimately, this provision will make sure the contact person has the information they need and is declared as such to carry out their functions.

Mr S.K. L’ESTRANGE: The minister has not answered the question. The question is a simple one: if the board thinks the contact person is not capable of carrying out their role, can the board intervene to see whether a new contact person is appointed? It is a simple question.

Mr R.H. COOK: The board could talk to the contact person; it could contact the coordinating practitioner; it could contact the patient and have a discussion about these things. Under the legislation, it does not have the power specifically to bar someone from being a contact person.

Mr S.K. L’ESTRANGE: What support services will be available to assist the contact person to comply with the requirements referred to in clause 148(a)?

Mr R.H. COOK: That will be provided for in the implementation phase. The member will understand that it will be reviewed and updated as experience provides.

Mr S.K. L’ESTRANGE: Can the board delegate this function to a committee under clause 144?

Mr R.H. COOK: No. The board is ultimately responsible for its own powers. It may choose to use the committee to undertake particular activities, but, ultimately, this will come down to the responsibilities of the board to ensure they take place. Ordinarily, it would be managed by the secretariat and the Department of Health for the day-to-day functions of these things. It is the responsibility of the board to ensure it takes place.

Ms M.M. QUIRK: I think clause 148 contemplates that the patient will undertake self-administration within a relatively short time; hence the instructions being sent immediately to the contact person. It may well be that the person who wants to self-administer does not do so immediately; in fact, it may be some time after the contact person has been appointed. The contact person might shove the letter in their drawer or whatever and not necessarily take a lot of cognisance of it at the time the material is sent, or the contact person might take cognisance of it and then forget the requirements by the time the patient ultimately gets around to self-administration. Under the Victorian legislation, the board is required to be notified seven days after death. In my view, that is probably a bit better because the whole circumstance of the matter will be fresh in the contact person’s mind— they will have the instructions in front of them and will see what they have to do. I think the difficulty with clause 148 is

Extracted from finalised Hansard
that it has the assumption that there will be a temporal connection between when the board notifies the contact
person of their obligations and when the death occurs. I make that as an observation. I would be pleased to have
the minister’s comments. Does there need to be some acknowledgement of receipt by the contact person? How
will we know that these requirements have been sent out and received?

Mr R.H. COOK: This sets out the very barest legal requirements for the board. Ordinarily, we would expect the
board to liaise with the contact person. If it receives information suggesting that the patient has passed away, someone
would pick up the phone and speak to the contact person to remind them. Clause 65(1)(e) provides that the contact
person must make a statement indicating they understand their role. The bill sets out the bare minimum to make sure
the system works. But to make sure the system works very well, a range of other informal processes will assist.

Clause put and passed.

Clause 149: Request for information —

Mrs A.K. HAYDEN: Clause 149(2) states —

"A person may comply with a request under subsection (1) despite any enactment that prohibits or restricts
the disclosure of the information."

The explanatory memorandum states that the provision does not provide power to compel someone to provide that
information. Is there any other person or body that can compel someone under this provision?

Mr R.H. COOK: Yes, member. Western Australia Police Force and the courts can compel someone under this
provision.

Mrs A.K. HAYDEN: Is the board able to delegate this part of the function to the committee?

Mr R.H. COOK: No, member.

Mrs A.K. HAYDEN: Just one final one. The board cannot pass information on to the committee. It can request
the information, but it cannot compel. As the minister said, it can send the request on to a police officer if it wants
to get that information, but it cannot compel. The minister is saying that other authorities can. Can the board make
that request to the authority that can compel?

Mr R.H. COOK: Does the member mean the committee of the board?

Mrs A.K. Hayden: The committee, sorry.

Mr R.H. COOK: The committee of the board is a function of the board. It is like any other subcommittee that is
established. P&Cs have fundraising subcommittees, for example. It is not a separate entity; it is part of the board.
If the board feels there is information that should be forwarded to the police for investigation, it obviously has the
power to do that.

Ms M.M. QUIRK: I move —

"Page 86, after line 21 — To insert —

(1A) A person must comply with a request under subsection (1) within the time, and in the
manner, required by the Board."

Penalty for this subsection: a fine of $10 000.

I have two amendments to this clause on page 9 of the notice paper. I have to say that I have reflected on whether
or not I should move this amendment because the contact person is, after all, being a good egg in agreeing to put
themselves forward and giving their name and address to act as the contact person. Under clause 149 as it stands,
the board may request any person, including the contact person for a patient, to give information to the board to
assist it in performing any of its functions. A person may comply with a request despite any enactment that prohibits
or restricts the disclosure of the information. The amendment is actually about noncompliance with the provision
of information. I think that is consistent with other parts of the legislation. There may well be good reasons why it
is not considered appropriate to have any sanctions for noncompliance. I appreciate that it could, for example,
include a patient, and we do not necessarily want to penalise the patient, but I would have thought that a recalcitrant
contact person should be subject to a fine.

I am not going to have a vote on this; I just make the comment. My second amendment on the notice paper relates
to line 22. Why does subclause (2) use the word “may” rather than “must”?

Mr R.H. COOK: I acknowledge the member’s comments about a contact person being a “good egg”—someone
who is simply trying to assist the process. We would not want them to be unnecessarily penalised or, indeed,
inappropriately discouraged from playing that role. I certainly accept the member’s arguments in that regard. This
is about making sure that a person can provide information to the board in a manner that allows the board to
undertake its functions. In the way they ordinarily would not be able to provide it to a third party, this simply provides
coverage for that person to provide that information so that the board can carry out its functions under the legislation.
The word “may” is used because some people are compelled to provide that information, such as a medical practitioner or someone to that effect, but, ultimately, a person at large cannot be compelled in that context, so the provision essentially empowers them to be able to do that if they wish to make that information available.

Amendment put and negatived.

The ACTING SPEAKER: The member for Girrawheen is not moving her second amendment.

Mr P.A. KATSAMBANIS: Clause 149(2) states —

A person may comply with a request under subsection (1) despite any enactment that prohibits or restricts the disclosure of the information.

If a person so complies, where is the protection for any breach of the prohibition or restriction of the disclosure that is contained in any other enactment? How are they protected from any prosecution under other acts if they comply with this request?

Mr R.H. COOK: By that very clause, member. That is the intent of this clause—to provide them with that protection. My attention is also being drawn to clauses 112 and 113, which provide further protections for persons acting in accordance with the legislation.

Mr P.A. KATSAMBANIS: Would that cover any prohibitions under federal law?

Mr R.H. COOK: State laws cannot bind commonwealth laws.

Clause put and passed.

Clause 150: Disclosure of information —

Mrs A.K. HAYDEN: Clause 150 states —

The Board may, on request, disclose information (other than personal information) obtained in the performance of its functions to —

(a) a public authority as defined in the Health Services Act 2016 section 6; or

(b) a person or body for the purposes of education or research.

If we have the purposes of education or research in paragraph (b), what is the reason for paragraph (a)?

Mr R.H. COOK: The purpose is basically to make sure that information can be shared in two different ways. The purpose of this provision is to enable public authorities, researchers and educational bodies to directly or indirectly improve or assist in the provision of the services these agencies provide to the WA community. The Health Services Act defines “public authority” as —

… any of these persons or bodies —

(a) a department of the Public Service;

(b) a State agency or instrumentality;

(c) a local government, regional local government or regional subsidiary;

(d) a body … or the holder of an office, post or position, established or continued for a public purpose under a written law;

(e) a person or body … prescribed …

The information about a person for the purposes of education or research is the one I was discussing with the member for Riverton earlier. If people are undertaking research in a university context to better understand, study or improve the system, that is obviously something that we would like to see encouraged.

Mrs A.K. HAYDEN: I thank the minister for that explanation. When he read out the list, he referred to a person or a body. Are they not already incorporated under paragraph (a)? My concern is that paragraph (b) says that information can be passed on for the purpose of education and research, but paragraph (a) does not say why it is being passed on—the purpose for it to be passed on. Under paragraph (b), there is a restriction that it is for research and education, whereas under paragraph (a), there is no such restriction.

Mr R.H. COOK: This is to further assist the board to carry out its functions of continued improvement of the legislation and the way it will operate. For instance, information may need to be provided to a disability services organisation that is involved in the provision of services to people accessing the voluntary assisted dying process or something of that nature. It is simply to make sure that the board operates in an open manner and provides information for the continued improvement of the legislation.

Clause put and passed.

Debate interrupted, pursuant to standing orders.

Extracted from finalised Hansard
Resumed from an earlier stage of the sitting.

Clause 151: Board to record and retain statistical information —

Debate was interrupted after clause 150 had been agreed to.

Dr D.J. Honey: Last night we heard questions around the coroner perhaps being involved in the collection of information for the recording and retaining of statistical information. The minister said that extensive data would be collected. When I look at the list of information here, it seems to be quite a short, restricted list of information that is to be retained. I wonder whether this is indeed the list. I see that the minister can give written direction, but obviously the minister will not have given written direction at this stage. A number of issues about this have been raised throughout this debate. One of those issues, for example, was the concern about doctor shopping. There is no restriction whatsoever in the act on the number of doctors that someone can approach to find someone to participate in this process—sorry, I thought the minister was distracted with another conversation.

Mr R.H. Cook: Sorry, I am going to take a quick break.

Dr D.J. Honey: I am sure the minister’s advisers can answer the question.

Mr R.H. Cook: They are more than capable, member for Cottesloe.

Dr D.J. Honey: As a reprise, Premier—I will not go through it in detail—the concern is about what appears to be a very restricted list of information that is to be recorded per se. As I said, one of the issues that members have spoken about is doctor shopping when either a patient or a coordinating practitioner gets repeated rejections and the person goes back to different doctors until they find someone who will go ahead with the process. Surely that would be an important piece of information for the Voluntary Assisted Dying Board to retain so that when it is reported back to the minister and Parliament, that information is available. That was a specific and legitimate concern raised by members in this place. We were told it is not going to happen very often and will be an infrequent occurrence. That would be an important piece of information to obtain to determine how well this bill is functioning. Is this indeed the list? Clause 151(1)(a) and (b) seem to contain a very restricted amount of information. Is that the information that they report on? I recognise that the minister can give direction, but in the first instance it is a very small list.

Mr M. McGowan: For the member’s information, the information as required under clause 151(a) and (b) is not the maximum, but the minimum required. As part of its reporting and advisory function, the board is able to advise the CEO of Health when the board is of a view that there is a pattern of doctor shopping amongst people deemed ineligible for access to voluntary assisted dying. In this way, the Department of Health may be able to look at how other areas of care support may be better developed. It may be that these patients require linkage to another part of the health system for care and support. The types of statistical information required to be provided in the Voluntary Assisted Dying Board’s annual report and stored and maintained by the board will include but not be limited to the number of people accessing and attempting to access voluntary assisted dying; whether the voluntary assisted dying substance was self-administered or practitioner administered; the age, gender and postcode of the participant; and whether the person died prior to the voluntary assisted dying process being finalised.

Dr D.J. Honey: I thank the Premier for that. Why was that not included in that clause? I appreciate that there is added additional information. Just to short-circuit discussions as I do not want to drag this out: How does this compare with the equivalent section in the Victorian legislation? Does the Victorian bill contain a more extensive list or, in fact, is it a similar list to this?

Mr M. McGowan: My advice is that the Victorian legislation has a similar base requirement, but the way it is structured here allows for the required information to be provided to expand, so it is a minimum. If we prescribed everything, in order to add more, we would have to come back and legislate.

Dr D.J. Honey: I am concerned about improper behaviour. I restate, I think and I am certain, that most people think that it will be a rare rather than common occurrence. But if, for example, the coroner was required to be involved in a matter, would that be part of a report? As legislators who are responsible for this legislation, how would we be aware of that information?

Mr M. McGowan: The answer to the member’s question is contained under section 154(2)(b). It will be all that information and potentially more. We will get to that clause shortly, but it states that the report must include — any information that the Board considers relevant to the performance of its functions …

Clause put and passed.

Clauses 152 and 153 put and passed.

Clause 154: Annual report —

Mrs A.K. Hayden: In relation to clause 154, titled “Annual report”, a lot of the questions we have asked today and over the debate have been about reporting—who we find the information, whether the minister has oversight,
and whether they report to the minister. Everything was referred back to the annual report. I understand that the annual report will hopefully answer all the questions that we have asked earlier on the minister having oversight of what the board is doing. Clause 151(2) states, as the Premier indicated, that anything to do with the board recording and retaining statistical information will be in the annual report. Clause 151(2) states that the minister may give a written direction to the board requiring it to look into a certain matter. If an issue comes up in the annual report, is the minister able to go back and ask the board a question on something within the report under clause 151(2)? In other words, although it has happened and has been reported on, does the minister have the ability to direct the board to look into something that has been raised and reported in the annual report?

Mr M. McGowan: Yes.

Mrs A.K. HAYDEN: The answer was “yes”, for Hansard, because normally we sit down and stand up.

Mr M. McGowan: Not always!

Mrs A.K. HAYDEN: Again, clause 154, “Annual report”, refers to a few other issues where details of any disclosure under certain sections are reported for everyone to read. Will those annual reports be tabled in Parliament or just made public online?

Mr M. McGOWAN: Clause 154(4) requires the report to be laid before both houses of Parliament.

Mrs A.K. HAYDEN: We talked about the board being able to create a committee and not needing to report back to the minister on that committee. Will the annual report contain details such as who the committee members are and what jobs and powers have been bestowed upon them by the board? Will the committee work also be tabled in the annual report, along with details such as who is on the committee, what they are being paid, what directives they have been given, and what powers the board has given them to act on its behalf?

Mr M. McGOWAN: The answer is yes.

Mr Z.R.F. KIRKUP: In answer to our questions in consideration in detail, the Minister for Health has spoken a number of times about information that will be contained in the annual report but is not specified in the bill. We raised a concern about medical practitioners who might have a higher than average involvement in being a coordinating or a consulting practitioner. I think the minister noted that that would be an issue as well, and that he would not want to see a particular entity set up for any particular purpose like that. Clause 154(3) excludes the medical practitioner’s details. I am keen to understand how it would be identified to the public, for example, if there were an issue like that with a certain entity that was to be established. If we cannot include the details of a medical practitioner or their facility, how would the public or Parliament be informed about any issues that the minister himself considered a potential problem?

Mr M. McGOWAN: It would be unusual and irregular to publish the details of the practitioner. If we did, for those people who are not comfortable with these laws, I would have thought that they would not want that.

Clause put and passed.

Clause 155 put and passed.

Clause 156: Communication between patient and practitioner —

Ms M.M. QUIRK: There has been an issue around situations in which the medical practitioner uses audiovisual communication, and whether that may fall foul of sections 474.29A and 474.29B of the commonwealth Criminal Code Act 1995. We heard last week that the Attorney General has written to the federal Attorney-General. Has the Attorney General had a response to that on the constitutionality or otherwise of discussing assisted dying over the federal communication system?

Mr M. McGOWAN: The advice I have is that this matter has been dealt with on a number of occasions in a number of clauses. The second reading of the Telecommunications Act through the commonwealth Parliament indicated that that act was intended to deal with cyberbullying with the potential outcome of suicide by a victim, which is not the circumstances with which we are dealing. The advice from the Department of Health is that there is no inconsistency, but it is liaising with the commonwealth.

Ms M.M. QUIRK: I had tabled a letter from the state Attorney General, John Quigley, to the federal Attorney-General, Christian Porter, dated late August. Have we had a response to that yet?

Mr M. McGOWAN: The advice is that we do not have a response.

Ms M.M. QUIRK: Finally, in this letter, the Attorney General said that he had taken legal advice at the highest level and it is his view that communications about voluntary assisted dying via a carriage service do not contravene the commonwealth Criminal Code. Who provided that advice?

Mr M. McGOWAN: The advice was received from the Solicitor-General of Western Australia and the State Solicitor and, in any event, clauses 156, 156(4), 157, and 157(4) ensure that there is no inconsistency with commonwealth law.

Extracted from finalised Hansard
Dr D.J. HONEY: During this debate there has been a bit of variation in some answers. This area has been covered before, but I want to get a clear answer on two points, please. The first point is that whilst we call it audiovisual communication, a pure telephone call without vision can comprise an appropriate communication.

Mr M. McGOWAN: I think it may have been answered before, but it is audiovisual.

Dr D.J. HONEY: The reason that I ask—I am not trying to be tricky; I just want to get clarity for the record—is that we have had three different ministers at the table giving answers and one response indicated that a telephone conversation by itself would comprise appropriate communication. I am quite happy for the Premier to confirm that it is in fact audio and visual and not simply a telephone call. It is just that a different opinion had been given in answer to a different question.

Mr M. McGOWAN: The advice I have is that there has been no inconsistency between any of the ministers, and that it is visual and audio at the same time.

Dr D.J. HONEY: Thank you, Premier. I would like to again confirm that a first request with a medical practitioner and request to access voluntary assisted dying via, for example, a FaceTime communication, would comprise a formal first request of a medical practitioner by that person.

Mr M. McGOWAN: As long as it complies with the requirements for a request contained within clause 17.

Clause put and passed.

Clause 157: Information about voluntary assisted dying —

Mrs A.K. HAYDEN: Clause 157 states —

(1) In this section —

authorised official means —

(a) the CEO; or

(b) a public service officer employed in the Department; or

(c) a person designated as an authorised official under subsection (2).

(2) The CEO may, in writing, designate persons, or persons … as authorised officials …

Can the Premier explained the purpose of the authorised official? If I understand it correctly, the purpose is to have an authorised official out there giving information on access to VAD. Why do we need that when we have medical practitioners who are already giving that information on first request? On the first day of the debate, we debated that medical practitioners are to give that information and not refuse that information. They can give a pamphlet or redirect the patient. Therefore, why do we need an authorised official?

Mr M. McGOWAN: This is to ensure that there is proper community and practitioner education as people would expect with such a significant piece of legislation.

Mrs A.K. HAYDEN: Premier, if it is to create awareness, where will the authorised official work out of? What is the actual plan and role for this person? What place within the department will it be? Will it be at a surgery?

Mr M. McGOWAN: That is a ministry matter that will be decided by the director general of the Department of Health, and no doubt it will be somewhere within the Department of Health.

Mrs A.K. HAYDEN: Will it be limited? Can there be an unlimited number of authorised officials, or will it be just one to enable the communication that goes out?

Mr M. McGOWAN: There will be no limitation on the number of people.

Clause put and passed.

Clauses 158 to 159 put and passed.

Clause 160: Interpreters —

Ms M.M. QUIRK: This clause deals with interpreters. In clause 160(2) an interpreter for a patient must be accredited by a body approved by the CEO. Are we able to contemplate what the body is?

Mr M. McGOWAN: It would be a body such as National Accreditation Authority for Translators and Interpreters.

Ms M.M. QUIRK: Premier, I understand that that is the only body, so I am wondering why we do not put that in the legislation rather than a body approved by the CEO?

Mr M. McGOWAN: It should not be limited because new bodies might be created or things of that nature. As long as it is nationally accredited, that is the requirement.

Ms M.M. QUIRK: I do not know that it says that anywhere, but I will look at the explanatory memorandum. I have had a bit to do with an interpreter who used to work at Sir Charles Gairdner Hospital. This certainly happened under

Extracted from finalised Hansard
the previous government and, I think, is continuing; that is, contract agency personnel are being brought in to interpret on health issues who do not have a good understanding of the nuances and issues around health conversations, so there have been some misunderstandings. The explanatory memorandum does not state “nationally accredited” either.

Mr M. McGOWAN: Clause 160(2) states —

An interpreter for a patient —

(a) must be accredited by a body approved by the CEO; …

Ms M.M. QUIRK: We can read that as the National Accreditation Authority for Translators and Interpreters because there is no other body.

Mr M. McGOWAN: Not at this point in time. It might change its name, or other bodies might come into existence.

Ms M.M. QUIRK: I refer to NAATI-accredited interpreters. There are a number of languages for which there are no NAATI-accredited interpreters in Western Australia, so the only availability is through a telephone interpreter service. As we discussed in other sections, the only way for that interpretation to take place would be over the telephone. Were the issues surrounding the use of a carriage service considered in the context of this clause?

Mr M. McGOWAN: The requirement will be for an accredited body, but if a telephone service is required to be used for assistance, particularly in remote or regional areas, the department will follow the Western Australian health system language services policy and detailed practical guidelines, which apply the state government’s “Western Australian Language Services Policy 2014” to the unique conditions and complexities of the Western Australian health system.

Ms M.M. QUIRK: I think this will be my final question on this. The question was slightly different from that. Cases in which an accredited interpreter is not available in Western Australia will necessitate the use of a telephone interpreter service to access an accredited interpreter in another state. Have the issues surrounding the constitutionality of the various clauses in which communication by telephone or audiovisual means was permitted been addressed in the context of this clause?

Mr M. McGOWAN: The interpreter will not be providing advice. They will just be interpreting. They will not be inciting or coercing or anything of that nature. The advice is that it does not infringe upon any laws.

Ms M.M. QUIRK: That is a great answer, Premier. I am asking whether that issue was considered in the context of this clause. It has obviously just been considered now.

Mr M. McGOWAN: Yes, it was.

Clause put and passed.

Clause 161: Regulations —

Mrs L.M. HARVEY: Clause 161, “Regulations”, creates a regulation-making power within the legislation. Can the Premier detail what regulations he thinks may be required to complement this legislation?

Mr M. McGOWAN: The bill does not require any regulations to be made. The bill has been drafted as a comprehensive piece of legislation to operate quite prescriptively and to stand alone. This general regulation-making clause is a futureproofing mechanism. However, it is not anticipated that any regulations will be made under the provision. The bill is very comprehensive. It is far more detailed than the Victorian legislation. CEO approval is required for certain aspects within the purview of the Department of Health.

Mrs L.M. HARVEY: Mention has been made of a number of forms that will be required. Are they likely to be gazetted by way of regulation or will those forms just be available on a website?

Mr M. McGOWAN: The forms will be approved by the CEO. There is no reason that they would be published on a website and no reason they would not. The forms will be created and issued by the CEO, not by regulation.

Mrs L.M. HARVEY: Just to be clear: the forms for people wanting to access voluntary assisted dying will not be tabled in the Parliament.

Mr M. McGOWAN: No.

Mr P.A. KATSAMBANIS: I am picking up on the Premier’s answer that the bill was drafted in a way that does not require any regulations to be made prior to its coming into effect. As the Leader of the Opposition pointed out, the bill provides significant discretion to the CEO to do many things, including to approve certain types of forms, which directly bypasses the need for any regulations. As a legislator, I think the power to make regulations is an important check and balance in our system. It particularly enables Parliament to scrutinise regulations made by the executive. The drafting of this bill to specifically exclude and bypass regulations in favour of a CEO’s directive is clearly a deliberate choice by the government. I believe it is another reason this legislation is not as good as it could be, because it deliberately bypasses parliamentary scrutiny for things that in the ordinary course of events are either included as schedules to acts or are done by regulation in lots of other legislation that relates to far more.

Extracted from finalised Hansard
innocuous matters than legislating for the taking of a person’s life. The Premier can take this as a comment. I know that is the clear intent of the government. I think it is one more indication to the public of Western Australia that this piece of legislation is clearly intended to bypass the scrutiny of Parliament and therefore bypass the scrutiny of Western Australians. It is one more alarm bell that causes concerns about this legislation.

Mr M. McGowan: The bill is actually far more comprehensive and far more prescriptive than the Victorian legislation. It is a far more substantial piece of legislation. The bill actually sets out what is required in the forms in far more detail. Obviously, legislation is a more accountable way of doing things than subsidiary legislation, such as regulations, because it goes through Parliament in this manner with full and comprehensive debate, as opposed to what happens with regulations, which are passed every day without that system of accountability.

Clause put and passed.

Clause 162: Review of Act —

Mrs L.M. Harvey: This clause relates to the review of the legislation. It is worded in a somewhat confusing manner. The way I read it is that the effectiveness of the legislation will need to be reviewed as soon as practicable after it has been in operation for two years and a report is to be prepared. After that first review on the second anniversary, there then needs to be a review after not more than five years. But subclause (2) reads —

The Minister must cause the report to be laid before each House of Parliament as soon as practicable after it is prepared, but not later than 12 months after the 2nd anniversary or the expiry of the period of 5 years, as the case may be.

I interpret that to mean that when we hit the two-year anniversary, a report will be compiled and the minister will be compelled to table that report. However, according to subclause (2), the minister will not need to table it until a period of five years has elapsed.

Mr M. McGowan: No. The wording essentially means that the report must be tabled within 12 months of the second anniversary, and then for the five-yearly reports, the report must be tabled within 12 months of each fifth anniversary after the second anniversary.

Ms M.M. Quirk: Was any consideration given to a review being conducted by a parliamentary committee rather than it being left somewhat ambiguous as to who will conduct the review? The clause states that the minister will “cause the report to be laid”.

Mr M. McGowan: It is quite standard for a review clause such as this to enable a review to be undertaken in this manner and then a report tabled, but there is nothing to stop a parliamentary committee from conducting an inquiry or review if it so desires.

Mrs A.K. Hayden: With regard to the review after two years, what will happen if, prior to the review, there is a wrongful death under this legislation? For example, it might be identified that there was coercion, an error was made in the diagnosis of the illness or an error was made in the decision-making. What happens if it comes out later that this did occur and there was a wrongful death? I understand that the intent of this bill is to assist people, but members have raised concerns in this place about unintended consequences for vulnerable people. Let us hope it does not happen, but what will happen if a person does pass wrongfully because it is later proven that they had falsely passed the criteria? Is there room for the minister to review the legislation immediately and table a report on that wrongful death or to advise Parliament on recommendations to either repeal or amend that flawed provision?

Mr M. McGowan: There is nothing to stop a minister from undertaking any such inquiry should they so wish. There is nothing to stop a parliamentary committee of its own accord or by motion of the house from undertaking any such inquiry. The review mechanism applies not to individual cases but to the operations of the act. We have already dealt with penalty provisions, which allow for a police inquiry if there is any unlawfulness or anything of that nature.

Mrs A.K. Hayden: I thank the Premier for that. Again, if there is a wrongful death in Victoria under a section of its legislation that is reflected in our legislation, will the minister advise Parliament that there is a possible flaw and look at addressing that immediately?

Mr M. McGowan: There is nothing to stop a minister, a parliamentary committee or the police from undertaking inquiries into any irregularities. If something happened in Victoria, I assume it would be published and that the Parliament, the press and/or anyone else who wanted to make known any such irregularities in Victoria would no doubt make it public.

Clause put and passed.

Clause 163: Act amended —

Mrs L.M. Harvey: Part 11 of the bill deals with consequential amendments to other acts. I want to go back to clause 95, which actually modifies the operation of sections 75, 77, 78 and 79 of the State Administrative Tribunal
Act 2004. I note that there is not a consequential amendment under this part to the State Administrative Tribunal Act, but that there are consequential amendments to every other act that will be amended by this legislation. I seek the Premier’s advice on why there is not a consequential amendment for the State Administrative Tribunal Act.

Mr M. McGowan: Any amendments to the SAT act are already in the substance of the bill.

Mrs L.M. Harvey: Could the Premier explain that in a little more detail? Every act that will be amended by this bill has a consequential amendment in part 11, except the SAT act. I want to know why that act is different.

Mr M. McGowan: The State Administrative Tribunal Act contemplates within its wording that any enabling act, which the Voluntary Assisted Dying Bill will be, can amend it in the actual act and not by a consequential amendment. There are provisions within the 162 or thereabouts clauses that we have dealt with that amend the SAT act, such as clause 91.

Mrs L.M. Harvey: I am not sure that the Premier has adequately explained it. I think the Premier may be referring to the SAT act perhaps having an overarching section that says that if other enabling legislation refers to the SAT act, that enabling legislation has priority over the SAT act. Is that where we are up to with it? As such, we do not necessarily have to amend the SAT act because there is an overarching section of the SAT act that says that enabling legislation will take precedence.

Mr M. McGowan: The answer is yes, and the State Administrative Tribunal said that the way that we have done it in the content, the first 162 clauses of the Voluntary Assisted Dying Bill, is the correct way to do it.

Clause put and passed.

Clauses 164 and 165 put and passed.

Clause 166: Section 3A inserted —

Dr D.J. Honey: We have discussed this in some reasonable detail before, and I want to make clear that I suspect the answer we will get has been given before. Not making this a reportable death that is subject to investigation by the coroner is, I think, a deficiency in the legislation. I heard the reasons that have been given, but I do not think those reasons hold water. We report deaths of people who are murdered, who are in motor vehicle accidents, from accidental drug overdoses and the like, and those things are potentially embarrassing to people. Having said that, I have never heard anyone quote a death certificate to me in a situation in which it is not a matter of choice for that individual. Those causes of death are reported on the death certificates. In this case, there should be a record on the death certificate, recognising that there is no shame in it. This has been previously answered at length.

Mr M. McGowan: Thank you.

Clause put and passed.

Clauses 167 to 184 put and passed.

Title put and passed.

Leave granted to proceed forthwith to third reading.

Third Reading

MR R.H. COOK (Kwinana — Minister for Health) [3.33 pm]: I move —

That the bill be now read a third time.

MR D.A. Templeman (Mandurah — Leader of the House) [3.33 pm]: I want to make some comment and compliment members on the carriage of the Voluntary Assisted Dying Bill 2019 during the last period to take us to the end of the consideration in detail stage. It is important to acknowledge the significance of this bill, in terms of legislation, and that the second reading and consideration in detail stages were conducted in a very respectful manner. I know that at times there were a few little periods of response, or passions and emotions highlighted, but generally I think it was a very respectful debate.

It is interesting to note the statistics on the analysis of this bill, and the time spent on this bill up to the end of consideration in detail is as follows. The second reading was debated for 20 hours and 52 minutes, and all members who were able to make a second reading contribution indeed did so. Again, the second reading debate and contributions by all members, irrespective of their views and where they had landed with their support or otherwise of the bill, were conducted appropriately. Until 1.00 pm today, we have spent some 45 hours and 13 minutes in the consideration in detail stage. If I add the time since question time, that would now be just over 46 hours. The consideration in detail process is the time during the debate of a bill that allows members to interrogate and analyse the bill in greater detail and I want to commend all members who partook in the consideration in detail period of the bill’s passage. It is also appropriate to acknowledge the staff of Parliament, of course, particularly as we had a long sitting period not last week but the week before, which saw, I think for the second time in my parliamentary career, a sitting that went into the early hours of the next morning. For some, that was quite a novelty and for others, it was not, but I just want to acknowledge parliamentary staff for their efforts and the work they did to
ensure that the house continued to operate appropriately during a long session of sitting for this Parliament. I also acknowledge—I am sure the Minister for Health will do this in his contribution to the third reading to conclude the bill next week—the staff who appeared as advisers to the minister, and the Attorney General and the Premier, who at various periods of consideration in detail supported the minister at the table. Those staff did an outstanding job representing the department and supporting the ministers who were at the table at the time.

I also want to thank the member for Dawesville for his cooperation. Although we have not been able to predict to the minute or even the hour when we would conclude various stages of the bill’s passage, there has been some good cooperation with getting the bill to the conclusion of the consideration in detail stage and now to the third reading. As has been indicated to the manager of opposition business, the intention of the government is to ensure that the third reading of this bill is concluded as early as possible next week—we would expect before question time on Wednesday; that would be the aim—and we will have a discussion about that. Certainly, the bill needs to be sent to the upper house as soon as is practicable, because it will be a government priority bill once it lands in the other place.

I conclude my third reading contribution by again acknowledging the support of various people to ensure that the house has been able to operate appropriately. I think many of us will not see a bill of this significance for some time. The conduct of all members during the debate on this bill has been commendable. I personally look forward to the passage of this bill from the Legislative Assembly early next week so that we can progress to other bills that are on the notice paper and that will be put on the notice paper in the fullness of time. I will conclude my remarks and I understand we will probably adjourn debate on this bill now so that further third reading contributions can be taken on Tuesday.

Debate adjourned, on motion by Mr D.R. Michael.

Legislative Assembly

Tuesday, 24 September 2019

VOLUNTARY ASSISTED DYING BILL 2019

Third Reading

Resumed from 19 September.

MR M. McGOWAN (Rockingham — Premier) [3.51 pm]: I rise to make a brief contribution to the third reading of this very important legislation. This has been an exhaustive, exhausting and long debate. It is one of the longest debates that I can remember in my time as a member of Parliament, which now stretches for nearly 23 years. I thank the parliamentary staff and members for the late nights and the long work hours that have been involved in this legislation. I thank the advisers and drafters of the legislation for all their work. I thought they were outstanding. When I sat at the table managing the legislation, I thought the advice I received was absolutely excellent and first-rate. I would like to thank the public servants and, indeed, Mr Malcolm McCusker, QC, for his assistance as well.

This bill has now had around 70 hours of debate in this house. No-one can say that this bill has not been fully scrutinised. People would be wrong to argue that the legislation has been rushed. Anyone who says that either has an agenda or has not been paying attention. For periods, it was taking over an hour to go through single clauses, including the name of the legislation. However, despite the often glacial and repetitive nature of the questioning, and some rather unusual analogies and hypothetical scenarios presented by some members, ultimately, throughout consideration in detail, I thought members conducted themselves fairly well. Amendments were handled in a timely manner and given proper consideration by the minister and the Parliament. In that context, I would like to thank the Minister for Health and the Attorney General for all their work as well.

We saw MPs dedicated to their jobs, being the legislators they were elected to be. We saw members telling their stories to this Parliament; stories of lives well lived but with terrible, horrible ends; stories of family members and friends, of constituents and relatives; heartbreaking stories of the end of life of people whom members knew. It showed that we are all human beings and we are all part of the community, and we all have family members, friends and people we know. Those stories came into the debate. I want to go through some of them.

The member for Baldivis told the story of his cousin Darren, his rapid decline from motor neurone disease and the heartbreak of Darren’s wife, Kirsten, having to watch her husband die. They were childhood sweethearts. They met over the back fence in Rossmoyne. The member for Butler spoke of his own diagnosis with T-cell lymphoma and the genuine experiences and wishes of people who find themselves in chemo rooms enduring long periods of treatment. The member for Kalamunda told the story of two of his brothers who have passed away. He believes
that both would have chosen differently if offered the option of voluntary assisted dying, and everyone would like
to have the choice. The members for Victoria Park, Fremantle and West Swan told the stories of their fathers’
deaths and the human desire to have our loved ones stay with us, even when it is time for them to go. The member
for Murray–Wellington told the story of her father, who, despite having the best of palliative care, it was not
even enough to stop him from screaming in pain for long periods of time.
The member for South Perth shared the story of Katherine McBarron and her family’s experiences with Huntington’s
disease. He told us that he will be thinking of her when he votes on this legislation, perhaps later today. The
member for Vasse shared Peta Quinlivan’s story of her husband, Russell. Russell was ill for 20 years, in chronic
pain for 10. In the end, he was not afraid of dying but he was afraid of how it would go or whether it would drag
out. Peta was certain that Russell would have wanted a choice as to the nature and timing of his own end.

The member for Belmont shared stories from the consultations that she has been a part of and the common reports
from seniors stockpiling their medication in case the time comes. The member for Maylands told the story of her
friend Mary’s struggle with an incurable disease. The member for Warren–Blackwood spoke of his brother, who
passed away from mesothelioma. He shared that he knew his brother wanted a choice and his sister-in-law
confirmed that his brother never changed his mind. My condolences go to the member.

The member for Collie–Preston told this house about his father’s battle with cancer and the frustration that his father’s
wishes about the nature of his own death could not be taken into account by medical professionals. The member
for Burns Beach shared his harrowing stories as a police officer, of being the first to attend scenes when members
of the public took their own lives, sometimes in horrible ways, when they saw no other dignified way out. The
member for Bicton told the heartbreaking story of her constituent Pat and his wife, Mary, who suffered from
Alzheimer’s, then a fall, bronchitis and ultimately pneumonia. He pleaded with her to support the legislation because
no-one should have to make that kind of decision for their loved ones. The member for Perth told us the story of
his mother, Dallas, and her diagnosis with a brain tumour, of the complications she suffered, of his time caring for
her, of the tears streaming down her face when she was in the hospice, and the fact that his story was all too common.

There are far too many stories in the chamber; they cross party lines and they reflect the broader community. Every
family in Western Australia has these stories. Every family in Australia has these stories. There are thousands and
thousands more, all over our state and nation, watching this debate and hoping that the Parliament does the right
thing by these people. They are the reason we debate these issues here today and in coming months in the
Legislative Council. We are hopefully finishing this house’s role in the legislative process. This is good legislation.
It is very well drafted and carefully considered. The government has devoted a huge amount of resources to this
bill. It does not require amendment. It does not require further frustration and delay from an additional inquiry.

I remind members, and all Western Australians, that we are nearing the end of a two-and-a-half-year process,
which has come to the culmination of a decades’ long campaign. People like Hon Robin Chapple and other
members of Parliament have been campaigning around this issue for many, many years. It should be above politics.
Members’ votes should not be decided based upon who is supporting the bill and who is not. Members should
decide their vote based upon their own view of the issue. Members should also decide their vote based upon the experiences of their constituents and the stories we have heard about the horrible, awful and lingering deaths of people in our community, who suffered pain and incontinence and everything that goes with death.

In that two-and-a-half-year process, there was the inquiry by the Joint Select Committee on End of Life Choices. That committee involved members of both houses, from across the political spectrum. It ran for 12 months, held 81 public hearings, and received around 700 submissions. There was also the work of the Ministerial Expert Panel on Voluntary Assisted Dying. That included the largest program of public consultation ever undertaken by the Western Australian Department of Health. The result of that extensive body of work is the legislation we are discussing now and that we have exhaustively scrutinised for more than 70 hours. Any additional inquiries would be a waste of time and taxpayer money. Moves to create another inquiry would be nothing more than a delaying tactic from the opponents of this bill, who never want to see it become law.

This is a safe and conservative regime. It is backed by a large increase in palliative care funding. We know that 88 per cent of Western Australians want this legislation to be passed. I hope that the final vote in this chamber will roughly reflect, while not matching it exactly, the level of public support. However, we also know that the numbers in the Legislative Council are much tighter. The Legislative Council has an important role to play in both our democracy and our legislative process. However, we also know that the Legislative Council is different from the Legislative Assembly. If the conventions and restrictions of the Legislative Council are used to further political agendas, that chamber will not be doing its duty. I would like all members of the Legislative Council, on all sides, to exercise the free vote that they have been given. I say to all members of the Legislative Council: this is your chance to truly exercise your conscience. Do not waste it by giving in to factional powerbrokers. This is your choice, on perhaps the most important issue you will ever deal with in this Parliament. When you look back on your career as a parliamentarian, make sure you look back with joy that you did something good and that you believed in, that you were not bound by party lines, and that you did not give in to those who would bully and intimidate—the factional powerbrokers.

Extracted from finalised Hansard
This is not a call to rush. Nothing about this bill has been rushed, and nothing will be rushed. From the consultation to the debate, and to the 18-month implementation period, we have moved deliberately and with the greatest of caution, given the gravity of the issue. But the public wants this done.

I said in my second reading contribution that this is a debate on which convictions are sincerely held and reasonable people can disagree. However, to politically delay and frustrate this bill is to needlessly prolong the suffering of other Western Australians. Worse still, to prevent a vote is undemocratic and cowardly. Members, this is not a choice between life and death. It is a choice about the manner in which death will occur for someone who is terminally ill and suffering in their last weeks and months of life. The public wants to have that choice. I say to members: think of yourself in that circumstance. If you are lying in that bed, would you want to know that you have that choice? Do you really want to go through those weeks and months of suffering, or do you not? Think of it in those terms—if it were you, or your parents. That is the issue of conscience we are dealing with.

To all Western Australians, I have a request: if you believe that there should be a safe and compassionate way for the terminally ill who are suffering to have a dignified end, if you believe that people who are of sound mind should have the freedom to choose a good death in the face of pain and distress without prospect of relief, and if you believe that Parliament must do its job and come to a final vote this year, please, in the coming weeks, make your voices heard. Post something online, write a letter to the newspaper, attend a rally, and contact the member of Parliament who represents you, whether or not you voted for them. Tell the members of the Legislative Council that you support the bill that has been developed based upon the advice of experts and some of the sharpest legal minds in Australia. Tell them you do not want this issue to drag on unresolved. Tell them you want to see leadership on this important issue. Finally, and most importantly, tell the members of the Legislative Council your personal stories, of your loved ones, your neighbours, and your own situation, whatever it may be. Make it so that you cannot be ignored, and they know that you are paying close attention. We have come so far on this issue. Let us take the last step together. Be brave, be kind, and let us pass this law together. Thank you.

[Applause.]

MR Z.R.F. KIRKUP (Dawesville) [4.06 pm]: I also wish to speak on the third reading of the Voluntary Assisted Dying Bill 2019. I note that the Premier suggested that the debate on the bill has taken 70 hours. On my count, it has now taken around 67 hours and 25 minutes. Nonetheless, I think we can all agree that a significant period of time has been dedicated thus far to this debate. It would be a fair suggestion from those outside this place that perhaps I could add little more to what has already been said. However, that would forget the critical point that this is a very important and historic piece of legislation. I suspect this is the most significant piece of legislation that this chamber has dealt with for some time.

Before I begin, I would like to take the opportunity to give a couple of commendations. This is perhaps more reflective of our end-of-year speeches. However, given my position as manager of opposition business, I want to recognise a number of people who have helped the legislation get to this place, and a number of people who have supported me along the way. I would firstly like to thank the people of my district. Since I made my second reading contribution to this debate, the people of my district have been immensely supportive of me and the position I have taken. Only one single, solitary constituent has suggested that they are dissatisfied with the position I have taken and the subsequent contribution I made on the bill. My engagement and my conversations with my community have been personally enriching and have served to reinforce the pride that I have in representing the amazing residents of the district that I represent within Mandurah.

Staying with Mandurah, I would like to reciprocate the thanks that were offered by the Leader of the House in the debate on Thursday. I do not think it was entirely necessary that on the first Thursday on which we debated this bill in consideration in detail, we broke our backs and took this bill into the hours of pre-dawn. However, since that time, we have worked well together in managing to land certain critical stages of this bill on the forecast days and at the forecast times. I appreciate the minister’s assistance in being able to do that.

I would also like to recognise the minister’s advisers, in particular Jane Laurence, Amanda Bolleter, Lisa Furness, Daphne Fernandes, Marion Huntly and Carol Conley. I have only ever advised a former Premier during budget estimates. I know it is a particularly taxing moment for advisers. From my reflection of how the advisers operated, they did exceptionally well and handled themselves with absolute equanimity. They should be applauded for their professionalism and dedication to what has been a very consequential and substantial task. No doubt the Minister for Health will speak to that as well.

I would also like to note the efforts of Hon Malcolm McCusker, AC, CVO, QC. I suspect that, much like the landmark bill itself, it is a rare experience for any of us in this place that the former Governor of Western Australia would be an adviser to a minister of the Crown. I doubt that has ever happened in the history of this place, and I doubt that in my lifetime, whether I am in this place or simply a citizen on the outside, it will ever happen again. I think it is probably a reflection of the very historic nature of what we have witnessed in this place. I have to say, with a moment of personal indulgence, that I found the interactions I managed to have with the former Governor to be personally very enriching. As a kid who grew up in Midland and was elected to Dawesville and is now a shadow minister, it is not lost on me that I am dealing with one of the most historic bills in this place. I have had the

Extracted from finalised Hansard
opportunity to discuss, debate and dissect this legislation with one of the most established, respected and decorated Western Australians I have seen in my lifetime. The adventure and beauty of our democracy was highlighted to me in the numerous opportunities I had to discuss this Voluntary Assisted Dying Bill, at length in some instances, with our former Governor. To him I say thanks for that opportunity.

It is with a similar spirit of adventure, I suppose, that I reflect on and thank all the Assembly staff for the work they did in supporting us here and, indeed, the parliamentary staff more broadly. The preparation put into ensuring ourselves as members were well supported and, of course, the measures put in place to support the staff were vitally important and shows the maturity of this important institution. To all those who are not necessarily on this floor but helped support us in immeasurable other ways, on behalf of all members, certainly on my side, I am sure we offer our thanks for the important work they did in getting us here.

Finally, I thank my Liberal colleagues for the support they have given me and the team I have been part of. This is particularly challenging legislation for me personally due to the exhaustive process I and a number of other members went through. Of course, this is the first bill I have had an opportunity to deal with as the shadow lead, although it was a conscience vote, and as the manager for opposition business. I found the support from my team, particularly my Whip and my leader, to be very beneficial and I thank them for their support.

I personally found during this legislative process of dealing with the VAD bill that the role of manager of opposition business is something I have immensely enjoyed. I suspect that if I had known about that job when I was much younger, that title would have been on the business card I handed John Howard rather than the words “Future PM”. Manager of opposition business and the relationship I have had with the member for Mandurah as Leader of the House has been really good. It has reinforced the importance of the relationship particularly when important —

Mr R.H. Cook: There is still time, member. You can do better than the current PM!

Mr Z.R.F. KIRKUP: You are very kind, minister. Our relationship and the importance of our roles are reinforced when we debate such substantial legislation as is here today.

I turn now to the bill itself. A number of issues were raised in debate in consideration in detail that I do not want to reiterate. I do not see the need to repeat them all but I would like to highlight a few critical points that deserve re-highlighting for a range of my own personal considerations. I will briefly discuss—not wanting to add more to the 67–70 hours—the forms we have discussed here, certainly during consideration in detail, the portal, the role of parliamentary accountability, the commerciality that exists between practitioners, some of the logistics and logistical issues that were raised and the use of audiovisual means to access the various voluntary assisted dying processes. I am conscious, of course, of the need to make my remarks typically third reading and ensure they appropriately pin to each clause of the bill.

Firstly, I want to talk about the provisions, of which there are many, covering the filling out of various forms as part of the safeguards the government has attached to this legislation. I think the minister can correct me if I am wrong but this legislation requires something in the order of 18 forms to be filled out at various stages, on various decisions or various changes by practitioners, contact people and the patients themselves. That means there is a high reliance on the paperwork with a number of penalties rightly put in place when those forms are not properly filled out and submitted. I do not take issue with the number of forms at all. I raised them a number of times and I implore the expert panel that if this bill becomes an act, to look at collecting as much information as possible attached to those forms. I echoed this concern at the start of the process and throughout that it is best that we collect too much information rather than too little. Given the domestic and global interest that maybe achieved in this place, it is important to have a rich dataset of people who wish to access this process. I realise there is a legislative requirement as part of those forms with the information that is collected. Even a census-like separate optional survey or something like that that could be collected will be important to help inform future decision-makers, and perhaps globally, about people wishing to access voluntary assisted dying in Western Australia. It is very important.

All of us here want to make sure there are no information gaps. I do not suggest there are here; I believe we could collect far more information than the minimum that is mandated as part of this legislation: information such as people’s socioeconomic background and their culturally and linguistic diversity. I would like to look at the locations people come from. I think that could help us to identify people throughout the process in a prudent manner. Perhaps we can look at diagnoses and see certain markers developing in Western Australia that can help us as future legislators and help future governments understand in better detail how people access voluntary assisted dying. I think the data we collect as part of this legislation, even in the form it takes now, will have a very beneficial outcome for future governments, both here and obviously in other jurisdictions. I think we can seek to better understand the treatment pathways, the patient profiles and any other improvements of the system to sustain the nature of the legislation as well as looking at possible other treatment and care options that might be available.

Secondly, and leading from this, I would like to talk about the mechanics of the Voluntary Assisted Dying Board and how it will physically deal with these forms. We have spoken a lot about distance and regionalism, in particular my concern about those in regional and remote Aboriginal communities, for example. As we know, the legislation

Extracted from finalised Hansard
provides that a number of forms have to be lodged within two business days, usually by practitioners, and give rise to the requisite penalties if that does not occur. Some of the forms have to be lodged by practitioners who have a high level of education and experience. However, some have to be lodged by the patient or their contact person who may not have such qualifications or experience. With this in mind, I encourage the department, the clinical expert panel and the minister to look at investing in an online portal to provide accessibility for all the people who participate in or interact with the process in some way, shape or form. An online portal will provide safeguards that will ensure appropriate accountability and that patients could not proceed without ensuring each form is lodged appropriately or each practitioner has lodged their form appropriately. The portal could, ideally, lay out a path and reflect the certain gates enshrined as part of the legislation, as we have seen during our deliberations. I think it would act as a necessary safeguard before we get to the ultimate administration of the substance. An online portal would also allow for the important translation of languages for those who might come from a culturally or linguistically diverse background which, as we know, could happen a lot easier with an online format than a paper-based one.

We have enshrined the requirement that information for practitioner resources can be found online. There are a lot of reference points throughout the legislation that state that the Department of Health will have information on its website or an associated website. I think there could be an opportunity for that portal to be part of that as well. As much as I believe it is possible, the system and the associated forms should be based online because of the protections, accessibility and accountability that that form will offer.

On the matter of accountability, I would like to briefly discuss the role of the Parliament in the legislation. Something I was very aware of from the very beginning was how much interaction we as parliamentarians will have when it comes to the provisions outlined here and the reporting that exists. I understand the legislation has provisions for a review clause and that routine annual reports have to be tabled in Parliament. As I said in consideration in detail to the minister, certainly within that review time at the very least, there was the opportunity for more extensive updates to Parliament. This is obviously very extraordinary legislation. Other extraordinary legislation such as the Terrorism (Preventative Detention) Act, requires quarterly reporting, and I think that that is something that could have been looked at for the review period. I realise the legislation requires the annual report to be tabled. However, perhaps given this is something that is certainly far and beyond the normal annual reporting processes, I do not think it should be up to members of Parliament to lodge questions during the annual reporting time. I think a more rigorous reporting regime could be looked at if there is an opportunity.

The Parliament certainly deserves that reporting frequency during the review, because I do not think this is a routine piece of legislation; none of us believe that it is. As such, as representatives, I think we should get as much access to information about what is occurring as we can—obviously that would be de-identified information. I would like to make sure that as legislators we see this through as much as we can and that the information that we harvest, the information that is published, is part and parcel to us ensuring that we have done our job—seeing that the spirit of what we have debated here gets implemented appropriately. That is about it right there; I will not continue down that line.

We also raised the matter of practitioners. We raised during consideration in detail and spoke at length about the role of any commerciality or financial interest that might exist between practitioners. I note that the minister said that ultimately it is very likely that there will not be much market demand, but the legislation does not explicitly rule that out. I still remain very concerned about there being an opportunity for some commercial or financial interest between practitioners. I take the minister’s point that it would, of course, be a small number, but I think some clarity could be afforded in that respect. I note that the minister and a number of other members said to us in this chamber that they would not want to see that happen. If there is an opportunity for that to be looked at down the line, we should surely pursue it. Ultimately, I appreciate the point that there might not be much market demand, but I think there could be an opportunity to guard against it as part of any future look at this legislation. That could occur as part of scrutiny in the Legislative Council. As I have expressed to a number of members, in an ideal world this process would be best run in a government facility with the highest possible constraints, but I realise that is an impossibility given our jurisdiction. It could be done in a government-run facility such as a hospital or an existing facility or something else like that where palliative care could be delivered. That would remove any sense of commerciality or financial interest that could exist between practitioners. I do not cast aspersions on practitioners; I think it is just something we should be aware of.

Another issue I would like to detail, which I raised in my second reading contribution and which is certainly the issue raised most often in my community, is that of the substance itself. I absolutely accept that there has to be a decision to self-administer; I absolutely accept the nature of the substance itself. Obviously, by virtue of the legislation and the processes we have outlined, it is impossible to bind the patient once they have received the substance, because ultimately if they have proceeded in the process, they will face their death, and it is impossible for there to be legal ramifications for any errors they make once they have received the substance and when they self-administer it. I do not want to take away from the need from self-administration or from the patient’s right to do so under the legislation. For much of the deliberations I have assumed that administration would occur in a home setting. That is the most likely, and I suspect that that will be the case in the majority of administration.
decisions, but there is the reality that it could occur outside of that setting. It could be done somewhere that is nostalgically important to the person or in a manner that might be culturally important to the person. I have always assumed that be done at the family home, but perhaps someone might not want that to occur at the family home because they do not like the environment there. I have approached the issue of the administration decision having made that assumption, and that is how we have debated it. I realise the shortcomings and innate risks of the fact that a patient cannot be demanded to do something anywhere in particular if they are self-administering. There could be the opportunity to look with a bit more understanding at where those decisions might be taking place. I do not think we should intrude on the autonomy of the patient, but it would be best for the state to understand where such a decision might ultimately be taking place and to encourage people to do it in a safe setting. I am conscious that doing it in a public setting could cause a very distressing situation—not by intent—for any onlookers or people who might come across it.

Mr R.H. Cook: Are you talking about the administration decision or the carrying out?

Mr Z.R.F. KIRKUP: Just the carrying out in a public setting. I realise, as I said at the start, that it is impossible to bind the patient, but ideally I would like to see a clinician or an observer be part of the process and encouragement to undertake it in a safe setting. I think that is very difficult to do.

Mr J.E. McGrath: What do you mean by a public setting? What are you thinking might be a public setting?

Mr Z.R.F. KIRKUP: I appreciate the interjection, member for South Perth. For example, I am conscious of datasets that show that other life-ending circumstances, such as suicides, are more likely to occur in hotels and motels. If there is a cultural or nostalgic decision, maybe someone will do it in a park or somewhere meaningful to them, especially if they were in a home environment that was abusive and so they might not want to do it at home. They might choose to do it somewhere else outside of their home setting. I am just conscious of the impact it has on the broader community, that is all. I have been approaching this issue for the entirety of the time as if it would be occurring only in the home environment, but I suppose we have to anticipate that that might not occur. In all reality it could occur anywhere. I realise that the counterargument they might be put to that is that these people are nearing the end of their lives; they are undoubtedly frail and possibly immobile. But if this happens at the very start of the six-months process and the prognosis, they might be still quite mobile and able to move around. That would be in the very early stages. We need to be conscious of every possible eventuality in practical terms. I do not have a solution; I am not suggesting that this is somehow a fatal flaw in the legislation. I do not have a solution of what things could look like; this is just something we need to be aware of. When I talk about that possibility to people in my district, they are aware of it. They are similarly concerned. As I have said previously, I think there is perhaps a limited window of opportunity for the practitioner to be more involved in the provision of the substance, or something like that, and has a bit more of a conversation. They might be encouraged to have a conversation with the patient about where they might seek to access this. Truth be told, outside of this being restricted to a hospital environment, I have no other solution. I think it is just the risk of what happens as part of this legislation. I have to trust that a lot of this detail will be pursued during the implementation stage, and I do have that trust.

A final issue I would like to highlight pertains to the various clauses that allow for audiovisual means that can be utilised for a patient to discuss voluntary assisted dying with their coordinating, consulting or administering practitioner. I think that is an important part of this, especially for those people living in a regional context, which I am sure you would appreciate, Acting Speaker (Stephen Price). There is now an increased reliance in our system on telehealth. We have highlighted a number of times, and this was confirmed by both sides across Parliament, considerable concerns about the interplay of the commonwealth Criminal Code Amendment (Suicide Related Material Offences) Act 2005, which made it an offence to use a carriage service for what is termed “suicide-related material”, with this legislation. I would like to briefly quote from the explanatory memorandum of the act. The minister spoke about this. I do not want to verbal him, and he is welcome to correct me if I am wrong, but he said to look at the debates from 2005, and he was right that the debate was largely silent on this issue, because I do not think anyone in 2005 had forecast that this is where society might be.

Mr R.H. Cook: It was in response to a couple of very high profile suicides that resulted from cyberbullying.

Mr Z.R.F. KIRKUP: I appreciate that, minister. I note that there was a heavy reliance in the second reading speech of Philip Ruddock, who I think was the minister, on that cyber aspect. Section 474.29A of the now amended commonwealth Criminal Code makes it an offence for a person to use a carriage service to access, transmit or make available material that incites or counsels for suicide, with the intention that they might use it themselves or somehow incite another. As the minister rightly pointed out, “access” is defined in that section as displaying material by computer or a format that is outputted from a computer. I appreciate the minister’s perspective here that voluntary assisted dying is not suicide—I understand that—but that is the confines of this place and our definition. The commonwealth Criminal Code is silent in that respect. We do not know the impact it would have if we just assume that the commonwealth will go along with what the state Parliament thinks. That is making a number of assumptions when we consider the ultimate fines that will be put in place are, I think, $110 000 for individuals and $500 000 for a bodies corporate that may be found to be unlawfully acting under the
commonwealth Criminal Code amendments of 2005. I understand that Attorney General Quigley has written to Attorney-General Porter about this and I know he suggested during consideration in detail that he was satisfied and that this process was not captured. I just have very serious concerns. Doctors have suggested to me that they would like to make sure they are indemnified in some way, shape or form if they pursue this and the commonwealth tries to prosecute someone if they believe this falls within the definition of “suicide”. I realise that is a complex argument to make. My concern is that we are very close. The definitions in our legislation are so close that obviously there was a similar issue in Victoria. I believe that Victoria ultimately removed “audiovisual” as an option. However, I think that the removal of “audiovisual” would be detrimental in its impact on regional Western Australians, given the nature of our jurisdiction.

As I round out my contribution, I point out that I have not sought to raise the issues of the portal, the forms, the role of parliamentary accountability, the possible commercial link between practitioners, the logistics around the substance or the use of audiovisual means to access voluntary assisted suicide in order to be controversial; I think they are necessary to highlight, and reflect, what has been very thorough scrutiny of this legislation. I suspect that members in the other place will pay attention to these issues, and probably much more than I have been able to do. If the bill passes the other place, there needs to be a very serious look at these issues by the Department of Health and the clinical expert panel as part of that transition and implementation process.

I am conscious that the Parliament has been asked to accept certain risks associated with this legislation. To regulate and mitigate risk is not unique in this place, but in this instance, the bill affords the greatest possible consequence in allowing for the hastened death of somebody who is terminally ill. Notwithstanding the issues I have raised in my contribution today, it is still clear to me that the vast majority of people in my district want to see this legislation passed. I have always maintained that I will vote to reflect their views, but also that my role as a legislator should always be to ensure that whatever legislation gets my vote, it is as fit and proper as possible.

As I talk about the substance of the bill itself, I note that a number of amendments were moved, mostly by members of the Australian Labor Party. Their own review of the minister was that there was no negotiation and no intention to consider any amendment whatsoever. I suspect this might change when the bill goes to the other place and that a number of amendments will be moved to try to satisfy its passage through the Legislative Council. If that is the case and we are asked to reconsider amendments that we have already voted against or that the government took a position against in this house, then that, to me, will be disappointing. We could have ensured that the bill that left this place was as fit and proper as possible so that the other place would be of the view that it had been negotiated as much as possible and that the minister had worked in good faith with all members here to possibly get an amended view, if there was an issue that they wanted put to the house more thoroughly.

Throughout this entire process I have done what I believe has been my best to work in good faith with the minister and the chamber to improve the quality, controls and overall intent of what is being proposed. I am not alone in that; I think all members of this chamber, and particularly those who have been engaged in the process, have had a not dissimilar intent. I reject the assertion that any members, and particularly members of the Liberal Party, have worked to intentionally slow down the passage of this legislation. We have been asked to consider a very serious, watershed piece of legislation, and I think we have done our job as parliamentarians exceptionally well. There is the right balance with this legislation; however, I note that I expect it to be improved on, or at least that steps will be taken to address these issues so that whatever legislation is passed meets the requirements of everyone who will be involved in it.

I again thank the district of Dawesville for its overwhelming support. I commend the Voluntary Assisted Dying Bill 2019 to the house.

MS M.J. DAVIES (Central Wheatbelt — Leader of the Nationals WA) [4.33 pm]: I will briefly close out the debate on the Voluntary Assisted Dying Bill 2019 from my perspective on behalf of the people of the central wheatbelt. I indicated my support for the legislation. I certainly agree with the member for Dawesville that this has been a watershed piece of legislation for this Parliament and for every member who has been included in the debate so far. Although I had indicated my support for this bill, the debate on it was an important period in which members of the opposition and members of the Nationals WA could scrutinise the bill. There was some criticism during the debate of the members who asked questions. I note that those questions came from both sides of the house. I may not agree with the ultimate position of some of those members on the bill, but they were absolutely entitled to ask those questions and satisfy themselves that there are no gaps or loopholes in the bill, to make this the best possible bill on its passage through to the Legislative Council. Perhaps I am less offended than some who have expressed their concern about this process, because I have been a member of the Legislative Council. It is the house of review; it is its job to go through that process. I saw that process up-front and personally for four years. But I think both houses are absolutely entitled to scrutinise legislation like this. I do not think there were vexatious or repetitious questions. As I said, I might not agree with the ultimate position that some of my colleagues in this place have arrived at on this bill, but I absolutely support their right to ask the questions that they asked. I felt that the debate was respectful and thorough.

Extracted from finalised Hansard
The feedback I have received as this debate has been carried out is that the public expects us to behave appropriately and set an example when we are dealing with such serious issues. I reflect on the numerous conversations I had while debate on this bill was underway. We have had what we call show season in regional Western Australia, so there have been multiple opportunities at agricultural shows and events right throughout my electorate in particular, and certainly in others as well, for us to test the waters as this bill has progressed. I have to say that an overwhelming number of those who came up to me support the bill and its intent, but always with the premise that we need to make sure that there are appropriate safeguards. The majority of the questioning from this side of the house was around the safeguards for eligibility and then also on the nitty-gritty of what will be put in place as part of its implementation. This is our opportunity, as members of Parliament, to make sure that we have a clear understanding of that prior to it getting to that stage, because the Department of Health and other practitioners will look at the intent of the legislation and the answers that the minister and the government have provided in the debate to clarify any concerns. It also provides us with an opportunity to go back and look at the debate to see how it was intended to be rolled out when this becomes law.

It would have been extraordinary if we had gotten through the business of this legislation in a week or even just two weeks. Most of the concerns that were raised with me—I am not sure if it was the same for my colleagues—were about the schedule of our sittings rather than the detail of the questions asked. There were concerns about whether we were doing our best work when we were sitting here in the early hours of the morning, for those who sat right through. They questioned whether we were able to apply ourselves to this incredibly important piece of legislation. The feedback, even as we carried on this debate, was that members of the public, particularly in my electorate, are supportive of the bill, but want to make sure that we are doing our job appropriately.

The questions we raised during the second reading debate and when following the debate through were predominantly from the perspective of regional people and the accessibility of the scheme should it become law. How can we ensure, if we introduce a new option, that those who live in our remote and regional communities can access it? There was significant conversation around that in terms of the implementation phase and the ability to use technology, but also about options utilised in other jurisdictions around the accessibility of GPs. For example, what will happen if a person lives in a single doctor community and the doctor chooses not to engage in voluntary assisted dying? What will that person in that regional or remote community do? The structure for that needs to be canvassed, and was at great length in the debate, to make sure that those who want to seek this option are not disadvantaged. If we introduce new services or initiatives, we should endeavour to make them as equitable as possible. That was certainly one of our serious concerns. I note that it was through the advocacy of the Nationals at the very beginning of this process that the schedule of hearings of the ministerial expert panel was expanded, because we felt that the panel was not going to enough locations in regional Western Australia for it to make sure that it was getting feedback on the ground and face to face. To the government’s credit, it did expand the number of sites the panel visited and added a number of opportunities through the community resource centres to make sure the information was provided.

We also sought clarification and confirmation—this was canvassed at great length in this place—on the interaction between commonwealth legislation and the state legislation, in light of the fact that some concerns had been raised in Victoria, as it implemented its legislation, about commonwealth laws that were preventing people from having discussions with their GP or health practitioner around suicide, the definition of “suicide” and the definition in the legislation of “voluntary assisted dying”. The government does not think we will be impacted by that commonwealth legislation. I suspect that that will be an in-depth conversation in the other house as well, because that is a significant concern for us. If you cannot access your GP or health practitioner on this via videoconferencing or teleconferencing at any point along the journey, once you have commenced it, because you are in fear of being prosecuted under a commonwealth law, it will be of serious concern to us. I know that was canvassed widely, but I think we can anticipate that when it gets to the other place there will be further questions about that.

We also had general discussions around the notion that palliative care and the provision of palliative care is not dependent on whether or not this legislation progresses. In general, I think the thread that ran through all of the discussions that this is not an either/or argument. We should not have to wait until palliative care is provided to a standard that everybody expects before we introduce this legislation. It is very difficult in the provision of health services to understand what that might look like from everyone’s perspective, particularly in a health jurisdiction as big as Western Australia. I think, undeniably, every single person in this place and in the broader community would agree that we need increased funding into palliative care services, because there is a real lack of those, not just in the metro area, but certainly in regional Western Australia. We all continue to advocate for that. This is about making sure that we have access to voluntary assisted dying for everybody outside the metropolitan area, in the same way that our metro counterparts have.

Before I move on to the last bit, I will turn to some other things that were raised. The member for Dawesville touched on some concerns about the remuneration clauses. Obviously when dollars are involved, concerns start to be raised. I am sure that there are appropriate safeguards in there. Also, community expectations will set the tone for that, going forward. There are a number of very technical details around implementation, and those were canvassed in-depth. I put on record my thanks to those members who went through the legislation with a fine
toothcomb. It was a considerable effort and, from our perspective of participating in and being part of that debate, after hearing the government’s responses I am confident in my assessment that this legislation should be supported. I have not been persuaded otherwise as a result of the consideration in detail process.

When I made my contribution to the second reading debate, I said that I spoke on behalf of the people of the central wheatbelt, and that they were both pragmatic and compassionate. It is my view that a majority of them—not all—certainly support this legislation, and I said that in the context that I voted against an earlier and very different iteration of this legislation in the Legislative Council, nearly 10 years ago. Over those 10 years, my views have changed. The work that has been done by the Ministerial Expert Panel on Voluntary Assisted Dying, the Joint Select Committee on End of Life Choices and the Parliament to this point has meant that I have confidence that this is a piece of legislation that should go through. I respect those who do not agree. I respect that not everyone in my community and not everyone in this chamber shares those views, and I thank everyone for the way that the debate was conducted to allow everyone to put their views on the table for what is a very sensitive issue. I thank everyone in the central wheatbelt who provided me with their details. I reiterate that, from my perspective, the people of the central wheatbelt are, by and large, supportive of this legislation and of allowing us to give to people who are in pain and suffering and likely to die within a foreseeable time frame the opportunity to go gently and to die with dignity. Once this debate is completed in this place, I look forward to the legislation progressing to the Legislative Council and I hope that it will conduct itself in the same way as everyone in this chamber has. That is not something that we are particularly known for in this chamber; we are normally more robust. But certainly from my perspective, kudos to everyone who has been involved, across the chamber and on this side, for making sure that we have been thorough in our investigation and consideration of what is, indeed, a landmark piece of legislation for this state.

MRS L.M. HARVEY (Scarborough — Leader of the Opposition) [4.45 pm]: I rise to contribute to the third reading debate on the Voluntary Assisted Dying Bill 2019. I will open my remarks by saying that I believe and agree that, for a very limited number of people in the community who have been suffering with the most horrendous diseases that have horrific symptoms and a high degree of suffering, an option like voluntary assisted dying is a choice that people should have. I have arrived at that conclusion after reading through many emails, listening to many people in my community, hearing their horrendous stories, and also from my own experience of watching a loved one go through death from cancer. I will be meeting in the very near future with Belinda Teh. I was, indeed, very moved by her account of her mother’s awful end-of-life experience. I also took counsel from my younger sister, who is a nurse at Sir Charles Gairdner Hospital. She works with people who have the most horrendous cancers—head and neck cancers—that are often horrific, symptomatically. I understand that for people in those situations, palliative sedation is not always necessarily an option that will relieve suffering; not in every instance. I believe that for 99 per cent of people, appropriate palliative care and palliative sedation are very gentle ways for people to be eased towards the end of their life, but for a very small number of people, palliative sedation actually does not work. I believe voluntary assisted dying needs to be available for those people.

I have to say that I have struggled with this issue ethically. I have a great ethical belief that it is wrong for a human being to end another human being’s life. That is an ethical belief that I hold dear; it feels like it is part of my DNA. But I also understand the other side of that ethical conversation. It is also wrong, ethically, to witness and allow people to suffer unendurably if there is the option to provide some relief to their suffering. In balancing those two things, I have come to the conclusion that I would like to support voluntary assisted dying legislation. However, I am not going to vote for it at this time, and I will articulate my reasons for that.

During the debate we raised various issues around making sure protections were in place for vulnerable people. The member for Armadale moved an amendment from his own personal experiences and his own deep-seated fear about the vulnerability to exploitation that come with his own daughter’s disability, and the possibility of coercion or being talked into accessing voluntary assisted dying. He moved the amendment to prevent a doctor from initiating a conversation and offering voluntary assisted dying to a patient. I thought that amendment was a sound amendment and an appropriate protection for vulnerable people. The minister has not adequately explained why that component, which is part of the Victorian legislation, was excluded from the Western Australian legislation. The minister said at the beginning that, notwithstanding that this was a conscience vote, no amendments would be entertained by the government, which is really how a government-sponsored bill is treated, not a bill on a conscience vote. I hope that members in the Legislative Council will do their due diligence with this legislation. The minister flagged that, although he would not entertain any amendments put forward from the Assembly, he expected that amendments would be made in the Legislative Council. I hope that means that when those amendments are moved in the Council, they can come back to this chamber. If the protection that I believe is essential around doctors not being able to offer voluntary assisted dying as a treatment option is included, I will vote for this legislation at that time. It is impossible to get legislation on voluntary assisted dying 100 per cent right. The sad thing is that when this is introduced, we will find out through trial and error whether it achieves the outcomes that the government says it wants to achieve.

We talked at length about the inadequacy of the provision of palliative care services in Western Australia. The minister was at pains to say that in other jurisdictions when voluntary assisted dying legislation was introduced,

Extracted from finalised Hansard
palliative care options and opportunities to access palliative care improved. We will wait to see whether that occurs in Western Australia, and I sincerely hope that it does. With the geography we have in Western Australia, the inequality of access to palliative care is of grave concern. It needs to be funded by the government, and we should have the highest proportion of palliative care specialists to population of all the Australian states, not the lowest, as it is at present. It concerns me that no key performance indicator or goal has been set by the government for the target we are hoping to achieve with palliative care specialists per 100,000 population. What standard will be put out there to achieve, and by when? None of those targets were revealed during the course of the debate, and I think they should be an important component of this debate.

Part of the reason I wanted the amendment to prohibit doctors from offering voluntary assisted dying as a treatment choice is that I do not believe it should be a treatment option. A person with cancer, motor neuron disease or some other disease that is symptomatic and causes pain and suffering, or whatever it might be, at the point at which they have had enough, should be making a request to the doctor asking whether something can be done about this. I mentioned during consideration in detail that my concern is about some seniors in the community, who revere doctors. If they were given a choice of chemotherapy or radiation therapy that would bring lots of side-effects, with the family waiting around watching the suffering, and all that that entails versus, “Or we could give you voluntary assisted dying, and you can assemble the family and we can give you an injection or you can take a substance, and in two weeks this would all be over, and you won’t be a burden on anybody”, for some seniors and some people from diverse backgrounds, it may be that they would take the easy option and not stay in the fight.

That is important, because people can access voluntary assisted dying, once this legislation is passed, if they have a prognosis of six months or less. I articulated that my late husband received that prognosis—that he had six months to live. In fact, in August he was told, “We’ll try and get you past Christmas.” He lived for three and a half years after that. He would have been eligible to access voluntary assisted dying. He did indeed go on to the Google medicine page to have a look at what was ahead of him, and he did not think he was going to be able to endure any treatment. He did not think he would be able to cope with any chemotherapy. He turned out to be a seriously tough patient, and lived far longer than anyone imagined, and lived for a long time with unbelievably poor physical condition, but he had an amazing will to live. I accept that it was his choice. He did not want, at the end, to access voluntary assisted dying. However, he could have done so early on, and we would never have been witness to the sheer courage and bravery that was on display in seeing him fight his disease. As I said, in his circumstance, with fantastic palliative care services, he did not suffer. It could be argued that over the last few days of sedation, there may have been some pain and suffering involved, but that was not apparent to me, as a witness to his experience.

The other aspect of the legislation that I thought was really curious was that the minister refused to put in a definition of palliative care, and a good reason was not really put forward for that. We know that palliative care is such an important part of voluntary assisted dying. Indeed, the minister said that in all jurisdictions where voluntary assisted dying was available, palliative care improves. When palliative care is mentioned as one of the founding, if you like, core principles of the bill—every individual should have access to good quality palliative care—why not put in a definition? That was not adequately explained, and I believe that that will be thrashed out in the Legislative Council.

There is another area that we need to keep a very close watch on. It was said that there had been a number of suicides of people with terminal illnesses who took their own lives in the absence of voluntary assisted dying. I will be interested to see whether the number of those suicides is reduced in response to access to voluntary assisted dying as an option of last resort. I say that because, with some of those suicides—we have heard talk about farmers, for example, with access to firearms, who get to the point where they think it is time to clock out—for police officers, emergency services and family members to find somebody who has died of a gunshot wound is not a pleasant experience, and I can understand why we would work hard to prevent that from occurring. However, when we look at the processes that that farmer would have to go through to access voluntary assisted dying, it may well be that he will choose the rifle option anyway, because it is easier, closer to home, and does not involve any rigmarole at all. That is something we will need to watch once the legislation goes through.

In regard to the interaction with the commonwealth legislation, with people in regional and remote areas being able to access voluntary assisted dying via video link, there is quite a way for that to play out. It is going to be an interesting debate, and we will need some very bright legal minds to look at how that can work. How will the interpretations in the Western Australian voluntary assisted dying legislation and the definition of suicide in the commonwealth jurisdiction intersect? What would be the government’s backup plan, should that video link option to access voluntary assisted dying be ruled incompatible with the commonwealth legislation? What then can we put in place for regional constituents to access voluntary assisted dying? Will there be doctors who can fly around regional WA to provide a service? How do we ensure equality of access to voluntary assisted dying, should that be introduced?

I would like to cover off on a couple of other things. I was not in the chamber, but I was listening to the Premier’s address in my office, and there seemed to be an inference—I do not know what it is in response to—that somehow members of the Liberal Party who might be voting against this legislation, or indeed for it, were not voting of their own volition or with their own conscience, but were voting somehow in response to undue influence of powerbrokers within the Liberal Party.
I find that highly offensive and a very insulting assertion to make. I am a 52-year-old woman. I bring significant life experience to this place. I consider myself to be an independently minded woman with some experience, both in this chamber and outside this chamber, which I bring to bear along with members of my community and people from outside my constituency on important matters such as access to voluntary assisted dying. For the Premier to imply that I am in any way, shape or form voting according to pressure from any other person, let alone the illusionary Liberal Party powerbroker, is highly offensive to me and all my members.

I said in my speech in the second reading debate that I believed that the vote on this legislation—for or against it—should largely be in keeping with how the community feels about voluntary euthanasia. Several polls have been conducted and it seems that 80 per cent are in favour and 20 per cent are against. If this is a true conscience vote, the votes in this chamber should be reflective of how the community is voting and there should be an 80–20 split of yeses and noes because that is a reflection of the views of the community. We were elected by our community to reflect their views. I believe that when we divide on this legislation, the voting outcome in this place should reflect the polling outcomes in the community. I do not condemn anybody who has a different view from mine. I certainly do not question that they have done their due diligence in arriving at their view. I would never accuse any member on any side of politics of abrogating their responsibilities to make a conscience vote on very important landmark legislation according to their ethics, beliefs and consultation to acquiesce to bullying in whatever party it might be. I would never accuse anyone of that. I wanted to put on the record that I respect the views of every person in the chamber. I respect how they vote and I will not pillory anybody for voting in a different way from how I intend to vote on this legislation. That is the treatment that I expect of the leader of the state government, and that is not what we have received.

The other issue that I would like to raise is the late sittings. We sat all night on a Thursday, and then we sat from nine o’clock in the morning until 5.30 on the Friday morning. We had 20 hours and 22 minutes straight of sitting. Goodness knows why; we still have weeks of Parliament left. People working in this chamber were being paid overtime. We had staff hanging around making sure that there were drinks and food available for members because members were tired. Some members brought in mattresses and pillows and slept. As a small team, most of the Liberal Party members did not have that luxury. We stayed together. I am very proud to say that most of my members were in the chamber for the vast majority of the debate.

Why there is such a rush has not been explained. I raise this because the Leader of the Opposition in the Legislative Council, Hon Peter Collier, said to me that he had been advised several weeks ago that the Legislative Council should expect the voluntary assisted dying legislation to pass through the Assembly by the end of September, with the expectation that the Legislative Council would commence debate in October. The leader of the Liberal Party in the Legislative Council provided me with a priority legislation list dated August 2019 for the Legislative Council. I would like to read that list. It states —

**Priority bills currently listed in the LC**

- TAB (Disposal) Bill 2019
- Betting Control Amendment (Taxing) Bill 2019
- Appropriation (Recurrent …) Bill 2019
- Appropriation (Capital …) Bill 2019
- Police Amendment (Medical Retirement) Bill 2019
- Road Traffic Amendment (Blood Alcohol Content) Bill 2019
- Criminal Appeals Amendment Bill 2019
- Corruption, Crime and Misconduct Amendment Bill 2017
- Consumer Protection Legislation Amendment Bill 2018
- Residential Parks (Long-stay Tenants) Amendment Bill 2018
- Births, Deaths and Marriages Registration Amendment (Change of Name) Bill 2018
- Human Reproductive Technology and Surrogacy Legislation Amendment Bill 2018
- *Ticket Scalping Bill 2018 will be prioritised once the Committee reports (due 5/9/19)*

**Bills currently listed in the LA, that will be prioritised in the LC**

- Terrorism (Preventative Detention) Amendment Bill 2019
- High Risk Offenders Bill 2019
- Wittenoom Closure Bill 2019
- Civil Procedure (Representative Proceedings) Bill 2019
- Criminal Law Amendment (Uncertain Dates) Bill 2019
- Transfer of Land Amendment Bill 2018
- Small Business Development Corporation Amendment Bill 2019

*Extracted from finalised Hansard*
I apologise; this is very dry. I continue —

Metropolitan Region Scheme (Beeliar Wetlands) Bill 2018

There were 21 pieces of legislation on the priority list for the Legislative Council with one piece of legislation missing. The Voluntary Assisted Dying Bill 2019 is glaringly absent. It has not been listed in the Legislative Council as a priority bill for debate. We can imagine that confusion is caused when we have late-night sittings; we were here until 12.30, then 1.30 and then overnight until 5.30 in the morning and the next week we had late night sittings until 12.30, or it might have been one o’clock. I think we might have finished at about seven or eight o’clock on the Thursday; I cannot remember when we finished. It was all a bit of a blur.

Mr D.A. Templeman: It was half past four. We finished early.

Mrs L.M. Harvey: We finished early; that is right. However, we had all those additional hours of sitting because of some supposed desire to get this legislation through so that it could go to the other place, be debated and get through by the end of the year, yet it is not even listed. It is not even on the second list of bills currently in the Legislative Assembly that will be prioritised in the Legislative Council. I suggest that the Leader of the House and the Minister for Health get on to Hon Sue Ellery, who is apparently managing business in the Legislative Council, to list this bill as a priority for debate if they would like to get it through by the end of the year because it is currently not listed.

Mr D.A. Templeman: I think you’ll see it there once it arrives in the other place.

Mrs L.M. Harvey: We have the alternative list—the bills currently listed in the Legislative Assembly that will be prioritised in the Legislative Council. The Voluntary Assisted Dying Bill is not on that list either, which is a bit curious.

Mr D.A. Templeman interjected.

The Acting Speaker: Members, please.

Mrs L.M. Harvey: I thought that was a bit curious and worthwhile raising in the third reading debate because it sends mixed messages about the priority of this legislation and the government’s commitment to getting it through by the end of the year, as it suggested it would like to.

In conclusion, I would like to thank all members who contributed to the consideration in detail stage, and indeed the detail and examination of this bill, particularly the members for Girrawheen, Armadale and Cannington. It is very brave to stand against a tide of people in your own political party who have a different point of view from your own, to stand in Parliament according to your beliefs, to really do your due diligence, and to move amendments against legislation when your own leaders have said that they will not accept them. It is very brave to push through for what you believe is the right thing to do, for what you believe is the ethical thing to do and for what you believe would be an improvement to legislation to protect vulnerable people from being exploited. I believe we should have more of that. In this day and age in politics, we need more people who are brave enough to have the courage of their convictions and push through. Notwithstanding that their view might not necessarily be popular, it is still relevant. I believe that our society has a great deal of respect for a broad spectrum of views on many matters, in particular, voluntary assisted dying, because it is such a complex area to try to get right.

In conclusion, although this bill has caused me a significant ethical dilemma, I believe people need to be given a choice in extreme circumstances in which their symptoms, pain and suffering cannot be relieved. We heard awful descriptions of people who have either experienced or witnessed that. I believe that should those individuals wish to end their suffering earlier than the disease would otherwise allow, that option needs to be available to them. I do not believe that the protections that are provided in this legislation are sufficient to enable me to vote for it at this time. I flag that if the very sensible amendment moved by the member for Armadale to insert a definition of “palliative care” was successful in the other place and the amended legislation was put before this house, I would vote for it. However, at this time, I cannot vote for legislation that I believe will leave vulnerable people open to exploitation and coercion and potentially accessing voluntary assisted dying against their will.

Dr D.J. Honey (Cottesloe) [5.11 pm]: I would also like to speak on the third reading of the Voluntary Assisted Dying Bill 2019. At the outset, I would like to thank the Minister for Health and his advisers for their considerable patience and help during the consideration in detail stage. This is a complex and emotional topic. As a number of members have said, this is the most important bill to come before this Parliament for some decades. I also thank the great majority of members who have been respectful of the contributions of other members in carrying out the difficult work required to ensure proper scrutiny of the bill.

I did not come into this debate with a firm view on this bill; nor did I view the bill based on any particular religious perspective or political or personal affiliation. In fact, had I been asked for my opinion on this topic 18 months ago, before I entered Parliament, it is likely that I would have expressed a view supporting the general concept of voluntary euthanasia. However, in this place, we are not asked to vote on concepts; we are tasked to consider the specific detail in a particular bill. In particular, other than considering whether a bill will achieve its intended outcome, we must consider whether there will be unintended consequences—what may go wrong, whether the bill will enable individuals to go outside the intended scope, and whether the bill will unfairly impact people.

Extracted from finalised Hansard
As I said in my second reading contribution, it is not simply a matter of being for or against voluntary euthanasia. It is quite possible to approve of the general concept of voluntary euthanasia, but to disapprove, even strongly, of this bill either in whole or in part. During the second reading debate and consideration in detail, I have been concerned to ensure that vulnerable people are not preyed upon; that decisions are made freely and are properly informed and motivated; that the person who will die has the capacity to make that fatal decision; and that untreated, preventable health conditions do not influence the decision. I have also been concerned to ensure that other people, for their own reasons, ranging from a sense of compassion to a loved one through to personal gain, do not influence the person to make the decision; that family and/or society abandonment of a person does not influence the decision; that the lack of other adequate alternative treatments does not influence the decision; and that people are not compelled to participate in an act or process that they find morally and/or personally offensive. Unfortunately, the answers to a number of these critical questions have been quite unsatisfactory.

My initial review of the bill heightened my concern about these issues, and the subsequent debate and analysis has confirmed my concern about a number of these issues. Perhaps my greatest disappointment has been the minister’s refusal to accept even one single amendment. Given the complexity of this bill, it is very unlikely that the bill is perfect. Members have highlighted obvious drafting mistakes that need to be corrected. The minister has refused to consider these appropriate amendments. Members have highlighted unintended consequences and uncertainties in the bill, but the minister has refused to consider any amendments to remove these unintended consequences or uncertainties. It was suggested to me that this had been done to prevent delay between the completion of consideration in detail and the commencement of third reading speeches. It would be extremely disappointing if sensible amendments were ignored simply to try to rush the bill through this place.

I believe that one of the most disturbing aspects of this bill is that it will compel medical practitioners to participate in the voluntary assisted dying process, even if they have a profound personal objection to it. Members would know that the Hippocratic Oath for Australian doctors has been updated by the Australian Medical Association. However, many medical practitioners feel bound by the original oath, which includes the statement —

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.

I am sure that many people in this place would regard the original oath as an antiquated relic. However, a large number of medical practitioners hold these values dear; and, with all due respect to other people’s views, they are equally justified in holding those views. They have dedicated their careers to extending and improving the quality of human lives and cannot contemplate being involved in artificially shortening someone’s life. As such, they are vehemently opposed to any involvement in the VAD process, even if they have a profound personal objection to it. Members would know that the Hippocratic Oath for Australian doctors has been updated by the Australian Medical Association. However, many medical practitioners feel bound by the original oath, which includes the statement —

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.

Once a person has asked a medical practitioner to assess them for the voluntary assisted dying process, that medical practitioner is compelled to respond. That is dealt with in clause 17(1), which states that a person may make a request to a medical practitioner for access to voluntary assisted dying. Subclause 2(b) states that the request must be made in person, or, if that is not practicable, in accordance with clause 156(2)(a). Clause 156(2)(a) refers to the means of communication. That includes audiovisual means. I believe that is very important when we consider this bill.

Clause 19 provides that the medical practitioner is required to accept or refuse the first request. Subclause (1) provides that if a first request is made to a medical practitioner, the practitioner must accept or refuse the request. The medical practitioner does not have a choice. Clause 20 provides that the medical practitioner must record the first request and acceptance or refusal. Clause 21(1) provides that within two business days after deciding to accept or refuse the first request, the medical practitioner must complete the approved form and give a copy of it to the board. The initial communication does not need to be in person. If a person requests a medical practitioner to participate in the VAD process, the medical practitioner must respond and may be subject to penalties if they do not respond. They cannot simply excuse themselves from the process. I would be pleased if the minister could tell me in his third reading response that this will not be the case. However, it seems to me that if any person, whether ill or not, were to approach a medical practitioner in any setting, that practitioner would be compelled to participate in the initial stage of the VAD process. From my understanding of the bill, this could be a person who had come into a hospital emergency ward, had walked into the practitioner’s surgery, or had even contacted the practitioner remotely by telephone using an audiovisual device such as an iPhone and the FaceTime app. The requirements in clause 17 are very general and do not place any limit on the time or place at which a request may be made.

I will not go through section 156 in detail, because I do not want to take the full time on this contribution, but that refers to communication between patient and practitioner. Subclause (1) states —

audiovisual communication means a method of electronic communication that is designed to allow people to see and hear each other simultaneously.

Extracted from finalised Hansard
Under clause 17, the person may make a first request to a medical practitioner. In 17(2)(b), the request must be made in person or, if that is not practical, it must be in accordance with clause 156(2)(a), hence my belief that a request using an application such as a FaceTime app would qualify as a legitimate request. If a medical practitioner fails to comply with any part of the voluntary assisted dying process, they may be subject to the penalties listed in clause 10. This includes a medical practitioner who fundamentally objects to the voluntary assisted dying process and does not wish to direct a person to any information relating to this process. I will not go through clause 10, but it refers to that offence resulting in a charge of professional misconduct or unprofessional conduct. If a medical practitioner fails to return a required form, including a form outlining their objection to participating in the VAD process, they will be subject to the penalty outlined in clause 10, which carries a potential charge of professional misconduct or unprofessional conduct as well as a potential $10 000 fine. The clause also applies to fines for failure to return a form for various sections of the legislation if a medical practitioner agrees to take part in the VAD process. I believe these very serious penalties are misplaced and could be characterised as bullying a medical practitioner to participate in a process that they are vehemently opposed to, in relation to that, in particular, being required to provide the person who has made that request in whatever form with information allowing them to access VAD. I do not believe medical practitioners who are morally opposed to the process should be compelled under threat of a charge of professional misconduct or unprofessional conduct to hand that information to a person. I believe that is fundamentally wrong.

Members will know that I have a particular concern about the potential for someone to end their life utilising the VAD process due to influence from others and not due to their own will. At the outset, I note that I am very pleased that the minister has indicated that people may raise concerns about these issues directly with the board and are not limited to applying to the State Administrative Tribunal. Although many people here may not be concerned about being required to attend SAT, this would be an intractable barrier for many other people who rarely deal with such bodies. I note that the Minister for Planning has taken this concern very seriously in developing regulations for the recent Strata Titles Act amendments and gone to great lengths to ensure people are very well supported through the SAT process both financially and physically. Maybe that can be a consideration for this legislation.

I cannot understand how any person listening to or reading the compelling contribution from the member for Armadale on why medical practitioners should not be able to suggest VAD to a patient would continue to support this possibility being enabled by this bill. Medical practitioners hold a special place in most communities. This is especially the case in smaller and remote communities. The simple reality is that the simple suggestion by a medical practitioner that someone may participate in the VAD process could be the sole reason they make this decision. Members may recall that I raised also the issue of the legal doctrine of presumed undue influence that applies to the interaction of medical practitioners and patients when a personal benefit may arise. In that situation, the law presumes undue influence by the doctor or by the medical practitioner and shifts the burden of proof to that medical practitioner to show they have not unfairly influenced the patient. I am sure this fact must have been in the minds of the Victorian government when it developed its legislation and deliberately excluded the possibility of a medical practitioner raising access to VAD with a patient. This is a major flaw in this legislation and I hope it is corrected by my parliamentary colleagues in the Legislative Council.

Further to the issue of undue influence and coercion, I am greatly concerned that there is no requirement for either the coordinating or consulting practitioner to have any prior knowledge of the patient, nor is there any requirement for a patient’s usual medical practitioner to be informed that their patient has entered the VAD process. These issues are compounded by the fact that none of the medical practitioners involved in the VAD process need even physically meet the patient. All communication leading up to the person accessing the poison they will ingest can occur via an audiovisual link. I simply do not share the minister’s confidence that subtle issues such as undue influence and coercion can be properly assessed remotely via audiovisual communication. Undue influence and coercion are by their nature usually carried out in private. It requires considerable knowledge of a person to determine whether this has occurred. The fact that a person may go through the entire VAD process and not a single person assessing or assisting in the process need have any prior knowledge of the patient is another significant risk not managed by this bill.

The estimate of probable longevity of a patient is a key qualification for someone to access the VAD process. I remain concerned that neither the coordinating nor the consulting medical practitioner making the estimate of longevity need have any expertise in the terminal illness that afflicts the patient. Whilst I hold the medical community in high regard, I recognise that there is a human diversity of competence and skill in that community. Despite the considerable training that medical practitioners undertake, it is unreasonable to presuppose that they will necessarily have the expert knowledge of identifying how a particular illness is likely to progress and cause death. I understand that either practitioner may seek an expert opinion from a specialist. However, there is no specific requirement for them to do this. I am sure that in the majority of cases, the assessment process will be carried out in good faith and the estimated lifespan will be reasonably accurate. However, this may not always be the case. We have heard several stories in this place about informed estimates of longevity being incorrect by decades.

It has become clear during both the debate in this place and discussions with other people that a number of people, including medical practitioners, believe this bill does not go far enough to liberate access to voluntary euthanasia.

Extracted from finalised Hansard
Inevitably, and as we have already seen in Australia, some medical practitioners will seek to test the limits of this legislation and the resolve of the government to contain the VAD process inside the legal limits. Given the lack of a specific requirement to involve a practitioner with expertise in a fatal illness, there is a risk of accidental misdiagnosis or deliberate misdiagnosis in that unusual and extreme circumstance. This problem is compounded by the lack of any requirement for the coroner to be informed of the death of a person who has gone through the VAD process to confirm the circumstances leading to the person’s death.

I understand that the intention of not specifying this requirement is to avoid a longer delay between the death of a person and their burial. However, we do not seem to have similar concerns for people who die in a range of other circumstances that are completely beyond their control, such as people who are murdered or die in motor vehicle accidents or through some other misadventure. Given that a key principle of this bill is that a person accessing the VAD process faces certain death from a terminal illness, surely it would be prudent to have a review process by the coroner to make sure the diagnosis was correct. As I have mentioned before, I am sure that most medical practitioners participating in this process will do so in good faith. However, it could be that some practitioners are consistently poor at diagnosing an illness or longevity. It could also be the case that a very small number of practitioners are deliberately misdiagnosing an illness or estimated longevity to expand the scope of the number of people who can access the VAD process. Ensuring that the coroner is notified of a VAD death and can, as required, conduct an autopsy is a critical safeguard to ensure that the process is operating in the manner intended by the government.

As I mentioned in my second reading speech, very many people are alone and uncared for by anyone they know at the end of their life. It is estimated that 40 per cent of people in aged care do not have a single visitor in a year. Those people are completely abandoned by everyone they know—brothers and sisters, sons and daughters, relatives and friends. Our community needs to do much more to end the desperate loneliness of so many older people. I have little doubt that loneliness must be a significant contributing factor for people who wish to end their life earlier than it might otherwise occur.

Palliative care is another key area for concern, in particular because one of the very common justifications for this bill is the great difficulty or impossibility of preventing extreme pain in some people who are dying. There are an appallingly small number of palliative care specialists in Western Australia and many general practitioners do not have enough knowledge in effective pain relief. There is effectively a complete lack of proper palliative care in many regional areas. In my view, even if the concept of voluntary euthanasia is accepted, it ought to be the option of last resort. Until Western Australia has acceptable access to palliative care, we cannot be sure that this inadequacy is not a contributor to people accessing voluntary euthanasia. I recognise that the government is committed to improve palliative care as part of this process, and I am very keen to see how this is implemented, especially in regional areas.

In conclusion, I have not attempted an exhaustive list of concerns with this bill for my third reading contribution, but have sought to highlight some of the major concerns. Legislating for the state to facilitate someone taking their own life or allowing someone else to assist someone taking their own life is an enormously important matter. This bill does not do enough to protect medical practitioners feeling compelled to participate in a process that they may fundamentally object to. It does not do enough to detect undue influence or coercion to participate in the VAD process. It does not do enough to prevent potential lack of expertise leading to misdiagnosis. It does not do enough to resolve issues such as elder loneliness and inadequate palliative care. The protections in this bill are inadequate, and I do not support the bill as it is presented.

In finishing, I wish to make a recognition of the member for Girrawheen, because I wish to especially recognise her contribution to the bill in this place, recognising that many members have made significant contribution. It does not require so much bravery to go along with the majority. It is much harder to go against the majority, especially when the great majority of people in your own party hold an opposite point of view. The member for Girrawheen has been tireless during this debate. She has been in the chamber for the great majority of the debate and has continued to participate and move amendments to the bill. I wish to place on the record my admiration for the considerable contribution she has made to the debate of this bill.

MR D.T. REDMAN (Warren–Blackwood) [5.32 pm]: I rise to talk to the third reading of the Voluntary Assisted Dying Bill 2019. I start with a bit of a compliment to the house for the way everyone has carried out this debate. It has been long, with late nights and early mornings, and testy for a very, very significant bill, in fact one of the most significant bills, if not the most significant, I have been a part of in nearly 15 years in this place. I thought everyone carried themselves admirably. They did the right thing. They quizzed the bill, as they rightly should have. The maturity with which the house undertook this debate is to be commended. There was no guillotine of anything, and there rightly should not have been any guillotining of debate on something as significant as this bill.

Mr R.H. Cook: There was one gag. The member for Armadale gagged his own amendment.

Mr D.T. REDMAN: Yes, he gagged himself. He is probably the only person in the chamber who could have done that! I recall that, the minister is right. I apologise for getting that wrong. I thought there were lots of appropriate questions, as there rightly should have been for something as significant as this bill.
I started this process, right from when this issue was put up, with my in-principle support for the voluntary assisted dying process. In my contribution to the second reading, I highlighted that the only qualifier to that was going through consideration in detail and fully understanding the mechanics of the bill, to listen to and get answers to questions, to ask questions, and to ensure that all the checks and balances that the community expects to be in a bill as significant as this are actually there. This might be a funny way of looking at things, but one of the best tests for a bill such as this is to listen to those who are opposed to it. They will be the people who put it to the greatest test, because they will draw out all the issues and scenarios that might play out. They will quiz the government, in this case the health minister, about the various aspects of the bill and how it works to see whether there are any cracks in it. I think the efforts of those who opposed the bill have supported the robustness of it. I think that is a really important part of the process.

I gave three points in my second reading contribution that were important to me in supporting this bill. The first, which I thought was compelling, was the level of public support. My assessment of the level of support in my electorate reflected that. Among people who gave feedback to me, whether while walking the streets of my electorate or through social media, emails and the like, there was a massive amount of support, so the expectation in my electorate is that I will support and pass this bill.

None of us can help but bring our family experiences to the table. As the house well knows, I have had some experiences in my family that I was able to bring to the table. I did not necessarily go through them directly, but someone very close to me went through very, very difficult circumstances. We cannot help reflect on those circumstances and the views of family members who went through the very difficult times that they did and what they brought to this debate. The third group I want to mention is the people who are affected. They are people who have a terminal illness and who in all likelihood will die in six months. As we know, the bill highlights that if a person has a neurodegenerative disease, people have 12 months. They also have to be going through insufferable pain that cannot be relieved. Those individuals have a right to be heard in this debate. The examples that were brought to us all, not only in this chamber, but outside of it through various forums, have been compelling to me and helped me support people having the choice. Some may not choose to take that path, but some would like to have the choice to take that path.

I will mention another occasion that was fairly significant to me, and I did not mention it in my contribution to the second reading debate. I remember when this issue was first taken to the Joint Select Committee on End of Life Choices. As members know, the National Party was represented by Hon Colin Holt on that committee. I was sitting next to Colin at dinner. We had a light conversation about the legislation, the scenarios and how it may play out. He gave me an example. He said to consider a circumstance in which someone is in hospital—we have all been there—tubes hanging out of our noses, drips in our arms and machines in the background running our blood pressure and heart beat. It is largely a foreign place for all of us. You are going through a terrible scenario and are approaching death at a particular point in time. Consider that scenario and passing away in that environment. Compare that with choosing a location of your choice, whether it be your home or another place of significance to you—making a choice of having friends around you and anyone you choose to be a part of that. You can choose the occasion to bring forward the death expected to occur in six months. I thought it was quite significant. It was quite a significant point to make. Having a choice like that between an unfriendly environment that you do not like, that you do not want to be a part of and with people you do not know, and a place of your choice with the people around you of your choice was fairly significant in setting up some of the first views in my mind of how this legislation might play out.

Members moved a number of amendments. I expect, as others do, that there may be some amendments that happen in the other house, in which case they will come back to our chamber for consideration. The one amendment that the Premier gave a commitment to consider in the upper house was on the issue of information. I think the amendments were to clauses 21 and 39. Clause 21 is about information reports in the first assessment and clause 39 is about information in the consulting assessment. The information is provided to the board. The amendment talked about having that additional information provided to the patient, the person concerned. That amendment came from the Leader of the Opposition. I think the Premier made the point at the time that, on the surface, it has some merit. I know that there was opposition to supporting that amendment in this place and there were a range of reasons for that, but I thought it had merit. If that amendment is made in the upper house and comes back here, it will make a bit of sense to me. It was not a show stopper for the passage of this legislation in this house for me, but I think it had merit.

The other test with this legislation was whether there were any drafting errors. It is a complex bill that interacts with other bits of legislation. There is a whole range of things on which it would be easy to make a mistake. I think the only genuine mistake that was identified concerned clause 26, in that a different word was used in the bill to the word used in the explanatory memorandum. The bill had “or” and the explanatory memorandum had “and”—I think the Leader of the Opposition highlighted that. When I looked at it, the wording in the bill was the right one for me, so that made sense. That, again, was not a show-stopping mistake. Nevertheless, I assume that it will be fixed by the time the bill gets to the upper house. In a book of words like this, that was the only thing that was
identified that might have been off the mark. I give credit to those who drafted this bill; it is complex, difficult and emotive, and they had to get it right. I think the bill stood up to the debate in this place, which is a measure of the effort that went into it.

New members of this place—those who were elected this term—will not deal with a piece of legislation like this again. It is the sort of stuff that happens once in your time in this place. In my 15 years, it is the most significant piece of legislation I have been a part of. Take notes, write it down in your memoirs or do whatever you like, because it will not happen again. Members do not get the opportunity too often to put in the level of effort that goes into a bill like this. This bill offers the Western Australian community the ability to choose voluntary assisted dying. The level of robustness that needs to go into the legislation to ensure that it is right when it leaves this place just does not happen very often. As others have said, when the debate on this bill is finished—I dearly hope it gets through the other place—there will be those in the community who will think it has gone slightly too far, and those who will think that it has not gone far enough. One of the challenges the government had in putting up this legislation was in pitching it at a level at which it would successfully pass through this place, so that, once it gets through two houses of Parliament, the option is available and it meets community expectations. I think it has been pitched right. If there had been overreach, it probably would not have got the support of this house, and certainly would not get the support of the other house. I think the pitch has been appropriate.

I will make one more point about the Legislative Council. If the bill does not get through the Legislative Council, with or without amendment, we can expect that this sort of legislation will not be back for a decade. We just do not put this sort of legislation through this place every year. For those who are supportive of it, we dearly hope it gets through with the scrutiny that it deserves, but if it does not, it certainly will not be back in my time in this place.

In closing, I can absolutely look my electorate in the eye and say with a clear conscience that I have acted here in their interests to support a piece of legislation that they want, and that the legislation is robust. I commend the bill to the house.

MR A. KRSTICEVIC (Carine) [5.43 pm]: I also rise to make a contribution on the third reading of the Voluntary Assisted Dying Bill 2019. I will start by acknowledging all the hard work that was undertaken by everybody during the consideration in detail stage. I commend the people who genuinely participated in that debate and took an interest in every aspect of the bill for going through that process and being so precise and concise in the way in which they went through it. I would also like to acknowledge the great work done particularly by the Labor members for Girrawheen and Armadale, who moved a number of very sensible amendments to this legislation that I strongly supported and hoped would be able to get over the line so that the legislation could be better than it currently is and so that its flaws, which I will go through very briefly, could have been corrected.

As legislators, it is incumbent to always act in the best interests of all our constituents and the people of Western Australia during the course of our debates. I initially struggled to come to a firm position on this issue; however, it was very easy to decide on a position once the legislation was introduced into the Parliament, and especially after the thorough consideration in detail stage raised numerous issues. I can advise everybody that all the concerns I raised in my contribution to the second reading debate have been confirmed as valid. As such, I will not be changing my initial position on the bill. Unfortunately, the government has chosen to ignore all the reasonable amendments that were put forward to this Parliament. I assume that most, if not all, will be accepted in the Legislative Council and that the bill may well find its way back here. It is very disappointing that we could not fix those problems before the bill gets to the Council. This house has been treated with a level of disrespect, in that we are viewed as not being capable enough to make those amendments and must leave it up to the other place.

I still have a number of very serious concerns with this legislation, including the fact that many people suffering from a terminal illness who do not qualify to access euthanasia or high-quality palliative care will commit suicide because their needs will be ignored by this legislation. Even without taking into account the future strong growth in our ageing population, it is evident that this government will never be willing to invest the required amount of money in both palliative care and the health system generally. It is still difficult to reconcile the giant leap we are taking here today when we are coming from a very low base, rather than taking an incremental approach by firstly identifying the gaps and then closing them. I know people say that there are 102 protections in the legislation. However, those of us in this place who have taken the time to look at them properly know that many are just eligibility criteria and that there are very few protections.

The Victorian legislation banned doctor steering, which means that a doctor cannot start the conversation around euthanasia if the patient has not raised it first. Unfortunately, our legislation does not provide this critical protection to vulnerable Western Australians. Alarmingly, allowing doctors to initiate conversations about euthanasia will put vulnerable patients at risk of undue influence. Inexperienced, incompetent or unscrupulous doctors could lead patients down an extremely dangerous and possibly unnecessary path. I realise that, historically, very few doctors have fallen into that category; however, some doctors have fallen into that category. It is incumbent on us as legislators to make sure that we protect those who are most vulnerable. Ultimately, doctors will be able to steer
their patients towards euthanasia and assisted suicide as opposed to palliative care. It is even possible that loved ones, and not the patient, may ask a doctor to start the conversation. Loved ones may also be present during the first discussion and encourage the patient to seriously consider the doctor’s advice, as “the doctor knows best”. The Western Australian Ministerial Expert Panel on Voluntary Assisted Dying acknowledged that up to 60 per cent of Australians have low levels of individual health literacy, meaning that a large number of patients are completely reliant upon their doctors to provide guidance, support and advice on their health decisions. Unfortunately, the bill does not even require the doctor to be specialised in a person’s illness or possible areas of treatment for them to make a decision about a patient’s request for euthanasia.

During the brief life of the Northern Territory legislation, there was a valid requirement for everyone to undertake a psychiatric assessment. Again, our legislation does not have this critical requirement to protect people when they are at their most vulnerable. I still have serious concerns about the physical security of the medication once it is given to the patient, not to mention the possible pressure the person might get from family members to end their life sooner rather than later. There is also the possibility of the medication falling into the wrong hands. Multicultural considerations have also not been properly taken into consideration. As we know, when people from non–English speaking backgrounds age, they generally revert to their native language and customs, and thus are more vulnerable than most to both coercion and confusion.

The principle of suffering is still confusing to me, because it does not just reflect the principle of physical pain but also seems to include things like feelings of demoralisation, depression, stress, sadness, giving up, loneliness and numerous other possibilities, effectively meaning that anything can be characterised as suffering. Doctor shopping and practices specialising in euthanasia also concern me. These behaviours have taken place and will always take place where this legislation exists. Doctor shopping is a well-entrenched practice in our society. We also know that doctors can get things completely wrong, such as when guessing the length of time someone has left to live.

Elder abuse is a serious issue in this state. The commonwealth inquiry into elder abuse has indicated that there are as many as 75 000 victims of elder abuse in Western Australia, not to mention the fact that around 40 per cent of people in aged care never get a visitor. Some of these people could undoubtedly become victims of this legislation. This is something I am not willing to risk.

I am also concerned about how it will be decided whether someone has capacity, and why a thorough mental health assessment will not be undertaken in every situation to make sure everything is above board. It is well documented that some people without capacity can from time to time present as if they do have it. The minister has presented a bill that I consider to be flawed in many respects. My responsibility as a legislator is to make sure that the interests of all Western Australians are protected and that they are not exploited by the government or others in our community. Since the minister is not prepared to fix the serious concerns raised in my contribution to the second reading debate, I will have to vote against this bill and hope that the Legislative Council will get it right.

MR K.M. O’DONnell (Kalgoorlie) [5.50 pm]: I, too, wish to rise for a short moment and congratulate all those involved in bringing the Voluntary Assisted Dying Bill 2019 to Parliament. I can agree with various members that had various concerns, but I think the spirit of the bill is why I am voting with the government on this. I have had a very good journey with this bill from when it first started. I met some very important people and some very good, decent people, including Belinda Teh, Andrew Denton and Angela Miller. I also wish to acknowledge the member for Girrawheen for all her comments, questions and proposed amendments; the member for Cannington; the member for Armadale; and, I think, the member for Midland. I thank my party for giving us a conscience vote. If it was not a conscience vote, I would still be going over to the other side on this.

I mentioned during the second reading debate that Andrew Denton made a comment about how, when he saw that this bill was being debated in the eastern states, party members from both sides turned on each other in Parliament. I do have concerns that the bill will not get it right.

The member for South Perth was very vocal on our side.

Dr M.D. Nahan: Is he a nice person?

Dr D.J. Honey: Not really!

Mr K.M. O’DONnell: He is sitting over there!
There were not a lot of vocal ones, but I commend the member. I remember when he went on the committee, he stood up in our party room and said —

Mr Z.R.F. Kirkup interjected.

Mr K.M. O’DONNELL: Sorry! Rookie mistake; I apologise. He never said anything! I was never there! I never heard anything!

Overall, I reckon this was handled well by both sides of the house. I like how our side asked questions, similar to the member for Girrawheen and the member for Cannington. With regard to the members for Girrawheen, Cannington, Armadale and Midland, it was like being back playing in a combined school sporting team. One minute I am playing against Hale or Wesley, next minute I am training midweek in the state squad with players from both schools. When the member for Cannington got up and spoke, even though I am not on his side even on this bill, I enjoyed listening to how he questioned the minister, and I took note.

I would like to repeat that I have reservations about the death certificate; I really, really do. I struggle with the idea that we put on the death certificate the cause of death when the cancer did not cause the death; the voluntary assisted dying caused the actual death. I still firmly believe that that is what should be on the death certificate as well; whether it is abbreviated or whether we refer to it by a different name, I still think we should put that on the death certificate. The minister said that people had reservations, and I think religious concerns—their own beliefs and so on—but we should not be falsifying a document. Maybe “falsifying” is the wrong term, but if the person submitted to voluntary assisted dying, that should be included on the actual death certificate, along with the other cause of death, whether it is cancer or any other illness.

I still support the government on this legislation. If there have to be more amendments, it can come back another time, and that is fine, but I wish it luck in the Parliament.

DR M.D. NAHAN (Riverton) [5.57 pm]: I would like to make a contribution to the third reading debate on the Voluntary Assisted Dying Bill 2019. As with many other people in the house, I think the debate has, to a large extent, been respectful, thorough and detailed, and appropriately so. This issue gives rise to a great deal of contention—appropriately so—and emotion on both sides; given the nature of the subject, you would not expect anything different. As I said in my contribution to the second reading debate, I praise the government firstly for bringing the debate forward on voluntary assisted dying, and for the wider debate it is engendering in the community about death. It is important. It took a lot of effort to bring this forward, so to all the range of people from the various committees that have been involved in preparing this draft and the papers that came forward to it, I congratulate them.

I came to this debate with some trepidation, mainly ethically. It was not because I am under the control of some powerbroker—I am not—or because of a religious issue, but because I recognise that we are going into the unknown; we are crossing the Rubicon. A fundamental ethical value of civilised society is: do not kill. We have seen uncivilised societies that have lost touch with that. I am not being over-dramatic here. Secondly, the implementers of this will be our doctors. We are blessed. Our medical profession, particularly our GPs and specialists, are some of the best in the world and well trained, but they are at the forefront, and many of them were very concerned about this legislation because, as the member for Cottesloe indicated, it changes and goes against the established Hippocratic oath—that is, always help; never hurt.

As I indicated in my contribution to the second reading debate, because we reach the Rubicon, it does not mean we do not cross it; but we must make sure we know where we are going and put restrictions on the expansion of the boundaries of human behaviour. That is what this bill is all about. As we all have, I have some personal experience, but I have tried to not use my personal experiences as general examples. They might be case studies, but they are not generalities. I indicated in my contribution to the second reading debate that I had three sets of problems, which is why I voted against the second reading. I wanted to go through consideration in detail, and I would like to thank some members who made consideration in detail a learning experience for me, particularly the member for Girrawheen, who had obviously gone through a great deal of work on the Victorian and international experiences of this sort of legislation, and she highlighted a number of issues.

Sitting suspended from 6.00 to 7.00 pm

Dr M.D. NAHAN: I am glad that there are some people in the room following the dinner break, and I will continue. I want to reiterate that I support everybody who has made a contribution to this debate. Understandably, this is a contentious issue. I received quite a bit of feedback both before the debate and more recently from all sorts of people in my electorate, and, I might add, outside my electorate, and there has been a tendency for people to be concerned about us dragging on the debate for too long. Let me reassure those people of two things. First, if the bill passes, it will come into effect on 1 July 2021 because of the preparations needed. Our debate has not slowed up the enactment or, indeed, the implementation of the legislation at all. More importantly, as the member for Cottesloe said, whatever members’ views are on voluntary assisted dying, they have to make sure that the bill will work and that they understand it—that is why we are here.

Extracted from finalised Hansard
To my views: in my contribution to the second reading debate, I stated that if the bill would do what most people perceive it aims to do, I would support it, but I do not think it will. Let me be more precise. Most people think that the bill will address situations in which people are on their deathbed and in pain because palliative care does not work or they have a neurological disease that is equivalent to that. If the bill would do just that precisely, I would support it. I had concerns before the consideration in detail stage that the legislation would go beyond that, and our consideration in detail of the bill showed me that it would. Secondly, I said that I was concerned about not just the lack of investment in palliative care, which is still a significant and pre-emptive concern from my perspective, but also that, as part of the legislation, palliative care should be a necessary precursor to VAD. Palliative care should have been defined widely in the legislation and available to patients. Patients should have availed themselves of palliative care before they could access the VAD process, but that is not necessarily the case. Thirdly, I am concerned—we went through this in great detail—about the chance for subtle abuse.

These issues of the lack of palliative care, the risk of abuse and people availing themselves of VAD before they are in physical pain and before palliative care no longer works will be rare, but we are dealing with death. Although it will be rare, even a few examples are too many. We debated the bill. For me, the flaw in the bill is that primarily, even though access to palliative care has eligibility criteria, we did not define palliative care and we did not make it a necessary precursor for people to take before availing themselves of VAD. I will go through that. Also, the definition of suffering is left up to the patient. I guess that follows from the primary objective of the legislation—that is, patient choice. In overseas examples—we do not know about Victoria yet, because it has had only one case—the majority of people availing themselves of the equivalent of VAD do so not because palliative care has failed or they are in deep pain and palliative care is not working, but because of what is called existential trauma; that is, they have been given a death sentence and they are in trauma. I simply cannot accept that VAD should be used to address anxiety and existential trauma; I just cannot accept that. We have heard of too many cases in which life is uncertain, life is short, life is valuable—you do not take pre-emptive action before you have to. That is my position. People will disagree with me, but I think we are going too far on this legislation.

The minister kindly provided some material on funding for palliative care. The government has increased the expenditure for palliative care over the forward estimates by around $30 million. We acknowledge that. The data provided does not include the expenditure in hospitals. The minister identified that that funding was hard to ascertain as separate. I accept that. However, all the evidence I have received from my discussions with palliative care specialists—in the private and public sectors, in the home and in hospitals—shows that there is inadequate access to palliative care. I would think that before the government goes down the path of legislating VAD, it would ensure in parallel that palliative care was adequately provided. In other words, there would be a dual-path process of preparing for, debating and identifying access to VAD, and it would be the same process for accessing palliative care. I believe the government has now undertaken a pathway to improve and define palliative care. I congratulate the government on that, but we are here voting on a bill today, not down the track. I do not think the government has performed adequately on palliative care.

This is the most important issue for me. Most of us live in loving families and have family doctors whom we can trust. I think that is the norm, but it is not always the case. I would like to read out one of a range of statements on this issue provided to me by a Western Australian doctor. I do not have permission to give this doctor’s name yet, but he has worked for decades as a general practitioner, dealing with all sorts of patients, but particularly people who are old and dying. This is his experience: he has spent his life dealing with this. From all of what he says, he is an excellent doctor. If all the doctors who would be dealing with VAD were like him, my concerns would be greatly lessened. He states that the VAD legislation will place a burden on some of the most vulnerable members of our society to take their own life and remove the self-perceived burden they place on society and family for advanced end of life. He says that although sanctions can be, and he thinks have been weakly, enshrined in the legislation, it is not possible to remove the pressure that these individuals will feel. He states that he knows that they feel like a burden, because he has spoken to them. He says that even if it is not external pressure that is placed on them, they put pressure on themselves, and external pressures can be extremely subtle—a look, a word, a suggestion. This will happen in a quiet room with no witnesses. It may be a person with little family support—we have heard that that is unfortunately common in our society—or dysfunctional relationships. It is not right to impose even the possibility of this decision on the vast bulk of the terminally ill who would not otherwise consider it. This is something that we in this house deal with all the time, on a range of issues—people acting improperly, as we define it. I have personal experience and advice that people, particularly at the end of their lives, when they are old, feel themselves to be a burden on society, their family or the community, and they take it upon themselves to take drastic action to end that burdensome association. If voluntary assisted dying is provided to these people without the necessary counselling identifying their feelings of inadequacy and addressing them, it is improper. The doctor I just referred to goes on at length in his article about how he identifies these feelings of inadequacy. He knows his patients. He discusses it with the family, which is often the source of it. Unfortunately, in life, many of us do not have that family. We do not have functional relationships. We do not have a relationship with a doctor, and therefore it is incumbent on this legislation to have other supported processes to scrutinise and ensure that there is not undue influence, whether external or internal, for people to perceive themselves to be a burden on
themselves and the community. I do not think the legislation has gone far enough. I cannot support that; it should have been done. We are not looking for perfection here, but we should have gone much further. Again, people tell me that these will be the exceptions, and they will be, but we are dealing with premature death, and exceptions should be the focus.

The bill has been structured in such a way as to take voluntary assisted dying into the norm of medical activity. That is a fundamental change for the whole medical system in our society. Therefore, in my view it should be really restricted to where it has been promoted for most of the advocates, but we have gone beyond that. This bill goes beyond what is in Oregon and in Victoria. One of the things that hit me most was that when I talk to people, they think it is about a person on their deathbed, when palliative care is not working, and the disease is incurable. However, one of the changes of this bill from the Victorian legislation is that in Victoria, the disease is required to be essentially incurable—it is a death penalty. This bill does not have that. We could come up with a hypothetical. Someone could have a disease that would kill them in six months, but not if they did something about it. This is too wide open for me and, I think, too wide open for most people in the community. It should be narrowed. The Leader of the Opposition indicated that if the bill came back from the other place, under certain conditions, she would support it. I do not expect that to happen in this case. We have gone through at great length and in detail my concerns with it, and the government, with all due respect, chose to take a different pathway. If it did change—if the government narrowed it down, invested more in palliative care and put greater effort into identifying and, indeed, scrutinising patients who wanted VAD to make sure there was no internal or external coercion upon them—I would support the bill. I do not expect it, and therefore I will vote against the bill at its third reading.

MR R.S. LOVE (Moore) [7.14 pm]: In discussing the third reading of the Voluntary Assisted Dying Bill 2019, I want to start off by saying how impressed I was with the operation of the Parliament as a group of people throughout this whole process, in terms of the spirit in which the debate was conducted. Generally speaking, the debate was conducted in a very respectful manner. I would like to pay some tribute to the member for Darling Range, because she has been acting as the Whip for people who initially voted against this bill. It is a bit unusual, because it does not fall along traditional party lines. We heard the Premier during his speech talking about some sort of a party line on this, and that is completely erroneous. I know that some members of the Liberal Party, for instance, voted in favour of the government on every amendment, and other members of the Liberal Party voted against every amendment. Similarly, in the National Party, some members have not yet voted on any of the substantive matters, but where they have, some, such as me, have voted against the bill, and others have voted for it. It is certainly not something that is being conducted along party lines. I thought it was a bit unfortunate that the Premier spoke that way in his third reading contribution, because that is not the way the bill has been dealt with, in my view, generally.

It was very refreshing, and very impressive, to see someone of the eminence of Malcolm McCusker sitting in the adviser’s chair. It does not happen every day that we see a Queen’s Counsel, a former Governor, recognised nationally for his contribution to the community, being involved. I know he was involved deeply with the ministerial expert panel as well. Even though I have opposed the bill at different stages, I want to give my thanks to those who have been involved in the discussion and in advising the various ministers who have sat in the chair.

I know the member for Kalgoorlie spoke of this, but I did think some of the comments from the Attorney General were at times a little unhelpful and perhaps a little aggressive, and were not really aimed at the spirit of what we were trying to do, which was to interrogate the legislation through the consideration in detail stage. I know that members spent many hours asking questions, to such an extent that, by the time they had finished on every matter, everyone had had their say. I think I was actually to some extent a passenger through a lot of the consideration in detail, because I was listening to the excellent contributions from people such as the member for Hillarys, the ministerial expert panel as well. Even though I have opposed the bill at different stages, I want to give my thanks to those who have been involved in the discussion and in advising the various ministers who have sat in the chair.

I know the member for Kalgoorlie spoke of this, but I did think some of the comments from the Attorney General were at times a little unhelpful and perhaps a little aggressive, and were not really aimed at the spirit of what we were trying to do, which was to interrogate the legislation through the consideration in detail stage. I know that members spent many hours asking questions, to such an extent that, by the time they had finished on every matter, everyone had had their say. I think I was actually to some extent a passenger through a lot of the consideration in detail, because I was listening to the excellent contributions from people such as the member for Hillarys, the minister for Armadale, the member for Girrawheen, and the member for Armadale, who made a considerable contribution throughout consideration in detail on this matter. It cannot be easy to do that when only a handful of people in that party are opposed to the bill. They showed a level of personal conviction and strength, although I think the member for Armadale supported the bill in its entirety, but wished to see some amendments. I do not think that was the case for the member for Girrawheen, but they showed that they were willing to stand up for what they believed was right.

I know that we are here as representatives of our communities, although I do not think we actually slavishly follow what public opinion might be. We are elected because people think that we are the people they want to represent their area. It does not mean, I believe, that we are slaves to an opinion poll on every issue. As the member for Scarborough, the Leader of the Opposition, mentioned, when we look at the way the house voted in the end, it is pretty much how the community has considered these matters. There is no doubt that most people in the community support a form of voluntary assisted dying; that is not disputed, but what may be disputed is the merits of the particular bill we have before us.

Extracted from finalised Hansard
A couple of matters that I would like to raise were, I thought, disappointing. First, the government did not make any amendments to the bill. I do not believe that any legislation when it is presented to the house is perfect, even when it is drafted by people of the eminence of the aforementioned Malcolm McCusker. That does not necessarily mean that it cannot be improved. I think the view that amendments can happen only in the other house, because somehow it is imbued with some greater ability, is wrong. In this situation, we have a bill that is very open and we have people with considerable intellect on both sides, who are able to discuss the issues and point out the deficiencies, which should be acted on. I will highlight a couple of those deficiencies. I know others have gone through a whole list of them; for instance, the possible conflict with federal legislation on telecommunications, leading to the encouragement of suicide, and that this may possibly be captured within that, as the Victorian government feels that its legislation may be in that situation. But, because I do not really support the concept of assisted dying in this form, I am not going to argue the merits of country people being able to access it the same as everybody else, because I do not think I want to go down that path.

Nonetheless, I think the government is being a bit naive if it thinks that this is not going to be a problem when it comes to putting this legislation into place. I think country people will be disadvantaged in the area of palliative care in particular. The member for Girrawheen tried to move an amendment to have palliative care defined in the bill, as it is not actually defined. If “palliative care” is not defined in the principles or the bill, I do not know how we can assure ourselves that everybody in this state who may indicate that they will apply for voluntary assisted dying has been given proper palliative care. If there is no definition of what constitutes palliative care, or an actual requirement for that to be provided, I think that is a very serious omission, especially for regional people. The further we go from the centre, the more difficult it is to provide any service. Palliative care is one of those services that I think is particularly difficult to access in regional areas, and I know this from the experiences that my constituents have brought to me over many years.

Every year that I have been in Parliament, I have had examples of people who have had difficulty accessing pain relief and proper palliative care in their areas. It is very real and it is not going to go away in a hurry. I do not think that I, or anybody from regional areas, would like to see people decide to access the VAD process because they are in an extreme amount of pain simply because they have not been looked after properly. That is a huge issue. The member for Girrawheen tried very hard and very valiantly to put in place a definition of palliative care, but the definition did not actually ensure that palliative care would be available. I was not supportive of the definition that she put forward. I thought it was a little bit restricted so I did not personally support that measure, not because I do not think there should not be a definition; I just did not agree with the definition. Nonetheless, it needs to be interrogated and inserted into the legislation. If the government is of the view that it is not going to accept any amendments in this house—and it did not—I hope that that is not the up-front position of the Legislative Council. Some of these measures are quite sensible and necessary, and if the government is going to make sure that this legislation does what it proclaims it will, those measures should be put in place.

Another matter raised throughout the debate that I thought had a lot of merit and a very compelling argument was made for it was the member for Armadale’s very reasonable amendment in proposed new clause 9A that registered health practitioners are not to initiate a discussion about voluntary assisted dying. I have a lot of respect for the member for Armadale. I think he has a very fine mind, and he has a personal reason for this. In these types of circumstances, personal reasons help to inform members about what might be the best way forward. His amendment was about ensuring that registered health practitioners did not initiate discussion about voluntary assisted dying. Again, I thought it was a very strong argument for why that should be accepted by the government and the house. Unfortunately, again, it was opposed, and it was not successful. I note that he and a couple of other members of the Labor Party voted that way. I hope that when the bill moves to the other house and this is discussed that that amendment will be reconsidered and, perhaps, put in place. I think it is a real danger when we have such a tool at our disposal, we do not suggest a course of action that someone may not have, on their own volition, wanted to consider. The member for Armadale highlighted that certain people with certain disabilities, for instance, might be highly susceptible to the suggestion that that is a good way to go. Therefore, someone such as a medical practitioner, who is very powerful in their lives, could put that proposition to the person with disabilities, and then the person decides that that is the way they will go. I agree with member for Armadale: that is not something that we necessarily need to see in the legislation. It is not in the Victorian legislation. I did not hear, even after the discussion here, a convincing argument for why this legislation is different from Victoria. I do not think that the legislation that the government has put forward is perfect, but it obviously does because it does not want to see any amendments to it. I think it is an act of hubris to believe that anything that is written cannot be improved. We sat through many, many hours of this debate and discussion, a whole range of ideas were put forward and every one of them was rejected. I do not think that the government can claim that the people who are putting these amendments forward are necessarily acting with malicious intent and trying to disrupt what the government wishes to achieve. I think in some cases, and certainly in the member for Armadale’s case—he is someone who has a very fine legal mind; a personal understanding of the issue—he supported the bill, but did not support that particular provision. Members from the government’s own party put forward amendments, which were just rejected. I find that very, very hard to understand.
I suggest that the government look at that issue and at palliative care again. I am still of the view that those are the two issues that are very wrong in this bill. Apart from the fact that I will not support the bill in its entirety, those two issues, I think, are glaring and could be addressed. Members of the Labor Party put forward amendments to help address those issues, but the amendments were not considered or accepted by the government. I hope that when the bill goes to the other place, those amendments will be re-interrogated, and palliative care, especially, will be looked at. As a regional person, there is a twofold benefit in that: it will improve this bill and it will improve the lives and the ending of lives for not only the patients but also their families. There is an enormous amount of distress on families when they see their loved ones suffering, when they have to drive them to and fro, here, there and everywhere to access care that should be available approximate to where they live. That needs to be urgently addressed. I know the government has made its commitment to palliative care in the budget, but, unfortunately, I am not seeing too much strategic or structural change that will actually make a difference to the palliative care that is provided in regional Western Australia. We will probably talk more about that in other forums, and the Nationals WA have a notice of motion on the notice paper for private members’ business tomorrow, during which I am sure some of these issues of palliative care will be interrogated further. As regional members, we are very, very mindful of the disparity in the level of care for regional people and people in the urban area.

In conclusion, I thank the Minister for Health for his patience when he was sitting at the table. I am not sure whether I would thank the Attorney General for his patience. Occasionally the Premier was there, and I think he did a pretty good job for someone who is not the lead speaker on this issue in explaining and trying to show respect to members who put forward their points. I am still trying to fathom the reason the house sat until 5.30 am on one occasion. I do not understand that. There was discussion taking place outside this chamber by certain members of this place who went out and criticised members for properly examining the issues and interrogating the clauses one by one. It is the right of and the expectation on this chamber that we do that. I thought it was very wrong for members opposite to criticise us for doing our job, and to try to tire us out by sitting to 5.30 am. I make a confession: I went home and had a little sleep. The member for Warren–Blackwood stayed here all night. I went home for a few hours and had a kip, because I knew I had to drive to Geraldton the next morning, and, in all honesty, I could not hop in the car at six o’clock in the morning and drive to Geraldton after having no sleep whatsoever. If I did that, I think I might have been another statistic on the Indian Ocean Drive. That was not going to happen, so, reluctantly, I went home and had a few hours’ sleep. I do not think that is a proper way to run the process of the house. I know that senior members of staff are expected to stay for these types of occasions, and it probably did not cost the Parliament that much money, but I question the value of it in terms of decision-making, a considered discussion and a rational process going forward. I question why the government would expect people to sit here from nine in the morning through to 5.30 the next morning. That is just silly. There is not another industry where we would do that, except, perhaps, in medicine, because we hear of the horrendous hours that they work.

Mr R.H. Cook: Member, I bumped into one of our former colleagues. I didn’t share time with him in the Parliament, but he was here for a function. He said, “Look at you mob! You sit late one night; all of a sudden, you consider yourself hard done by. We used to do that all the time!”

Mr R.S. LOVE: Yes, and I would accept that as a really good thing if it were not for the pyjama party that was going on upstairs, and the fact that Labor Party members were not here for much of the discussion. On this side, there were a few members. The ministers were taking it in turns. I think the whole idea was to tire this lot out so that they would all go to sleep, and the government would get through the bill quickly. It did not work, and people continued to do their very best to interrogate these clauses one by one by one. If that was the intent of the late sitting, it was a failure on the part of whoever intended that to happen. I do not think it was a great way to do things. I think we are going to finish tonight pretty much early. After all that, this will go to the other house at the end of September as always anticipated, I think. If we look at the sitting schedules, it was always intended that we would finish at the end of September. If we had finished on Thursday, it would not really have mattered that much; we would still have got it to the upper house so they can look at it first thing in October, which was surely what the government was trying to do. It was completely unnecessary! The government could have knocked it off at two o’clock or something, but 5.30 am—come on! There was no sense in it.

Mr D.A. Templeman: Where’s the strength in you? Where is it?

Mr R.S. LOVE: I do not think it is a matter of strength. That is the sort of talk we used to hear in the bush: “We’ve only had six cans and we’ll drive down the road.” That is not actually the proper way to conduct yourself. The government did not show respect to the members of Parliament. To all those on the other side who were upstairs asleep, they were not paying much attention to what was happening anyway, so what was the point? The Minister for Health was not even here to listen to the debate. I know that the debate took place, and we had alternative ministers, but the Minister for Health was the lead, and it would have been really good if he had been sitting there throughout the consideration in detail. He would have heard everything; he would have been able to inform his department of what was needed. That would have been the proper way to do things—surely? Can the Minister for Local Government imagine the City of Joondalup council sitting until 5.30 in the morning?

Mr D.A. Templeman: Some of them sit quite late.

Extracted from finalised Hansard
Mr R.S. LOVE: I am sure they do, but they are probably not discussing much of any interest by then. Anyway, I do not want us to be here until midnight tonight. I think I am now running into a situation in which I might be threatening to do to the government what it did to the people who were not supporting it by making them stay around. Maybe I might just do that. I have another nine minutes. I am sure the Minister for Health would like to go home. Look, I think that has made the point. I hope that when this goes to the other place, it gives it due regard, and there is no sense of rush on this. This is landmark legislation for Western Australia. The idea that it needs to be rushed through to some predetermined timetable is a bit unseemly, given the gravity of the matter being discussed. Although I think that in general terms the whole debate has been conducted very respectfully, that was the only issue of conduct that I would raise—pushing people to the point of exhaustion was unnecessary and in the end unproductive and not a good process for Parliament to consider in the future.

In conclusion, I did not support this bill in the second reading. I think the fact that the government refused to accept any amendments, including some very reasonable amendments, has not done anything to allay my concerns about the bill. So if this goes to a division, I will probably be voting in the same manner as I did in the second reading stage. However, in doing that, I bear no judgement to pass on anyone who has a contrary view. Most of the members of my party have voted in a different way. That is fine. They are all good people. I know that they are doing so for the very best of intentions, and are not only trying to slavishly reflect what their constituents are telling them, but also filtering that with their own knowledge about what is written here and the long-term implications of what has been proposed. With that, I thank the house for listening to me, and it will be interesting to see how this bill progresses through the other place.

MR P.J. RUNDLE (Roe) [7.38 pm]: I rise to briefly support the Voluntary Assisted Dying Bill, as I did in my second reading contribution. As the Premier said today, there has been nearly 70 hours of debate. It has been very comprehensive. I congratulate the Minister for Health and his staff, and make special mention of Malcolm McCusker as the chair of the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying, because I think Malcolm is very methodical, very fair, and very measured. I think he and his panel certainly did a good job there, along with the Parliament’s Joint Select Committee on End of Life Choices, of course. Well done to the Minister for Health and his advisers, some of whom are in the chamber at the moment. Also, well done to the staff of the Parliament for the many long hours they spent working. I tried to spend as many hours as possible in the chamber to listen to the many stories of loved ones, family and friends in their last days during the second reading contributions and also the stories of great palliative care and, in some cases, a lack of palliative care. My strong interest is in the improvement of these facilities in regional and metropolitan WA. I trust that the health minister will follow through on his promises and convictions and will continue to fund palliative care in the budgets that lie in front of him. I can assure the minister that should there happen to be a change of government in 2021 and I am still a member of Parliament, I will happily fly the flag to continue the funding of palliative care in the regions and in metropolitan areas. We will see what happens, but I will certainly be there if possible.

Mr J.E. McGrath: Member, you could be the Minister for Health!

Mr P.J. RUNDLE: Well, you never know what is around the corner.

I had to miss some of the debate to fulfil my duties as member for Roe at the Newdegate Machinery Field Day. As members know, Newdegate field day is one of our biggest events. I stayed as late as possible to listen to my leader’s speech, then set off to both Katanning and Newdegate, which was a total of seven hours driving. I was slightly frustrated to be marked as absent on the initial vote, but I am sure that after my second reading contribution, my constituents are aware of my position in favour of the bill. I will certainly be voting in favour of it after the third reading contributions. I might also add that the minus two and three degree temperatures down in Newdegate on the night and morning of the debate enabled me to stay awake for most of the night and follow the debate anyway. I sent my traditional photo of the car with about a quarter of an inch of ice on the windscreen to “Tuck” Waldron, but as I said, I was awake most of the night anyway because it was fairly cool down there in Newdegate.

I thought everyone handed themselves very well during the debate and were very respectful. I congratulate both the members of the opposition and those of the government who had many questions during consideration in detail. I was happy to attend as many hours as possible in the chamber to reassure myself that the many safeguards in the bill were investigated and covered in as much detail as was required. I am comfortable that the interrogation of members in this chamber have covered those many elements and I am confident that, without doubt, the Legislative Council will take it to another level.

One of the only two points I would like to mention is the matter of doctors and the Hippocratic oath. I fully understand their hesitation. Many doctors whom I have spoken to have some hesitation. I made the point during my second reading contribution that many doctors are members of a small local or regional community and are part of the community. It is quite a difficult relationship when they might play tennis at the tennis club or whatever with someone. This bill will take it to another level. There will be difficulties there. The good thing is that doctors have the choice, like patients. For me that is reassuring.

I will be very interested in the telecommunications issue—telehealth. I understand there is a meeting with the federal minister or his people going on either right now, today or in the very near future. That is my understanding. I think
it will be great when we hear the outcome of that because that is something that is very important in a regional context. With that in mind, I believe the most important thing for me to do is to vote on this bill on behalf of my constituents. I can assure this place that a strong majority of my constituents are in favour — anywhere from 80 per cent to 90 per cent. I have not run a process equivalent to that of the member for Dawesville, with over 6,000 people consulted. I congratulate the member for Dawesville because I thought his opening contribution set a good tone for the debate. The fact that he had done such a comprehensive job, I thought, was a great example for everyone. I have spoken to many constituents, as have my electorate officers and so forth, but I certainly have not taken it to the level of the member for Dawesville. I congratulate him on the way he set about the debate and the process.

I spoke in my second reading contribution of my aunty who recently passed away from motor neurone disease. I know that her close and extended family would be pleased with the comprehensive debate that has happened. That was the opportunity they wanted to see. She was also very pleased to be able to talk to members of the Legislative Council. It comforted her in her last days. I am very comfortable that this has been a robust process and I can inform my constituents and my electorate of that. I respect the views of those who are against. However, my overriding sentiment and that of my electorate is in favour of this bill. For me, it is about choice. For my constituents, it is about choice. It is choice about the manner in which death will occur and dying in a controlled and timely manner in the right place and surrounded by family. For me, that is the overriding sentiment. I think this will be the most important legislation many of us will ever vote on. I commend the bill.

MS M.M. QUIRK (Girrawheen) [7:46 pm]: Over the lengthy and at times torturous debate in past weeks, I anticipated that we would have a complete and transparent picture of how these laws would operate. Alas, that is not the case. Many questions remain. Before I address these, I commend the many advisers who were put under extraordinary time pressure to assist in drafting, advising and briefing members. Amongst the questions remaining unanswered is the reason for undue haste. No satisfactory response has been given. This undue haste has led to late sitting hours, which are not amenable to clear and lucid deliberation. More significantly, the undue haste has meant that mistakes have been made. As was pointed out, the explanatory memorandum and the bill do not readily coincide. Most importantly, the explanatory memorandum asserts that in various dealings doctors will act independently of one another. Nowhere is that contained in the bill itself. There are even spelling errors in the explanatory memorandum. Such an observation may seem nit-picking and petty, but if minor details escape attention, I do not know that we can accept confident assurances that compliance on major and serious matters will be conscientiously adhered to. Similarly, that very independence has been cited as one of the so-called 102 safeguards.

Another question to which I regrettably did not receive an answer was why none of the amendments moved were accepted. Most dealt with giving greater clarity to the proposed laws. One of the most significant of these, and a number of members have mentioned this, was moved by the member for Armadale and dealt with the prohibition on a doctor initiating the subject of voluntary assisted dying. He raised this for the very real and cogent reason that many people who are suggestible for one reason or another may agree to that course of action without fully appreciating the import. Also perplexing is that if the measures proposed in the bill are so non-controversial and straightforward, why was it felt necessary to use opaque terms throughout the bill? Why is this not just euthanasia? Why is it not suicide, albeit with physician oversight? Why is it okay to produce a misleading and incomplete death certificate?

Another query that was not satisfactorily explained concerns the numerous examples of the wording of clauses throughout the bill varying slightly from the equivalent clause in the Victorian legislation but in a material particular. Usually these variations have had the effect of diluting the level of accountability and protection. Likewise, the constitutional conflict with the Commonwealth Crimes Act concerning inciting suicide through communication services is not yet resolved. We were advised that the Attorney General secured advice from the State Solicitor and Solicitor-General. Neither advice has been tabled and the exact nature of that advice has not been disclosed, but the Attorney General for the state assures us that there is no difficulty. His letter to Attorney-General Porter on the matter in late August is yet to receive a response.

The format for training medical practitioners and nurse practitioners is in its early stages of development. However, it was confidently asserted that even with the minimal training planned, practitioners could readily identify coercion or lack of capacity. We all know that identification of these is problematic, even to the most experienced practitioners. In some cases, it requires a series of encounters over days, weeks or even months to assess properly. This is simply not possible under the time frames in the bill.

The creation of the criminal offences attracting substantial penalties on its face looks like an effective deterrent to wrongdoing. However, these clauses are also inferior to the Victorian equivalents and I question whether there is an overlap with existing provisions of the Criminal Code. What kind of evidence would be available to make out a prosecution beyond reasonable doubt? This is especially so given the lack of real-time monitoring by the board, minimal or no intervention of the coroner, a misleading death certificate and the setting in which this offence may have taken place. Also, the many things ordinarily dealt with by way of regulation are to be addressed by guidelines issued by the chief executive officer of the Department of Health or his delegate. Is it to be assumed that this is to keep the process streamlined and less onerous?

Extracted from finalised Hansard
Finally, on the issue of questions not satisfactorily addressed is the definition of “palliative care”. We are told that this bill does not address palliative care and, accordingly, the focus on it in the consideration of the bill is misplaced. However, under clause 26 of the bill, a practitioner is obliged to discuss palliative care and treatment options. As has generally been conceded, “palliative care” means different things to different people. A definition in the bill may have assisted in a greater understanding and added greater precision to any discussion with patients. It is also understood from the consideration in detail stage that the shortage and lack of palliative care in the regions will be addressed by funding. I certainly welcome the commitment given to additional palliative care in this year’s budget. As I said in my contribution to the second reading debate, calculations suggest that the appropriate ratio for palliative care specialists in Western Australia should be 2:100 000. Western Australia has 0.57:100 000. We have a lot of catching up to do. The estimate is that over four years, $600 million is needed and medical specialists in the field need to increase from 15 to 50.

In the context of my constituents, the minority report of the Joint Select Committee on End of Life Choices found in its finding 10 on page 67 —

Apart from a small number of private beds at Glenngary Hospital, there is no inpatient specialist palliative care hospice in the northern suburbs of Perth.

The committee recommended —

The Minister for Health should facilitate the establishment of an inpatient specialist palliative care hospice providing publicly funded beds in the northern suburbs of Perth.

I want to stress that there is already an area within Joondalup Health Campus that was specifically built as a hospice, but it is not being used for that purpose. With the expansion of Joondalup Health Campus, I hope in the near future, maybe that space can be freed up so that the northern suburbs are better serviced with palliative care.

The underlying premise in these laws that I find impossible to reconcile is that there are occasions when it is morally justifiable to intervene directly, but mercifully, to hasten death when death is inevitable. It is morally unjustifiable because intentionally killing a person is a crime. Our society has always forbidden taking an innocent life and for that reason such an action carries with it the most serious of consequences. This prohibition is so fundamental that legislating to allow euthanasia and physician-assisted suicide does not eliminate the very sound social policy bases that the risk exists that voluntary suicide could turn too easily into involuntary suicide. Effective procedural safeguards are an exercise in wishful thinking or, as Paul Keating said, “bald utopianism”. Establishing robust protections has been problematic in all other jurisdictions.

The actions permitted of doctors under the bill, however willing they are to participate, is totally incompatible with the notions of healing and doing no harm. The laws are bound to have a profoundly corrupting effect on the practice of medicine. Although this bill covers any eligible person over 18, it is likely that a preponderance of those seeking access to an early death will be elderly. This demographic inevitability creates a situation with which I am extremely uncomfortable. Knowing that these laws exist, I consider the socially isolated elderly and those with limited capacity and those coerced or unsupported by friends or relatives to be more likely to meet the subjective test set out in the eligibility criteria under clause 15. They are more likely to feel that they are a burden.

This scenario is by no means a new one. Seventeenth century playwright Thomas Middleton wrote a play called *The Old Law*. In it, the good characters are those who follow conscience and the natural law, defying the unjust and unnatural law laid down by the state. The duke of a fictional empire passed a law condemning all men at 80 years of age and all women at 60 years of age to be executed as they were regarded as being of no use to the state. Selfish young courtiers and wives of elderly husbands praised the law, which allowed them to inherit wealth and broaden the scope for irresponsible living. The law encouraged falsification of parish records so that a character could get rid of his elderly wife. Another, with the help of his wife, attempted to save his father by staging a mock funeral and then hiding him. Eventually discovered, the pair were brought to trial before the young irresponsible heirs who have positions of judicial authority now that their elders have been executed. At the last moment, the duke reveals that the elders have not been killed and the new law has been a means of discovering the true nature of the young courtiers. The play ends with the young heirs dismissed from their positions of authority and the husband and wife raised in their places. We can see that the issue we confront is by no means a new one.

To the extent that this bill fosters the awful notion that the elderly are a burden, it is inimical to a community that values those people and can enable them to have a quality of life in their last years, months and days. Nowhere is the phrase attributed to Vice President Hubert Humphrey more apt. He said —

The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in shadows of life, the sick, the needy, and the handicapped.

*Extracted from finalised Hansard*
The proponents of this bill declare that they are motivated by love and compassion, and I do not doubt this, but good intentions alone will not cut it. Good intentions will not prevent the sick and elderly from feeling as if they are a burden. Good intentions will not adequately source the palliative care system, either non-existent or stretched to the limit. Good intentions will not ensure that coercion of those susceptible to persuasion are not agreeing to something that they in reality would rather not do. Good intentions will not enshrine a level of independence between doctors, which is not in the legislation itself. Good intentions will not prevent persons from travelling elsewhere to avail themselves of this process, possibly placing added burdens on the Western Australian health system. Good intentions will not prevent one-stop shop practices being set up and the advertising of those centres. Good intentions will not fix the lack of real-time oversight by the Voluntary Assisted Dying Board of the process and nor will good intentions effectively guard against the possibility of wrongful death.

MR J.E. McGrath (South Perth) [8.00 pm]: I rise to contribute to the third reading debate on the Voluntary Assisted Dying Bill 2019. Legislating for voluntary assisted dying has been very difficult; it has been controversial and confronting. But the breadth and depth of consultation and rigour of the processes to develop this bill gives me confidence that this is good legislation. As it heads off to the upper house, which will happen sometime tonight, I do not think that this legislation requires another inquiry, and I will explain that a little later. By my calculations—it has also been mentioned by the Premier and the member for Dawesville—this chamber has devoted 67 hours to the second reading debate and the consideration in detail stages of the bill. In Victoria, where similar legislation was passed, its Legislative Assembly, which has 84 members, took 38 hours for the second reading, consideration in detail and third reading stages. In all my years in this place I have never experienced such close scrutiny of a bill, which I think is good. Even some of our friends in the upper house joked to me the other day: “It’s about time you guys in the Legislative Assembly did what we do all the time.” They are very critical of how we often send stuff to them that they have to fix up. But I think that the scrutiny of this bill has been outstanding.

I have never experienced so many “what if” questions or so many questions about the meaning of words, the details of implementation or the content of regulations and forms that have not yet been drafted, and that is fair enough. That is good scrutiny. The point has been made by other members that this is probably the most important legislation that will ever go through this place, at least during our time. The government ministers painstakingly responded to each of those questions, in particular the Deputy Premier who showed commendable endurance. I felt that the Deputy Premier acted in good faith throughout the whole debate and his resilience was pretty good, even though he was criticised for having a break. I recall how once Premier Barnett sat at the table when Troy Buswell was the Treasurer and needed a break, so it is not unusual to have people stand in for ministers.

To a significant degree, the bill is not new. It is largely modelled on the Victorian Voluntary Assisted Dying Act 2017, which in key respects was itself drawn from the Oregon Death with Dignity Act and the practical knowledge gained by more than 20 years’ experience in that state of the United States. It is also important to recall that the bill was informed by the advice of the Western Australian Ministerial Advisory Panel on Voluntary Assisted Dying. This panel was chaired by eminent jurist Malcolm McCusker, AC, QC, and supplemented by another 12 members with a breadth of expertise and experience, six of whom were medical practitioners, including four whose field of speciality included palliative medicine, and two of whom had previously been presidents of the Australian Medical Association WA. It is important to mention the experience on that panel. The panel called for submissions, released a discussion paper, held public forums throughout the state and held stakeholder meetings at round tables with topic experts and groups that might be impacted by the legislation, including health professionals and peak bodies representing specific populations. The panel’s work built on the work of the Joint Select Committee on End of Life Choices, of which I was a member. That committee had a life span of roughly 12 months. During that time, more than 700 submissions were received and 81 hearings were convened with more than 130 witnesses. I understand that it is the largest parliamentary inquiry in the state up until now, which is another reason why I do not want this legislation go through another inquiry process.

The lengthy and painstaking process has now been underway for in excess of two years. Members should be aware that this process reflects the process adopted, as I said, by Victoria in creating the Voluntary Assisted Dying Act, which was assessed as one of Australia’s best examples of evidence-based policymaking. Both the Institute of Public Affairs and Per Capita in Australia considered that the equivalent of a green and white paper process had been adopted in Victoria for public feedback and final consultation purposes and to explain complex issues and processes. Both also considered that the Victorian process demonstrated a need for voluntary assisted dying based on hard evidence and consultation with all the stakeholders involved, particularly interest groups that would be affected. Once again, the government, in putting this legislation together, followed the same process that happened in Victoria.

I will talk about some of the issues raised in consideration in detail. The first is the language of the bill. Its title contains just three words: voluntary assisted dying—all plain English and easily understood. How is the title, which includes the word “dying”, too coy about its subject matter? Voluntary assisted dying is not at all like suicide, as I said in my contribution to the second reading debate. Access to voluntary assisted dying is not only very restricted, but also a highly regulated process. Medical professionals must be consulted and eligibility is determined by them, not by the patient. They must report in next to real-time and this will be monitored by a government agency—

Extracted from finalised Hansard
another process. This is a very long way from the often impulsive, brutal and lonely suicides of desperate people, particularly those whose decision to die might not have been acted on had they first consulted professional health services or had their capacity assessed. Some critics say that they value life, yet they insist on referring to voluntary assisted dying as assisted suicide. The chair of The Royal Australian and New Zealand College of Psychiatrists WA believes that this will undermine suicide prevention efforts. I agree that the term “euthanasia” is often used in the community and might have been a substitute title for the legislation had the bill allowed for only practitioner administration, but it does not, so to use the term “euthanasia” would not have been accurate.

I will now get on to safeguards. Existing end-of-life choices such as palliative starvation and terminal sedation also lead to death, perhaps enabled by others if the patient has lost capacity, and yet neither of these two choices—palliative starvation and terminal sedation—have the legislated safeguards proposed for voluntary assisted dying. There are no safeguards if a patient decides not to take food or liquid. I ask: why is there no concern now, in the examples that I have just given, about subtle coercion by family members with so-called inheritance impatience when they, and not the patient, can make the decision to end the patient’s life? It is because those working in the field—we heard evidence from Canada about this—say that families are much more likely to resist, rather than encourage, the decision of their loved ones to end their life. They say, “We want you around. We do not want to lose you.” The evidence in other jurisdictions is that people are not saying, “Go on. It’s time to go.” I think a lot has been made about this, but I have greater faith in human nature than that.

I think there are a multitude of safeguards in the bill. For instance, clause 15(2) is very critical because it excludes access to voluntary assisted dying on the basis of just a disability or mental illness. If a person has a disability or a mental illness, that is not enough justification to even apply for voluntary assisted dying; they must have a terminal disease that will end their life.

Practitioners involved in voluntary assisted dying are required to have lengthy experience and additional training to specifically identify and assess risk factors for abuse or coercion. I think in part of this debate we lost sight of the fact that practitioners are very good at what they do. They deal with people all the time. When you come out from seeing your GP, there are half a dozen people waiting in the surgery to see him. GPs know how people feel and how they will act, especially their patients. Even if a person goes to see a practitioner who is not their regular GP, GPs will be trained; that is another safeguard.

Patients need to have capacity. They need to demonstrate that they understand the voluntary assisted dying decision and its effect, and must be able to weigh up the various factors. As I said, professionals will be able to gauge whether people have that capacity and whether they really understand what they are getting themselves into. I believe that practitioners will sit down with people and ask them whether they really want to do this. I do not think they will say, “Go on; I’ll sign the form and we’ll get you in there.” I do not think that will happen.

A minimum of four people will need to certify the voluntariness of a patient’s request for assisted dying and there will be a lot of hoops to jump through. If certification is found to be false or misleading, practitioners will be liable for criminal prosecution. Practitioners will risk their professional accreditation as well. Other criminal offences include administering lethal medication without authorisation or inducing a person by way of undue influence or coercion.

I now come to the scourge of elder abuse in our community. A lot of members raised this matter and how it would impact on the legislation. I draw members’ attention to the report of the Select Committee into Elder Abuse from the other place. That committee spent a year inquiring into elder abuse for the Legislative Council before tabling its report titled “I Never Thought it Would Happen to Me: When Trust is Broken”, which was tabled on 13 September 2018. In that report, the committee rejected mandatory reporting by professionals of abuse even when they suspect an older person is being abused. The committee resolved that even if a professional thinks an older person is being abused, the committee did not recommend that they must mandatorily report that. Why did the committee decide that? It concluded that because —

... the dignity of older people must be respected as must their right to decide what action to take, if any, ...

The committee concluded that if an older person is being abused or another person thought that they are being abused, it is the older person’s right to decide whether they want to take action against the abuse. I think the same should happen with this legislation.

Another issue that came up was whether voluntary assisted dying should be put on someone’s death certificate as happens with suicide. During consideration in detail, I said that voluntary assisted dying is certainly not suicide. These people are dying and are being treated for a condition that will end their life within either six or 12 months. They are like those who now deliberately hasten their death through palliative starvation and the potential effect of terminal sedation or double effect. No reference is made to any of those practices on a death certificate, which instead records an underlying medical condition. If a person with cancer undertakes palliative starvation or does not take fluids, the cause of death is cancer. I do not think it should be any different with voluntary assisted dying.

Another issue with placing voluntary assisted dying as the cause of death and not the actual disease on the death certificate is that it could cause a problem with life insurance claims. Nick Bruining pointed out in his column in The West Australian the importance of recording an underlying medical issue as the cause of death because
it would mean that if a person’s superannuation fund has life insurance and a policy that operated outside of superannuation, there would be no issue with the cause of death. This legislation is intended to give terminally ill people the dignity to make their own choices when they are dying. We should not make their families suffer even more after they have passed away by putting voluntary assisted dying on their death certificates.

I now come to palliative care, something that was raised throughout the debate. Opponents of voluntary assisted dying say that the right to palliative care needs to be included in this legislation and that there should be huge increases in government funding for palliative care. I do not believe that palliative care is the silver bullet and that if people have access to palliative care they will not need voluntary assisted dying. Professor Ian Hammond, AM, recently said that in his entire career as a gynaecologist and oncologist at least 20 patients had asked whether there was anything he could do to end their suffering. Professor Hammond has become an advocate of voluntary assisted dying, and he says that he would like the choice were he to have a disease that made life unbearable.

Much concern has been expressed about the low numbers of full-time palliative care specialist practitioners and the rate of palliative care hospital admissions in Western Australia. I would like to point out that just last year WA’s community palliative care model was assessed as the gold standard in Australia for palliative care following a Productivity Commission inquiry—that is, the gold standard in a country ranked second in the world for its palliative care. In WA, specialist palliative doctors provide consultancy services for patients in the community rather than work full time caring for hospital inpatients. This means that fewer full-time palliative care doctors and palliative hospital admissions are required. According to the Productivity Commission, WA palliative care is the gold standard because far more people in WA are able to die at home. I think we all agree that that is the wish of most people. Do we want more of our health funding used for additional full-time palliative specialists and palliative hospital admissions and fewer people having the choice of being supported to die at home? The fact is no matter how much we spend on palliative care or how many full-time specialists we have, it will not resolve all suffering at the end of life.

In conclusion, after being involved in this matter now for more than two years, I have no doubt that voluntary assisted dying is required in this state. However, I expect that some opponents of the bill will not vote for it regardless of whatever amendments are offered to accommodate their concerns. This is a free vote and it is their right to oppose the bill. I will always respect members’ right to do that and I expect the community will respect that, too.

If a member genuinely does not believe in an end-of-life choice—it might be a religious belief or just a normal faith belief—I think the community will understand that, but the community needs to know where we all stand on the position. I respect the views of our leader. I took down what the member for Scarborough said in her speech earlier because her comments were very interesting. The member for Scarborough thinks that the amendment to prevent doctors from raising voluntary assisted dying as an option with patients should be passed when the bill goes to the upper house. The Leader of the Opposition said that she would consider supporting this legislation if that happens. I personally do not have a great problem with that amendment. There are two schools of thought. People have said to me, “Well, doctors give you a lot of advice when you are very sick at the end of life. They can recommend that if you really do not want to, you don’t have to take food or fluids. They can make all sorts of suggestions.” I personally do not mind the member for Armadale’s amendment. Someone said to me, “Maybe some patients won’t know about voluntary assisted dying.” I would be very surprised if patients were not aware of VAD by the time this legislation, if it passes the upper house, comes into force. If this legislation passes, it would be fairly well known that VAD is an option. I support what the Leader of the Opposition is doing on that amendment. I do not think it would impact on the bill greatly; it is the same as the provision in the Victorian legislation. If people are really crook, I think their friends or someone else will say, “You know there is another way if you really need to do that.”

Our leader also said that she would like to see a definition of palliative care in the legislation. I am not so sure about that because palliative care could be an ever-changing thing and how do we define it. This legislation, if it passes, will be in force for a long time. I am not sure about that amendment, but we will see what happens in the upper house.

Mrs L.M. Harvey: That’s not a deal-breaker. I just think it’s silly not to have a definition in there.

Mr J.E. McGrath: Yes. I would support the Leader of the Opposition on that.

In closing, I have confidence in the rigorous process we have undertaken. I think the government has spent a lot of time and effort putting together this legislation. I have watched from afar since our committee finished its work. I think it is good legislation. Obviously, it will be scrutinised very seriously and in great depth in the upper house. We will see what happens up there, but I think that this is good legislation and the public wants it. I meet a lot of people and, wherever I go, I say to people, “We’ve got a difficult decision to make. What do you think of this?” They just say to me, “John, do it. It’s a no-brainer.” I have always supported the bill, I still support it and I look forward to it going to the Legislative Council after tonight.

Distinguished Visitor — Sandra Nelson, MLA

The ACTING SPEAKER (Ms J.M. Freeman): Before we move on, I welcome Sandra Nelson, MLA, member for Katherine, from the Northern Territory Legislative Assembly. Welcome to the chamber.

Extracted from finalised Hansard
Debate Resumed

MR D.C. NALDER *(Bateman)* [8.22 pm]: I stand to contribute to the third reading debate on the Voluntary Assisted Dying Bill 2019. At the outset, I pointed out that my position was that I was not principally opposed to the legislation; in fact, I understood and supported the intent of this legislation. That said, I did have some concerns and I wanted to abstain from making a final decision until we had been through the consideration in detail process. Unfortunately, that consideration in detail process did not leave me with confidence in the legislation and I am unable to support it at this time. Again, it is not because I am principally opposed to the intent of this legislation; it is more my fundamental concern about what sits around this legislation.

We talked about palliative care. I like to think of it as more than palliative care; I like to think of it as the whole end-of-life care. We talked about the standard of living in Australia. I believe that we have one of the best standards of living in the world, and we should aspire to ensure that every Australian has access to the best end-of-life care in the world. The member for South Perth pointed out that our palliative care is gold standard. That is fantastic and that is what we should expect, given the standard of living in Australia, but fundamentally it concerns me that not everybody has access to that gold-standard palliative care and that as many as two in three patients, or people facing terminal conditions, may not have access to palliative care. I feel that we are jumping from an unsatisfactory situation in which we have not resolved the issue of palliative care to voluntary assisted dying or euthanasia. I believe that, as a minimum, palliative care should be done in conjunction with, if not before, we finalise voluntary assisted dying. That is my position, and I feel that we have not tackled that.

I also had concerns about some of the approaches by the Premier and the minister to the amendments raised in this house. I believe that some of those amendments deserved our proper consideration. I was left with the impression that it was a predetermined decision that 100 per cent of the amendments raised in this place would be rejected. I found that unfortunate. I believe that some very good amendments were raised, particularly by the member for Armadale, the member for Girrawheen and others, that warranted proper consideration. I do not feel that proper consideration was given to those amendments, irrespective of the hours that were put into the debate. I do not care how long the debate was; to see these amendments disregarded, which seemed like a predetermined position, left me feeling very concerned. I hope that those amendments will be addressed properly in the other house, but I believe they should have been addressed here.

My point around addressing palliative care is that I do not think it is acceptable that as many as two-thirds of people do not have access to quality palliative care. I accept that it is impossible to deal with palliative care in every remote location, but we need to ensure that there is proper palliative care for people facing terminal conditions in the regional centres near some of those remote locations. In the absence of being able to deal with that, for me, it is akin to making this an economic decision in which we are saying that we cannot afford to provide proper palliative care for everybody and, therefore, it is more convenient if you die. I have a concern that in this bill we have made it an economic decision to not address this issue. I think the member for Girrawheen pointed out quite correctly that a lot of the so-called additional funding for palliative care has not been additional funding, but funding rebadged from other programs. To me, there should have been as big an inquiry about total end-of-life care as there was for voluntary assisted dying. I believe that to do it in isolation of the complete picture is a mistake and for that reason, unfortunately, I cannot support voluntary assisted dying at this point. I repeat that I am not against the principle or the intent of what this legislation is trying to achieve; it is that in the absence of a whole proposition for end-of-life care, I feel that we have created some stark gaps in our end-of-life care options for people. On that basis, I cannot support this legislation at this time.

MS A. SANDERSON *(Morley — Parliamentary Secretary)* [8.28 pm]: I want to make a brief contribution to the third reading debate on the Voluntary Assisted Dying Bill 2019. I thank those members in the chamber who have contributed thoughtfully and meaningfully to the debate. It has been an extensive debate, as is right and should happen with this kind of legislation, with nearly 70 hours of consideration up to earlier today—longer with this evening’s speeches. I want to thank the member for Girrawheen for her contributions, which are motivated by a genuine desire to see improvements in palliative care and supporting people at end of life. Although we may not agree on what that looks like, broad opinions in this place are an important part of the process. I thank her for her diligence and thoroughness in this matter.

By and large, the debate has been respectful and courteous, and I sincerely thank those who have shared their own stories and those of their constituents. I have been struck by the tenor of the debate from some members that emerged during the consideration in detail stage—that is, a deep distrust in our medical community and health sector and that many doctors are not to be trusted. I find this quite extraordinary, particularly from members opposite, who probably represent more doctors than do any of us in this place. Claims that there are broad community concerns about so-called doctors’ loops never once emerged in the two years of consultation that preceded this bill—not in the joint select committee process or in the biggest consultation ever undertaken by the health department and the Ministerial Expert Panel on Voluntary Assisted Dying. I find the fixation on the independence of doctors an interesting reflection of those members’ views of the profession. It is common practice for doctors to review each other’s opinions. It will be no different in the case of voluntary assisted dying. In fact, I would expect more caution, not less, from doctors.
Although we heard some very sensible inquiry into the bill, we also heard, quite frankly, the most outlandish and hypothetical scenarios. Our job as legislators is not to legislate for crazy hypotheticals, but to look at the evidence with a level head and to ask ourselves whether what is happening now is safe and acceptable. The answer to both those questions is no; it is not safe and it is not acceptable. I remind members that there are no safeguards now, as pointed out very articulately by the member for South Perth. There are no safeguards when a physician can decide to sedate someone into a coma. No consent from the family is required; it is entirely up to the physician to do that. There are no safeguards when discussing with a patient the options to withdraw hydration and nutrition to essentially slowly starve themselves to death. There does not seem to be overwhelming concern about any subtle or overt coercion or about the lack of current safeguards. That is where I come from as a legislator: is it safe now and is the current situation acceptable? The answer to both those questions is very clearly no. Based on the evidence, no, it is not.

This bill will make the end of life safer for patients and for practitioners. As the Leader of the Opposition pointed out during the debate, people regularly have schedule 4 and schedule 8 drugs in their house. We heard about fentanyl lollipops and oxycodone. Not everybody has a safe to keep them in, and there is no requirement to keep them in a safe. Morphine, oxycodone and fentanyl—heavy sedatives that will kill people—can be found in the home of any palliative care patient who is receiving home care, and there is no requirement to necessarily return them. It was entirely up to the Leader of the Opposition to do that once her husband had passed away. There are no safeguards. With this system, there will be clear and current monitoring of those very dangerous substances, whereas currently there is not.

Terms such as “euthanasia enthusiast” do nothing to contribute meaningfully to the debate. Similarly, I find deeply objectionable the assertion that autopsies should be performed on people who access voluntary assisted dying. We are talking about terminally ill people who have probably had multiple surgeries and years of invasive treatment and are a shadow of their former self and about subjecting their families to an autopsy. The depiction of the bill as capital punishment is also quite beyond my comprehension. We heard over and over the concerns about coercion. The data from jurisdictions that have voluntary assisted dying does not justify these heightened concerns. In fact, it demonstrates that we can legislate for a scheme that provides this option and protects people from abuse. The profile of the majority of people who access VAD is clear: they are white, they are educated, they have access to palliative care, they are over 65 years of age and they are terminally ill.

I completely reject the assertion that this bill is not safe or needs tightening. This will be the most restrictive regime in the world. This has been the well-worn strategy of “not this bill”. Because community sentiment is so supportive, it is not palatable for members to say that they do not support it. I give credit to those members who are honest about their decision not to support it. Instead, there has been an attempt to make it so restrictive as to be unworkable and to unpick the two years of consultation and legal and clinical guidance that has shaped this bill. I completely reject the idea of the government dictating what a doctor can and cannot talk about with the legal options that are available at the end of life. This was also roundly rejected by the public and the health sector during the consultation process. To quote one doctor, if there is a sacred cow in medical ethics, it is the sanctity of the doctor–patient relationship. Other than Victoria, no jurisdiction in the world has this unusual interference, and I do not believe it has any place in Western Australia.

I and my fellow committee members heard hundreds of harrowing, horrific stories of people experiencing bad deaths in palliative care. The evidence was laid bare by the palliative care sector itself that between two and five per cent of people will suffer significantly at the end of life. To put that into context, in Western Australia, that is 300 to 700 people each year. I think they are worth legislating for. This is not to say that many people will access voluntary assisted dying. Should the Parliament pass this bill, we know that will not be the case. But these people will have a choice, and that choice itself will be therapeutic and an enormous comfort.

Many people have been instrumental in the development of this bill and I have genuinely enjoyed working with members across the aisle on this issue. It is a rare opportunity in our divided political system to work with other members, and the significance of that has not been lost on me. I hope this bipartisan approach can continue in the other place. The Minister for Health wins the award for most patient and courteous in his handling of this bill, at times under very trying circumstances, and, of course, there were his outstanding advisers. One of the great benefits of being in government is working with incredibly talented people in the public sector, and on this issue there was no shortage. Like the member for Dawesville, I, too, say that it has been a real honour to work with former Governor Malcolm McCusker, QC. Again, I thank the Premier for his leadership on this issue. It has been considered, principled and unwavering. People tell me it has given them hope to believe that politics is not an entirely self-serving pursuit.

This has been an exhaustive process involving the community, health professionals and the legal community. It is a sensible and compassionate response to the way we are dying now. The way we are dying is changing. We are taking longer to die, with terrible suffering. For neurodegenerative diseases such as Huntington’s disease, supranuclear palsy and motor neurone disease, from which people can choke, cough and suffocate to death, there is a better and more humane option. This bill provides that option. This is our opportunity to provide a humane choice.
MRS A.K. HAYDEN (Darling Range) [8.37 pm]: After listening to two weeks of speeches during debate on this legislation, my third reading contribution will be a summary of what I have observed and heard during the debate. Along with many members, I have said during the debate that this bill is one of the most important and challenging pieces of legislation that we may ever debate. At the outset, a respectful debate was to occur, in which every member was allowed the right to voice their opinion and ask as many questions as required in order to comprehend the bill’s significance and purpose. I sat through the majority of the speeches and listened politely, even when I did not agree with the comments being made, as I believed, and still do, that this debate required and deserved this courtesy. Sadly, I cannot say that all members or ministers showed the same courtesy. To say that I was disappointed in the behaviour of this government during debate on a bill of this importance is an understatement.

Many members raised their concerns during the second reading debate and the minister indicated that he would answer them during the consideration in detail stage. However, many of my concerns were either glossed over or left unanswered. I do not believe the concern about palliative care raised by numerous members during the debate has been addressed. As highlighted throughout the debate, palliative care is poorly understood and is unavailable to many within the community. The limited supply of service is the key issue. It is due to either the community’s remoteness or the lack of resources required to accommodate the numbers in need. Sixty per cent of Western Australians who could benefit from palliative care are either unaware of the service or unable to access the service. As I have mentioned previously, sadly, WA has the lowest number of publicly funded beds per capita in the nation, with only 15 full-time palliative care specialists. As the minister outlined in his second reading speech, and I quote from Hansard of Tuesday, 7 August 2019 —

Work is underway to improve the quality of advance health directives, and to strengthen and resource palliative care services.

He went on to say that members will not be considering voluntary assisted dying instead of palliative care—he is referring to this bill, of course. It continues —

We are considering the compassion we should show those people for whom palliative care does not relieve their suffering … I might also advise members that detailed planning is underway to implement the Department of Health 10-year “WA End-of-Life and Palliative Care Strategy 2018–2028” …

It continues —

In those jurisdictions with voluntary assisted dying, they are accessing palliative care at increasing rates. Palliative Care Australia has reported that if anything, in jurisdictions where assisted dying is available, the palliative care sector has further advanced.

Minister, I am still struggling to understand how we can be willing to legislate for euthanasia before attempting to improve awareness of and access to palliative care services for all Western Australians first. It deeply concerns me that the minister’s comments in the second reading speech outlined that in jurisdictions where assisted dying is available, there was an increase in people accessing palliative care services. Why do people need to seek out euthanasia before being able to access palliative care? To me, this debate has only further highlighted the need for this government to invest in and improve palliative care across our state.

I also do not believe that the concerns I raised around elder abuse received an adequate response. With the government admitting the need to develop policy to combat this tragic yet emerging issue, we are again seeing the implementation of assisted dying before we are seeing any policy around protecting one of the most vulnerable groups that could be coerced into ending their life early for the benefit of others. With 75 000 older people already at risk of elder abuse in Western Australia, I again, on my conscience, cannot support this bill. There is no safeguard when the time comes to act on the passed legislation, those responsible for the structure, training and delivery of this bill will have no doubt about the intention of the government and Parliament. I do not believe that the government has achieved that over the past two weeks. The only intention that was made very clear by this government was
that regardless of the contribution and regardless of the merit, no amendments would be considered, let alone accepted. We have a government that either believes it is far superior to any other mind within this chamber or simply shows no regard for the role of this Parliament.

Sadly, the Premier continued this behaviour right through to the third reading this afternoon, with his inappropriate and unnecessary comments, implying that anyone who opposes this bill is not thinking independently and alluding to them being bullied. I can assure the Premier and everyone else in this chamber that no-one is bullying me and none of my colleagues has been bullied. The insinuation that I cannot think for myself and that others are telling me what to say and how to vote is totally unacceptable for a Premier in 2019 and I find it absolutely appalling. Sitting until 5.30 am was completely unnecessary. It was a burden on the staff within Parliament, the staff of the minister and every member of Parliament. It was not needed or required, especially when the government’s plan was to pass the legislation this week and to have it ready for the upper house to debate it in October. We are on track with that, yet there seemed to be some need for political points scoring by sitting until 5.30 am, which benefited nobody.

The Premier started this debate by saying that all members would be granted a conscience vote and that all members and their positions would be respected, yet the Premier has not been able to control himself and has shown his true character with comments like the one I just explained and his overall attitude to any questions asked during consideration in detail. I wish to congratulate all the members who spoke in his place, no matter what their position. They showed courage and strength. It is a lot easier to be sheep and follow. It takes conviction and belief in yourself to stand up about what matters to you and what is important. I respect the positions of all members. What I do not respect is bad behaviour.

In closing, for the reasons I outlined during my contributions during the second reading and consideration in detail stages and in this speech, topped off by the government’s lack of flexibility and willingness to improve the legislation, or even contemplate any other opinion or assistance, I oppose the Voluntary Assisted Dying Bill 2019. I will close on a quote attributed to Tolstoy that I believe sums up this debate: wrong does not cease to be wrong because the majority share in it.

MR S.K. L’ESTRANGE (Churchlands) [8.45 pm]: In my speech at the second reading stage, I reflected on the consultation that had taken place. I listened to constituents and read their letters and emails. I attended information briefings. I met with medical practitioners and sat down with palliative care experts to hear their views. Like many others in this chamber, I reflected on my own lived experiences in dealing with life, death and suffering by family members in particular. As I said in my speech at the second reading stage, I remain empathetic to what motivates fellow Western Australians to want the option of voluntary euthanasia. As I said in my speech at the second reading stage, it is the horrific cases and the small percentage of people who will face incredible pain, suffering and humiliation for themselves and their families in the final stages of life when dying from a degenerative terminal illness that motivate the yes vote for voluntary euthanasia. I, too, am empathetic to the need to help people who face this traumatic end to their lives.

I also referred to a Roy Morgan poll on assisted dying/euthanasia that was taken in November 2017, which found that 87 per cent of Australians are in favour of letting patients die when they are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the vast majority of people who have communicated their support for voluntary euthanasia to me were seeking legislation that focused on offering voluntary euthanasia for those who were hopelessly ill and experiencing unrelievable suffering with no chance of recovery. Had this legislation been focused on this aspect of eligibility, it would have enabled carers to distinguish voluntary euthanasia for those who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the vast majority of people who have communicated their support for voluntary euthanasia to me were seeking legislation that focused on offering voluntary euthanasia for those who were hopelessly ill and experiencing unrelievable suffering with no chance of recovery. Had this legislation been focused on this aspect of eligibility, it would have enabled carers to distinguish voluntary euthanasia for those who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the vast majority of people who have communicated their support for voluntary euthanasia to me were seeking legislation that focused on offering voluntary euthanasia for those who were hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the vast majority of people who have communicated their support for voluntary euthanasia to me were seeking legislation that focused on offering voluntary euthanasia for those who were hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the vast majority of people who have communicated their support for voluntary euthanasia to me were seeking legislation that focused on offering voluntary euthanasia for those who were hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the vast majority of people who have communicated their support for voluntary euthanasia to me were seeking legislation that focused on offering voluntary euthanasia for those who were hopelessly ill and experiencing unrelievable suffering with no chance of recovery.

I also referred to a Roy Morgan poll on assisted dying/euthanasia that was taken in November 2017, which found that 87 per cent of Australians are in favour of letting patients die when they are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the vast majority of people who have communicated their support for voluntary euthanasia to me were seeking legislation that focused on offering voluntary euthanasia for those who were hopelessly ill and experiencing unrelievable suffering with no chance of recovery. Had this legislation been focused on this aspect of eligibility, it would have enabled carers to distinguish voluntary euthanasia for those who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. I believe that the majority share in it.
ensure information consistency, so that the patient would be provided with all the information provided to the Voluntary Assisted Dying Board. Another amendment proposed by the member was to require that a patient would receive information provided to the board by the consulting practitioner, particularly if they are deemed ineligible. The member for Darling Range proposed an amendment to avoid doctor shopping by limiting assessment to no more than three times. Then the member for Girrawheen proposed an amendment to section 42 to add further constraints on who can witness documents, in line with Victorian legislation, so as to reduce the undue influence of healthcare proprietors. She proposed an amendment to clause 57 to ensure that the board safeguards come into effect before a patient has died—that is, a real-time monitor—and referred to proposed new clause 117A in cases that the board gives a notice of no objection. The member proposed a new clause at 86A giving a right of appeal to the tribunal in the case that the board is not issuing a notice of no objection under clause 117A. At clause 87, she proposed an amendment to shut a loophole of residential status in Western Australia. She proposed new clause 102A to restrict medical practitioners from advertising VAD services in line with lawyers not being allowed to advertise for personal liability claims. She also proposed new clause 117A to give the board a monitoring function in real time, not after the patient has died, by requiring a notice of no objection application from the practitioner. The final proposed amendment was to clause 149, adding a penalty for a contact person who does not comply with board requests.

Those are some examples. These were not radical; they were simply efforts to improve the bill and the safeguards. Whilst all of these amendments were voted against, there was also debate on clauses without amendments that were put to a vote. Many of the genuine issues of concern raised by both sides of the chamber were ignored. This approach disrespected those in our community who want the choice but also want a bill that will offer them the necessary protections. Some of the negatived clauses included things like acknowledging and accepting the definition of suicide in the bill, protecting doctors who refuse to participate and offering better protections for those doctors, and tightening the eligibility criteria. Finally, the notion that there be no reference to voluntary assisted dying on the death certificate did not make sense to many in this place. It is akin to doctoring the actual death certificate itself. These are just some of the main examples.

The government paid little attention to a key concern I have about palliative care. What impact will the introductory of voluntary euthanasia have on the sick at a time when we are yet to build up the most effective palliative care regime? That related to clause 4, titled “Principles”, under which an amendment was moved by the member for Girrawheen, I believe, to insert a palliative care definition under clause 5. That was taken out. Whilst it existed as a key principle in the bill that the patient must be informed of palliative care services, there was no effort to define in the bill what that service actually provides.

In the report of the Joint Select Committee on End of Life Choices titled “My Life, My Choice”, the committee made several findings on palliative care, as follows —

**Finding 16**
Access to hands-on specialist palliative care is limited for metropolitan and non-metropolitan patients.

**Finding 17**
Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population.

**Finding 18**
There is a gap in care for people who are seriously unwell but not close enough to death to be admitted for inpatient hospice care.

**Finding 19**
There is limited access to palliative care medical specialists in regional Western Australia.

**Finding 20**
There is limited medical oversight, coordination or governance of medical palliative care services across WA Country Health Services.

They were real concerns about palliative care, yet when we asked for palliative care to be defined and put in the bill so that at least those reading the legislation would understand what they should be looking at, the minister refused to do so. The fact that the government is ignoring a principle of the bill makes me wonder whether a serious approach to palliative care as a treatment has been properly considered.

Another key concern related to the risk of coercion. Several members raised this concern. I feel that coercion can be both subtle and overt. Because of this bill, and particularly if a patient is made to feel like a burden, it is an issue. The presence of undue influence can be difficult to identify and can be easily missed. That was a finding by the minority report of the parliamentary inquiry, “The safe approach to End of Life Choices: License to Care not Licence to Kill.” These concerns about coercion were explored by a number of members in this place. In particular, in clause 54, we asked how coercion could be assessed, and we were not given a clear understanding of that.
The issue of subtle and/or unintentional coercion was also explored in debate, particularly in the proposed new clause that was put forward by the member for Armadale. The member for Armadale was very concerned. He gave a very personal example of his daughter, and he worried that the legislation allowed doctors to suggest voluntary assisted dying to a patient rather than ensuring that only the patient may raise the idea. The member for Armadale’s amendment was that a registered health practitioner was not to initiate a discussion about voluntary assisted dying. I use the amendment proposed by the member for Armadale as an example of what could be unintentional coercion. Although the doctor might be presenting all options to the patient in good faith, if the patient has a certain style of thinking, they might not have been considering voluntary euthanasia as an option, but they might think: the doctor has presented it to me, I now need to think about this as a serious option; otherwise, why would the doctor have mentioned it to me? I do not think we provided enough safeguards around that concern.

There was also considerable debate on, and practical solutions offered for, the clauses that dealt with self-administration, yet all suggestions were ignored by the minister and the government. If the minister was in the chair, he ignored them; anybody in the chair representing the minister ignored those recommendations and suggestions. I focused a fair bit on one issue relating to clauses 57 and 64 around self-administration, where the patient was to appoint a contact person, and the role of that contact person. I made the point that the contact person has a very serious role to play in self-administration. They are responsible for receiving, possessing, supplying and disposing of the prescribed substance, as it is called in the bill, which, of course, is the poison that would enable euthanasia to take place. But the only eligibility criteria offered for that contact person was that they needed to be 18 years of age. The minister was asked whether there would be any merit in having, at the very least, some restrictions placed on who could be selected to be that contact person—for example, limiting people who might have a criminal history, possibly even relating to poisons, or other criminal history that suggests they are not a decent citizen or somebody capable of fulfilling these duties properly—whether they should be excluded, and would the minister think of introducing some safeguards in the act in this regard, creating some restrictions around the eligibility criteria of the contact person, who has such an important role in the self-administered process. The minister simply answered, “That is not necessary”, without allowing the Parliament to explore options, methods and ways that doctors might actually be able to care for the patient to make sure that if the contact person is that patient’s loved one, they can still be intimately involved in the process, but they are not the contact person for the purposes of, as I said earlier, receiving, possessing, supplying and disposing of the substance. As I said, those types of recommendations or suggestions to the government were not done to slow up its bill, or to inhibit the bill from progressing, but to introduce some safeguards; however, they were ignored.

I also wanted this legislation to care for those in need. I thought we had to think very carefully about the impact the option of voluntary euthanasia would have on the mental health and decision-making ability of the depressed, the demoralised, the isolated, the lonely and the mentally ill. In my second reading contribution I posed the question: will voluntary euthanasia devalue life in the eyes of those who are demoralised when confronting a chronic or terminal illness? Those are very real concerns because, first and foremost, we must make sure that if a person is demoralised, they are cared for and receive the appropriate counselling support services as part of a suite of palliative care offerings to make sure their state of mental health is focused and in the right space so they can make clear decisions. They might not be depressed, but they might be demoralised. If one of those decisions down the track is to access voluntary assisted dying—voluntary euthanasia—so be it. At the very least, it would make sense that those people who are demoralised are offered the right palliative care options to get their head in the right space to be able to deal with that decision properly. I am very concerned about that. Again, that was an aspect of this bill that was brushed over. We often heard the government minister, or whoever was representing the government in the chair during consideration in detail, almost say that the fact that we were putting that forward as a key concern of constituents who had brought that to us was ridiculous and disrespectful to all the people who wanted voluntary assisted dying, rather than listening to us and considering that if that is a genuine concern of members of the community, how can the government better cater for that concern when drafting the bill to build it in. It could then open up the discussion on the floor of the chamber to put in measures for aspects of mental health in palliative care so that it is addressed and focused and in all good conscience, the government could say that it is offering voluntary assisted dying as an option, but is making sure that before a person goes down this path, they have had every possible mental and physical health care option provided to them so that when they are making a decision, they are making it with a clear and focused mind. I do not believe that any approach like that was taken in good faith in this chamber during consideration in detail. I think that is a shame, because so much more could have been achieved had the government done so.

To conclude, I do not think this euthanasia legislation will achieve what I said it should in my second reading contribution. I was of the view that, if as a society, we were going to go down the path of voluntary assisted dying or voluntary euthanasia, as I stated in my second reading contribution—

... it should be tightly controlled through the prism of supporting those who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery ... because to cross this euthanasia threshold early brings with it inherent risks, as evidenced in countries around the world which have decided to move in this direction.

Extracted from finalised Hansard
Having sat through the consideration in detail stage and having witnessed the government’s failure to consider any sensible safeguards put forward by both Labor and Liberal members of Parliament in this chamber, I am of the view that this legislation is not safe and has let down those in our community who are in favour of having euthanasia as a choice. It is for that reason that I will not be supporting this bill.

MR P.A. KATSAMANIS (Hillarys) [9.03 pm]: I would like to make a contribution to the third reading debate. In my second reading contribution, I outlined that I had a personal concern that the legislation that we are considering crosses the threshold beyond which I did not believe there existed appropriate legislative authority of the Parliament—that is, legislating a procedure for the taking of a person’s life. I do not want to traverse that area in my third reading contribution.

In my second reading contribution I also highlighted some of the concerns I had about the specific legislation that was put before our house. During the consideration in detail stage, I deliberately tried to focus solely on my duty as a legislator to examine the legislation before the house—firstly, to understand how it will operate in practice, clause by clause if necessary, and, secondly, to identify any gaps or concerns in the legislation so that they can be fixed and the legislation that passes is the safest and most appropriate legislation possible. I think it is critically important that we as a Parliament did that on this piece of legislation, because it addresses an issue of a legislative framework for the ending of a person’s life. You cannot get much more serious subject matter than that. I think that, in the main, Parliament rose to the occasion. I thought the scrutiny of the legislation in consideration in detail was excellent and the scrutiny came from not only people who are opposed to the principle of the legislation, but also people who either expressed support for the principle contained in the legislation or have expressed support for the legislation presented. I thought that was the great value in this process. Often during consideration in detail the minister and the shadow minister ask questions, and the rest of the Parliament pays almost no regard to what is going on. For this extraordinary piece of legislation before us, we saw a greater number of members of Parliament taking an active interest in the consideration. I think that was a good thing and showed how well a Parliament can operate. It affirmed my belief in the primacy of the Parliament as the greatest decision-making body in any democracy.

During the consideration in detail debate, there was some angst and some elevated tempers. I understand that. I know some nights we were forced to stay here for a long time. I do not think that was wise. I have been in three different parliamentary chambers in two states and I know that we like to do that to ourselves on far too many occasions. I want to put on the record that, as legislators, our profession as members of Parliament is in a bit of an existential crisis. If we want to attract the brightest and the best to this chamber, we should pay attention to the sort of ridiculous things we put ourselves through sometimes, including sittings that start at nine in the morning and go to 5.21 the morning after. That is the concern I have about those long sittings, as well as the health and welfare of members and staff, and, in particular, the ministerial staff who were at the table for long periods of time. I think we do our profession a disservice, because we paint ourselves as outliers and outsiders when we are not. No human being in the rest of the world is expected to work for 20-plus hours with nothing more than bathroom and meal breaks. As I said, we do that to ourselves all too often on both sides of the house and in all sorts of parliamentary chambers. But I digress from the subject matter of this third reading contribution.

During the consideration in detail stage, some of the concerns I outlined about the specific legislation before us in my second reading contribution were amplified and magnified. I have to express my disappointment that as some of those concerns were highlighted by members of the house—not only by members who are opposed to this legislation, but also by members who voted for it in the second reading and will vote for it in the third reading—the position of the government was reflexively: no thanks. I think that was a disappointment. We will see what happens when the bill gets to the other place and we will see whether the legislation returns to this place at some time in the future and in what form it returns. I think we missed a really good opportunity as legislators—not as people in favour of or against this legislation, but to provide the best possible legislation as it is leaving this chamber to go to the other chamber. Some of the issues that came to the fore—I am not going to highlight all of them because they have been highlighted by other members—ought to have been fixed and it would have made for better legislation.

Other members have highlighted the concern about the genuine lack of independence of the two medical professionals, a coordinating practitioner and a consulting practitioner, required to sign off on the voluntary assisted dying process. Members highlighted the concerns about the possibility of financial interdependence, co-location and other factors that reduce the level of independence of those two doctors. Those issues were not addressed. The issue of some form of specialisation of a medical practitioner who diagnoses the terminal illness that triggers the process contained in this legislation also was not addressed. Any medical practitioner can offer a diagnosis. They do not have to have any specialisation or experience in that field. They also do not have to have any ongoing experience of dealing with the patient. I think that is a severe weakness of this legislation.

The issue around mental capacity of someone to make a valid decision under this legislation was also not addressed. We know that the Chief Psychiatrist and others made submissions on this issue to the Joint Select Committee on End of Life Choices. We know that the short-lived Northern Territory legislation some years ago required...
an assessment of capacity by a psychiatrist. That is lacking in this bill. I think when we marry up that lack of expertise in making an assessment about mental capacity with a possibility that a medical practitioner making that assessment may also not have any previous knowledge of the patient’s medical history, that is a significant danger sign and it could have been addressed, but it was not addressed.

There were concerns about coercion of vulnerable people more generally outside whether they just plainly have the mental capacity to make a decision. Members raised serious concerns about the more coercive nature of undue influence or duress and the pernicious nature of coercion and how that is addressed. A solution to part of that concern was offered in very good faith by the member for Armadale—a man who supported the legislation on the second reading and who provided this chamber with an amazing speech, based on his own personal family experience, about why the bill needs specific protections for vulnerable people who may be prone to suggestion or coercion. He provided an elegant solution for that. As I said at the time, it was one of the most moving contributions that I have heard in this place. When I made those comments, I was not to know that it would be so moving as to convince certain people who supported the second reading, who I assumed would support the third reading and otherwise ignore the rest of the amendments that were put, to move across with him and vote in favour of that amendment. I commend him for his work and his contribution. I encourage the other place to consider seriously the amendment moved by the member for Armadale, because it would improve this legislation. The amendment was based on what is already contained in the legislation in Victoria, so it was not radical or very different from accepted practice.

Many parties expressed concern about the jurisdictional issue of the use of audiovisual means. We know that telehealth is really important here in Western Australia, particularly in regional and remote areas that, unfortunately, do not have easy access to medical practitioners. We still do not have an answer on that. We know it is a live question in Victoria and the Minister for Health has had to instruct medical professionals not to use telehealth services or audiovisual means until this matter is addressed. Really, the whole issue was batted away, rather than dealt with. I know that there is correspondence from the Attorney General to the federal Attorney-General but no indication of what that answer may be and no indication of what needs to be done to ensure that the legislation is safe from the jurisdictional question that remains.

The issue of palliative care has been well traversed. I think it is a genuine concern. Good palliative care ought to be available to Western Australians irrespective of whether this legislation is in place. It should not be an either/or. We should strive to provide good palliative care as a First World state that wants to pride itself on having a first-class medical system. Unfortunately, as has been highlighted during the debate, we are nowhere near that here in this state, and very little has been done to improve it. I know some has been done. I commend the government for putting more funds towards it, but we are still a long, long way away from being in a position to say that we offer good palliative care and it is a genuine option for all people in this state who need it. In my contribution to the second reading debate, I offered my personal experience of palliative care and I not only said how good it can be for relieving pain and extending quality and length of life, but also highlighted how expensive it, unfortunately, can be. It is beyond the realms of a lot of people in this state unless it is provided by our public health system. It is not an issue in only regional and remote areas, as many members have pointed out, including me; it is also an issue in the suburbs.

The further away we get from our tertiary hospitals located close to the CBD in Perth, the more concerning the lack of availability of palliative care becomes. It is a genuine fear that in the absence of good-quality and readily available palliative care, any options that hasten the end of life may, unfortunately, become the most readily available form of pain relief for people. If that happens, that would be a shame, and it would be a horrific outcome for, as I said, a state that prides itself on having first-class health care, because it would highlight a failure in our health care.

Those are some of the issues that I wanted to highlight that raise concerns that the legislation before us is not as safe as it could be and could be improved. I want to thank all the members who have participated in this debate. In particular, I want to thank all the members who participated in its scrutiny at the consideration in detail stage. The member for Girrawheen did a sterling job. She has been praised by others but I want to add my admiration for her —

**Ms M.M. Quirk:** This is not helping my preselection!

Several members interjected.

**Mr P.A. KATSAMBANIS:** Yes; that is a concern. Just hearing that interjection from the member for Girrawheen is a concern; it is not about one particular political party or another, but about the political process whereby members are elected to this place and asked to exercise their vote according to their conscience.

**Mr R.R. Whitty:** It was made in jest.

**Mr P.A. KATSAMBANIS:** It is a concern if anyone has any fear that the exercise of someone’s conscience in a vote as important as this one is held against them. I hope that is not the case. I hope that interjection was made more in jest; I really do.

*Extracted from finalised Hansard*
As I said, in my second reading contribution, I made my position on the principles contained in this legislation crystal clear. But as a legislator, I think I owe it to my constituents and the public of Western Australia to scrutinise what this legislation purports to do and to make sure that it does it without unintended consequences. Unfortunately, it is on those grounds that this legislation has failed the consideration in detail stage. I said in my contribution to the second reading debate that if this legislation becomes law, I hope it provides the relief that those people who access it want it to provide without any unintended consequences. Unfortunately, from the process that we went through, everything that came out indicates to me that that concern has not been alleviated. In fact, as well intentioned as this legislation may be, it leaves vulnerable people open to exploitation and being forced and coerced into making choices that they would not have made without that force or coercion. Thank you.

MR R.H. COOK (Kwinana — Minister for Health) [9.20 pm] — in reply: Thank you very much for the opportunity to close off this very important and, as a number of members have observed, very historic debate. My second reading speech and my response to the second reading debate was very technical, so I want to take the opportunity in my brief speech tonight to acknowledge my aunt Ethel Mary, who left us and was laid to rest during the period of this debate. She was able to access palliative care services at Bethesda Hospital. God bless her soul. Although there has been some commentary about how often I have been in the chamber, it was decided by the family that I should be in the chamber for the debate rather than go to her funeral. I want to acknowledge her and to give my apologies for not being able to send her off properly.

From the outset, can I also commend all members of this place for their careful and thoughtful consideration of the Voluntary Assisted Dying Bill 2019. I think we have done credit to ourselves. I remember receiving counsel from the Minister for Health in Victoria who ushered a similar bill through that Parliament. She made observations about how difficult and quite aggressive the debate was. I think we have done a great job in making sure that we have communicated our views passionately, but with a level of respect, decorum and good faith in the way people have conducted themselves. Members have shared deeply personal stories about their families and constituents. We have not all agreed on every issue, but opposing views have been expressed in good faith and, as a whole, with great respect. I join other members in acknowledging the member for Girrawheen who did more work than all those who rigorously cross-examined this bill. I commend her for the research and effort that she put into scrutinising this bill.

I want to acknowledge the difficult stories that people brought to this place. There were some pretty tough stories and I know that a lot of people left, as they say in sporting parlance, a lot out on the field in relation to this bill. It is a difficult debate and from that perspective it was really important to have those stories brought in here because it laid bare just how personal and important this debate is.

The community has been clear that there is a need to go beyond palliative care services to provide Western Australians with the genuine choices they require to experience both a fulfilling life and respectful death without unnecessary suffering. As a number of members have observed, 88 per cent of Western Australians are in favour of voluntary assisted dying. Many have expressed their support for this bill and are watching us carefully to make sure that we do as they wish. Only a small number of people will be eligible to access voluntary assisted dying at the end of their life. As I indicated in my second reading speech, Western Australians should be supported in making informed decisions about their medical treatment and they should be able to choose to spend their last days surrounded by loved ones, coherent and without pain and ideally at home. This is the rational choice. The need for this was clearly identified by the Joint Select Committee on End of Life Choices during its extensive inquiry. In its report “My Life, My Choice”, the committee recommended that the Western Australian government draft and introduce a bill for voluntary assisted dying. The Parliament has been on a journey as many people have observed, but we should not forget that the whole community has been on this journey as well, many for a longer time than members of Parliament in this chamber.

The development of this bill occurred through three consultative means. Firstly, recommendations were made by the Joint Select Committee on End of Life Choices. The committee was established by the Western Australian Parliament in 2017 and the committee undertook an inquiry into the need for laws in Western Australia to allow citizens to make informed decisions regarding their end-of-life choices. Significant public consultation was undertaken by the committee in the development of its report. Over 700 submissions were received from individuals, peak bodies and organisations, as well as the Department of Health. Secondly, recommendations were made by the Ministerial Expert Panel on Voluntary Assisted Dying in its final report, which was tabled in June 2019. In March this year, the panel commenced public consultation on a number of voluntary assisted dying—related issues through the release of a discussion paper, public forums and key stakeholder roundtable meetings. This involved more than 1 400 interactions with community experts. Finally, consultation was conducted by the Department of Health on policy, procedural and justice-related matters that were generally outside the scope of issues being considered by the panel. These matters were discussed in detail with agency stakeholders within some of the panel-led roundtables and by other consultative matters. The Department of Health led a comprehensive and careful process to ensure that we have benefited from the best advice for the bill.

Extracted from finalised Hansard
I acknowledge the members of the joint select committee for their considerable efforts and recognise the extensive work undertaken by the committee. Its report paved the way for this landmark piece of legislation. In particular, I would like to acknowledge the outstanding efforts of the member for Morley, chairperson of the joint select committee, and the deputy chair, Hon Colin Holt, MLC, for their dedication and leadership. I would also like to thank the ministerial expert panel for its hard work and dedication. Its members listened to wideranging community views on this important and significant issue and reviewed a broad range of research both from Australia and overseas. The panel’s final report was a vital component in drafting the compassionate and safe legislation that has been put before members in Parliament. I would specifically like to recognise the remarkable work of Malcolm McCusker, AC, QC, as chairperson of the panel and for his continued advice to support the parliamentary debate. I think everyone would agree that his service to the public has been outstanding on this issue and I am sure I join all of you in thanking him for his work.

Members: Hear, hear!

Mr R.H. COOK: The bill was introduced on 6 August and I note that there are variations to the theme of how long the bill has taken to pass, but it has had between 67 and 70 hours of debate, including 46 hours to consider and debate the 184 clauses contained in the bill. It has properly undergone extensive scrutiny and is now ready for consideration by the house of review. I would like to acknowledge the tireless effort of my advisers, including Ms Daphne Fernandes, Ms Amanda Bolleter, Ms Lisa Furness, Ms Carol Conley and Ms Marion Huntly. I would particularly like to thank the hardworking staff at Parliament including the clerks and the chamber staff, catering, security, Hansard and building management who have kept the house running as we considered the legislation during the debate.

Much has been said in this place about palliative care. Palliative care should be a genuine choice for Western Australians. The McGowan government is committed to improving and strengthening palliative care so that people across the state have access to high-quality care at end of life. As an indication of our commitment, we have pledged an additional $41 million for palliative and end-of-life care in the 2019–20 budget across the forward estimates. The bill includes clear reference to palliative care. Both the coordinating doctor and the consulting doctor must—inform the person of all treatment options including palliative care treatment options. Any health practitioner involved in voluntary assisted dying must have regard to the principles enshrined in the bill.

Clause 4(1)(d) enshrines the principle that a person approaching end of life should be provided with high-quality care and treatment including palliative care and treatment to minimise the person’s suffering and maximise the person’s quality of life. This bill is for the small group of people for whom palliative care is ineffective.

It is also important to note that in the context of this debate, members are not considering voluntary assisted dying instead of palliative care; they are considering the compassion we should show those people for whom palliative care does not relieve their suffering. As I noted in my second reading speech, the government recognises the importance of all end-of-life care. The bill does not create a lower standard of care for people who are coming to the end of their lives. We are not replacing palliative care; we are providing another option for those who are dying.

There has been much commentary about the amendments that were put forward in the consideration in detail stage of the bill and some of that debate has been characterised as a failure of democracy in this chamber. It is simply a fact that the government believes that this is very good legislation, and we respectfully disagreed with the amendments that were put forward in this chamber. That is not to criticise the intent of those who moved those amendments. I think we all respect and recognise the passion that those members felt in moving them. But, as I said, we respectfully declined the opportunity to adopt those amendments. We believe that this is very good legislation; we believe it is very safe legislation.

Voluntary assisted dying is a significant issue for Western Australia. I thank every member of the Legislative Assembly for sharing their personal experiences with the chamber and for their valuable contributions to this crucial debate. Many people across the community who have had their parents or loved ones pass away in agony want something done, and that is what this is about. This legislation will bring relief for those who are suffering at end of life.

This is an important occasion. We are one step closer to providing safe and compassionate legislation to end the most severe suffering of those Western Australians who are currently dying without genuine choices. The bill is safe. The bill is compassionate. It is voluntary at all stages. It is a choice at the end of life—a choice only for those who decide they no longer wish to endure their unbearable suffering. Who are we to deny the option of such relief to those who we know experience such suffering? It is a choice we offer, respecting the views of the community and respecting the rights of everyone. It is the essence of compassion.

I am confident that this bill will now receive the endorsement of the Legislative Assembly and move to the other place. I know all members of the Legislative Council will undertake their review of the bill respectfully and in good faith. After all, that is nothing less than the community expects from us.

I commend the bill to the house.

Members: Hear, hear!

Extracted from finalised Hansard
Division

Question put and a division taken with the following result —

Ayes (45)

Ms L.L. Baker  Mr M. Hughes  Mr Y. Mubarakai  Ms J.J. Shaw
Mr I.C. Blayney  Mr D.J. Kelly  Mr M.P. Murray  Mrs J.M.C. Stojkovski
Dr A.D. Bati  Mr Z.R.F. Kirkup  Mr K. O’Donnell  Mr C.J. Tallentire
Mr J.N. Carey  Mr F.M. Logan  Mrs L.M. O’Malley  Mr D.A. Templeman
Mr V.A. Catania  Mr W.R. Marmion  Mr P. Papalia  Mr P.C. Tinley
Mrs R.M.J. Clarke  Mr M. McGowan  Mr S.J. Price  Mr R.R. Whilty
Mr R.H. Cook  Mr J.E. McGrath  Mr D.T. Punch  Ms S.E. Winton
Ms M.J. Davies  Ms S.P. McGurk  Mr J.R. Quigley  Mr B.S. Wyatt
Mr M.J. Folkard  Ms L. Mettam  Mr D.T. Redman  Ms A. Sanderson (Teller)
Ms J.M. Freeman  Mr D.R. Michael  Ms C.M. Rowe  
Ms E.L. Hamilton  Mr K.J.J. Michel  Mr P.J. Rundle  
Mr T.J. Healy  Mr S.A. Millman  Ms R. Saffioti  

Noes (11)

Mrs L.M. Harvey  Mr P.A. Katsambanis  Mr R.S. Love  Ms M.M. Quirk
Dr D.J. Honey  Mr A. Krsitcevic  Dr M.D. Nahan  Mrs A.K. Hayden (Teller)
Mr W.J. Johnston  Mr S.K. L’Estrange  Mr D.C. Nalder  

Question thus passed.

Bill read a third time and transmitted to the Council.

[Applause.]
Bill returned from the Council with amendments.

**Council’s Amendments — Consideration in Detail**

No 1

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

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

No 2

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

abuse or coercion;

No 3

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

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

No 4

Clause 5, page 6, after line 10 — To insert —

palliative care and treatment means care and treatment that —

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

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

No 5

Clause 5, page 7, after line 20 — To insert —

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

No 6

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

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

(1) In this section —

health care worker means —

(a) a registered health practitioner; or

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

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

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

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

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

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

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

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

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

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

No 7
Clause 11, page 10, line 16 — To delete “commit” and substitute —

die by

No 8
Clause 16, page 13, line 19 to page 14, line 2 — To delete the lines and substitute —

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

(a) the medical practitioner —

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

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

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

and

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

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

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

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

No 9
Clause 16, page 14, line 4 — To delete “subsection (2)(a), (b) and (c)” and substitute —

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

No 10
Clause 17, page 14, after line 11 — To insert —

(aa) made during a medical consultation; and

No 11
Clause 23, page 17, after line 12 — To insert —

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

Extracted from finalised Hansard
No 12
Clause 25, page 18, after line 8 — To insert —
(5) A registered health practitioner or other person to whom the patient is referred under subsection (2) or (3) must not be —
(a) a family member of the patient; or
(b) a person who knows or believes that they —
(i) are a beneficiary under a will of the patient; or
(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services in connection with the referral.

No 13
Clause 26, page 19, line 13 — To delete “or,” and substitute — and,

No 14
Clause 28, page 20, after line 7 — To insert —
(2A) As soon as practicable after completing the first assessment report form, the coordinating practitioner must give a copy of it to the patient.

No 15
Clause 28, page 20, after line 14 — To insert —
(v) whether the patient’s first language is a language other than English;
(vi) whether the coordinating practitioner engaged an interpreter in accordance with section 160(2) to communicate the information in section 26 to the patient;

No 16
Clause 28, page 20, line 27 — To delete “referral;” and substitute — referral (including a copy of any report given by the registered health practitioner or other person to whom the patient was referred);

No 17
Clause 28, page 20, after line 27 — To insert —
(ia) if the patient was assisted by an interpreter when having the first assessment, the name, contact details and accreditation details of the interpreter;

No 18
Clause 28, page 20, after line 27 — To insert —
(ia) the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment;

No 19
Clause 34, page 23, after line 10 — To insert —
(3) For the purposes of subsection (1), the consulting practitioner must independently of the coordinating practitioner form their own opinions on the matters to be decided.

No 20
Clause 34, page 23, after line 10 — To insert —
(4) Nothing in this section prevents the consulting practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

No 21
Clause 36, page 24, after line 5 — To insert —
(5) A registered health practitioner or other person to whom the patient is referred under subsection (2) or (3) must not be —
(a) a family member of the patient; or
(b) a person who knows or believes that they —

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

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

No 22
Clause 39, page 25, after line 2 — To insert —

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

No 23
Clause 39, page 25, line 25 — To delete “referral;” and substitute — referral (including a copy of any report given by the registered health practitioner or other person to whom the patient was referred);

No 24
Clause 39, page 25, after line 25 — To insert —

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

No 25
Clause 39, page 25, after line 25 — To insert —

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

No 26
Clause 41, page 26, after line 25 — To insert —

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

No 27
Clause 41, page 27, line 7 — To delete “declaration.” and substitute — declaration; and

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

No 28
Clause 49, page 30, after line 31 — To insert —

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

No 29
Clause 50, page 31, after line 29 — To insert —

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

No 30
Clause 53, page 33, line 17 — To delete “training.” and substitute — training; and

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

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

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

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

No 31
Clause 55, page 34, line 22 — To insert after “assisted” —

Extracted from finalised Hansard
No 32
Clause 56, page 36, after line 12 — To insert —
(ea) if the patient was assisted by an interpreter when revoking the administration decision, the name, contact details and accreditation details of the interpreter;

No 33
Clause 59, page 39, after line 12 — To insert —
(fa) if the patient was assisted by an interpreter when making the administration decision, the name, contact details and accreditation details of the interpreter;

No 34
Clause 60, page 40, lines 9 and 10 — To delete the lines and substitute —
(d) the date, time and location where the prescribed substance was administered;
(da) the date and time of the patient’s death;
(db) the period of time that lapsed between the administration of the prescribed substance and the patient’s death;
(dc) details of any complications relating to the administration of the prescribed substance;

No 35
Clause 61, page 41, line 5 — To insert after “appeared to be” —
free, voluntary and

No 36
Clause 62, page 41, line 17 — To insert after “unable” —
or unwilling

No 37
Clause 65, page 44, line 3 — To delete “disposer,” and substitute —
disposer and the penalties for offences under that section);

No 38
Clause 65, page 44, after line 3 — To insert —
(ea) if the patient was assisted by an interpreter when making the appointment, the name, contact details and accreditation details of the interpreter;

No 39
Clause 65, page 44, line 11 — To delete “patient.” and substitute —
patient if —
(a) the patient directs the person to complete the contact person appointment form; and
(b) the person has reached 18 years of age.

No 40
Clause 68, page 45, after line 20 — To insert —
(1A) In this section —
Schedule 4 poison and Schedule 8 poison have the meanings given in the Medicines and Poisons Act 2014 section 3.

No 41
Clause 68, page 45, after line 24 — To insert —
(aa) the Schedule 4 poison or Schedule 8 poison, or combination of those poisons, constituting the substance;

No 42
Clause 68, page 46, after line 4 — To insert —
(da) the method by which the substance will be self-administered;
(db) the expected effects of self-administration of the substance;

Extracted from finalised Hansard
(dc) the period within which the patient is likely to die after self-administration of the substance;
(dd) the potential risks of self-administration of the substance;

No 43
Clause 68, page 46, after line 14 — To insert —
(aa) the Schedule 4 poison or Schedule 8 poison, or combination of those poisons, constituting the substance;

No 44
Clause 68, page 46, after line 16 — To insert —
(ab) the method by which the substance will be administered;
(ac) the expected effects of administration of the substance;
(ad) the period within which the patient is likely to die after administration of the substance;
(ae) the potential risks of administration of the substance;

No 45
Clause 72, page 49, lines 6 and 7 — To delete “patient to whom it is supplied or their contact person.” and substitute —
contact person for the patient to whom it is supplied.

No 46
Clause 96, page 64, after line 23 — To insert —
(da) a former coordinating practitioner or consulting practitioner for the patient if the person is not a party to the proceeding;

No 47
Clause 96, page 64, lines 25 and 26 — To delete “the administering practitioner for the patient.” and substitute —
a person to whom the role has been transferred.

No 48
Clause 106, page 70, after line 18 — To insert —
(da) a former coordinating practitioner or consulting practitioner for the patient if the person is not a party to the proceeding;

No 49
Clause 106, page 70, lines 20 and 21 — To delete “the administering practitioner for the patient.” and substitute —
a person to whom the role has been transferred.

No 50
Clause 107, page 70, after line 27, the Table the 1st row the 1st column — To delete —
s. 21(1)

No 51
Clause 113, page 74, line 12 — To delete “faith,” and substitute —
faith and with reasonable care and skill,

No 52
Clause 151, page 87, after line 12 — To insert —
(ba) participation in the request and assessment process, and access to voluntary assisted dying, by patients who are regional residents;

No 53
Clause 154, page 88, after line 19 — To insert —
(ba) the number of any referrals made by the Board under section 117(c); and

Extracted from finalised Hansard
Clause 154, page 88, after line 27 — To insert —

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

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

Part 9A — Access standard

154A. Standard about access to voluntary assisted dying

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

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

(b) prescribed substances; and

(c) information about accessing voluntary assisted dying.

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

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

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

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

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

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

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

That amendment 1 made by the Council be agreed to.

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

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

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

Mr R.H. COOK: No problem.

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

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

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

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

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

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

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

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

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

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

Mr P.A. KATSAMBANIS: I would like to clarify this with the minister. In the debate in the other place around the insertion of this amendment, a guarantee was given by Hon Stephen Dawson representing the Minister for Health that, if necessary, the government would be prepared to fly a coordinating practitioner, a consulting practitioner, an administering practitioner or even a care navigator to regional and remote areas to facilitate access in those places where, as the Leader of the Nationals WA pointed out, such care may not be available on tap, if you like, and services have to be flown in. The indication was that an interpreter would also be flown in or provided, as the case may be, to facilitate those services if necessary. Can the minister confirm that that assurance given by Minister Dawson in the other place is the intention of the government?

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

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

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

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

The SPEAKER: Member for Riverton.

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

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

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

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

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

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

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

The word “entitled” is not an entitlement?

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

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

**The SPEAKER:** Member for Hillars!

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

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

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

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

**The SPEAKER:** Members!

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

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

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

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

*Extracted from finalised Hansard*
Mr R.H. COOK: I move —

That amendment 2 made by the Council be agreed to.

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

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

That amendment 3 made by the Council be agreed to.

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

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

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

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

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

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

Mr R.H. COOK: I move —

That amendment 4 made by the Council be agreed to.

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

**palliative care and treatment** means care and treatment that —

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

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

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

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

Extracted from finalised Hansard
Further on the same day, he said —

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mrs A.K. HAYDEN: I do.

Several members interjected.

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

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

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

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

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

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

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

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

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

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

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

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

This is the first of a number of amendments proposed by the government in the other place that really ought to have properly considered when they were put here by other members, and primarily by members of the governing party. People are exercising their conscience in this debate and are not voting on party lines. That is good. I personally think we should have more of that. But in this particular case, I did not want to miss the opportunity of highlighting this. This should be a celebratory moment, but it is not, because people were essentially shouted down, smashed on the numbers and in many ways bullied and abused—none more so than the member for Girrawheen and the member for Darling Range, as she pointed out in her contribution, for standing up and supporting not just this principle but also an amendment that will now be unanimously agreed to by both houses.

Extracted from finalised Hansard
of Parliament. We ought to reflect on whether this entire process could have been handled better. I am not going to make the same points again when we consider the other amendments, but I thought it was really important to make that point here today. On reflection, the government went away and thought it was a good idea. It would have been better if that reflection had happened earlier. It would have avoided a lot of nonsense—a lot of toing and froing—and we would have been in a better place. I think the public would have seen the greatness of a democratic Parliament and would have focused on that greatness rather than on the five per cent of our work that is adversarial and sometimes demeans us in the eyes of the public.

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

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

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

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

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

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

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

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

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

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

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

Several members interjected.

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

Mr S.K. L’ESTRANGE: I would.

The DEPUTY SPEAKER: Go ahead.

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

(1) If the coordinating practitioner is satisfied that the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters —

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr R.H. COOK: I just want to clarify two points. The member just made the comment that I said the AMA and the palliative care community were late to the debate. That is not the case. I have engaged with the palliative care community all the way along, and I maintain that. The reference I made to the AMA coming late to the debate is that it did a second survey. The AMA did an initial survey of members about their views, and that drove its policy positioning. Then it did a second survey of members about specific aspects of the bill, and that is when it came to us to discuss specific details of the bill.

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

Mr R.H. COOK: I move —

That amendment 5 made by the Council be agreed to.

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

Mr R.H. COOK: I move —

That amendment 6 made by the Council be agreed to.

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

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

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

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

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

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

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

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

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

Mrs L.M. HARVEY: I differ from my colleague’s perspective on this new clause and I thank the minister for including it. This new clause is tied with the amendment to clause 2 setting out the principles of the bill that there

Extracted from finalised Hansard
is a need to protect vulnerable people from abuse and/or coercion. If we read it in the context of those principles being reworded and reset, this new clause is a significant improvement to the legislation. I am pleased that it has been considered, although I accept that it may not go far enough for some members. I would like to put on the record that I am pleased that it clearly outlines that a doctor or medical practitioner having a conversation with an individual about voluntary assisted dying needs to include a conversation about the options for care and the likely outcomes of those options. It will be clearly defined in the legislation.

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

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

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

Proposed subclause (6) states —

Subsection (5) overrides section 10(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr R.H. COOK: I move —

That amendment 7 made by the Council be agreed to.

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

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

Mr R.H. COOK: I move —

That amendment 8 made by the Council be agreed to.

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

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

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

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

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

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

An opposition member: Withdraw! Withdraw!

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

Debate interrupted, pursuant to standing orders.

Extracted from finalised Hansard
Debate was interrupted after amendment 8 made by the Council had been partly considered.

Mr R.H. COOK: I rise in response to the comments of the member for Darling Range just prior to question time. She characterised this amendment as the government rejecting the amendment proposed by Hon Nick Goiran. We did not; we simply tidied up the wording, and I think that is accepted now. I made similar comments in response to those of the member for Hillarys. Further, I would like people to understand that this amendment simply codifies how medical practitioners have an ethical duty to make sure that they do not have issues of conflict of interest and, in that sense, these amendments simply enshrine good medical practice. This is not a question of something that we would expect medical practitioners to suddenly be aware of by virtue of this amendment; this is something that they do on a day-to-day basis. We accept that Hon Nick Goiran had some concerns about this and, as I said, to provide him with some confidence, we have made explicit what we already believe is implicit, and that is an appropriate way to go. In the context of the member for Darling Range’s comments, I want to distance the government from the conflation that she made between elder abuse and the conduct of medical practitioners. I cast my mind back to the Legislative Assembly debate in which we discussed the issues of elder abuse and independence, or, the appropriate nature of the independence of medical practitioners. I do not believe we ever suggested that medical practitioners would actually undertake elder abuse or, in that context, behave unethically. I am not sure what the member’s motives were, but I absolutely reject the notion that that would be something that medical practitioners would ordinarily engage in on a regular basis in their work. It is important that we put that on the record. I think our medical practitioners do an amazing job, and this amendment simply explicitly states what they would be duty bound through ethics to observe at any rate.

Mrs A.K. HAYDEN: Minister, thank you for that. I, too, would like to clarify that I was not alluding to that either, so I concur and agree with the minister. None of us would say that a medical practitioner would generally go out and do that type of thing. They are all professionals and are well respected in the community. I was referring to it not being a family member of the patient. That is the area we are always trying to avoid. Obviously, there are always rogue wolves in any industry, and making sure that it is not a family member who may have an additional reason for approving and being part of this process is what this amendment is clearing up. For the record, I agree with the minister.

Mr Z.R.F. KIRKUP: Paragraph (c) of this amendment reads —

the medical practitioner does not know or believe that the practitioner —

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

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

I recall that under the Australian Medical Association’s code of ethics, it specifically relates to a direct family member. The term zooms out to a larger, more extended family for a practitioner practising in a normal routine, to the best of my knowledge. If they are found to be a beneficiary of the will, for example, can the minister run me through a circumstance in which that might occur? In that case, what would the penalty be for that practitioner? Also, is there any obligation to advise the board of something like that, once that happened? I have a scenario in mind, whereby a practitioner did not reasonably believe that they were a beneficiary of a will, for whatever reason. They then find themselves going through the process after the death and find that they are. Is there any capacity for the board to deal with this? What process would that involve and what would the penalty be if they were a beneficiary and they were the ones who found out about it?

Mr R.H. COOK: The actual offence would occur if at the time of the death of the patient it could be reasonably believed that the medical practitioner would have knowledge. If they had no knowledge at the time, obviously they would not have contravened the bill. Contraventions of the bill by a registered health practitioner are covered under clause 10. Essentially, a contravention of the bill would occur if they knew and benefitted, but if they did not know or could reasonably be believed not to have known, there would be no penalty.

Mr Z.R.F. KIRKUP: Thank you, minister. I appreciate that response. Subclause 2(c)(ii), which is proposed to be inserted, states in part —

... other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the patient.

Why does that not also cover the administering practitioner?

Mr R.H. COOK: It essentially goes to the issue of the drafters. This is with regard to the coordinating and consulting practitioner.
Mr Z.R.F. Kirkup: Requesting access?

Mr R.H. COOK: Yes. I refer the member to the proposed amendments to clause 53, which reflect a similar approach in relation to the administering practitioner. That is covered under amendment 30, which, as I said, was part of this suite of amendments that has been moved.

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

Mr R.H. COOK: I move —

That amendment 9 made by the Council be agreed to.

This is the next amendment under this particular suite of amendments from Hon Nick Goiran and agreed to in the other place.

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

Mr R.H. COOK: I move —

That amendment 10 made by the Council be agreed to.

This is a government amendment. It comes directly from consultation with the Australian Medical Association about what it wanted included in the Bill. In a lighter moment, we have described this as the glass of wine or the dinner party conversation. That is, we do not think a medical practitioner should be captured under the first request for voluntary assisted dying if that request was made simply in the context of a conversation, or, as was put to us, we were having a glass of wine after dinner, farewelling a colleague or a friend, and they said, “By the way, I wouldn’t mind.” That would not considered to be the first request. This amendment simply explicitly states that the first request must be made during a medical consultation.

Dr D.J. HONEY: This is a critical amendment, and I am glad to see it go into the bill. In fact, it was not simply a glass of wine. I appreciate that was a metaphor. If we read the proposed law as it was written, someone would have been able to request access to this procedure using a mobile phone with FaceTime and simply ringing a medical practitioner and requesting that they participate. This is a very important change. I know that many medical practitioners who have actually read the bill were extremely concerned that they could be engaged in this process in any setting, and not in the normal setting of a patient requesting a consultation. I congratulate the originators of this amendment, and I also congratulate the government for supporting it.

Mr P.A. KATSAMBANIS: As the minister pointed out, amendment 10 came out in the discussions between the government and the Australian Medical Association. It is a very important amendment. It may seem pedantic, but we can all see in practice that it is an appropriate matter to be dealt with. It was an issue that was raised in the debate here in this chamber by various members, but we were at that stage that we spoke about earlier of not accepting any amendments. The legislation is now clear and unambiguous on when the request can be made; it must be made during a medical consultation, however that happens. The minister suggested that it cannot happen over a glass of wine, but as a number of people, including myself, have alluded to, some of the fears on how this sort of regime may be rolled out in practice are around the more entrepreneurial members of the medical fraternity—I do not use that pejoratively—perhaps during a seminar where a group of people are given information about the process of voluntary assisted dying. The question mark would have been whether a patient could have made a request in person that is clear and unambiguous as foreseen by the original clause 17 during that sort of seminar process. This amendment makes it very, very clear that it is a one-on-one consultation; it is a medical consultation. I think it is a good amendment and ought to be supported because it improves the workings of the bill.

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

Mr R.H. COOK: Amendment 11 is similar to amendment 20. It goes to the issue of coordinating and consulting practitioners having regard to reports or opinions that provide them with the necessary information they need to make an assessment of diagnosis and prognosis. It makes it clear that the assessing practitioner, when making the first and consulting assessments, can consider and rely on relevant information about the patient from a registered health practitioner. Again, this issue came out in consultation with health stakeholders. The health stakeholders were anxious to ensure that coordinating and consulting practitioners either have or could furnish themselves with the necessary information to be able to make a call on a decision or assessment. From that perspective, I think this is an appropriate addition to the bill.

The ACTING SPEAKER (Ms L.L. Baker): Just move it, please.

Mr R.H. COOK: I move —

That amendment 11 made by the Council be agreed to.

Mr P.A. KATSAMBANIS: This amendment has an interesting genesis as well. I note that in clause 23, as originally proposed in the Bill, there are two conditions that must be followed at the first assessment by the coordinating practitioner. The health stakeholders were anxious to ensure that coordinating and consulting practitioners either have or could furnish themselves with the necessary information to be able to make a call on a decision or assessment. From that perspective, I think this is an appropriate addition to the Bill.
eligible for access to voluntary assisted dying and must make a decision on each of the eligibility criteria. The third limb that is being added to clause 33 by this amendment is not a must. The coordinating practitioner does not have to do it. They may have regard, but it is not couched in those words. It is not a “must” or a “may”; it simply says —

Nothing in this section prevents the coordinating practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner. It is not an absolute obligation; it is an option that the coordinating practitioner can choose to follow or not follow. I think, simply from good drafting, it would have been better to have obligations on all three parts of the sections. That was rejected by the government in the other place. I know that the minister will say that there are all sorts of clinical and professional rules and obligations that doctors must follow, and a doctor who has a report before them who does not take it into account would be eligible to be brought up before the professional body that represents them and may be liable to punishment. That is true and I accept that. I am just pointing out that mandatory obligations are being placed on the medical practitioner in clauses 23, 24 and 25 and the like throughout the division. However, in relation to considering relevant information—I think that is the important point—about the patient that has been prepared at the instigation of another registered practitioner, there is no such mandatory obligation; it is just a best endeavour clause. It is still better protection than what existed before. I just point out that I think it could have been better but, clearly, the government contemplated it and chose not to go down that path.

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

**The DEPUTY SPEAKER**: Minister, do you want to say something, I have just put the amendment?

Mr R.H. COOK: No; I am getting up to the next one.

Dr D.J. Honey: We had questions for the minister to answer and you moved straight on to the question.

**The DEPUTY SPEAKER**: I am sorry; the minister did not indicate that he was going to answer, so I put the amendment. Of course, I will make sure I look your way.

Mr R.H. COOK: I move —

That amendment 12 made by the Council be agreed to.

As I foreshadowed earlier, this is part of a suite of amendments moved by Hon Nick Goiran in the other place and goes to the issue of which we spoke at length before about the practitioners not being a family member or financial beneficiary. It goes to provide further encapsulation or further voice in relation to those amendments.

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

Mr R.H. COOK: I move —

That amendment 13 made by the Council be agreed to.

This is an amendment on which the government was beaten to the punch by Hon Nick Goiran, as indicated to the member for Scarborough.

Ms M.M. Quirk: Minister, you said they were slow in getting it passed.

Mr R.H. COOK: No, we were a bit slow.

Ms M.M. Quirk interjected.

Mr R.H. COOK: He beat us to the punch on this one. This is an issue that the Leader of the Opposition raised during debate in the Legislative Assembly. Upon further reflection, it was obviously absolutely appropriate to include the word “and” instead of “or” in clause 26, so we are happy to commend this hefty amendment to the house!

Mrs A.K. HAYDEN: On reflection, I note that on the night that it was raised by the Leader of the Liberal Party, it was not deemed necessary. It was put forward with a whole pile of other amendments that were not deemed necessary. When we look back at the way it was handled and what was said in the media, in the public arena, about how we were filibustering and wasting time on silly amendments such as small grammatical amendments, we are now seeing that it was fixed in the upper house. As the minister said, the government was beaten to the punch by Hon Nick Goiran because the government was also going to put forward the amendment. On reflection, the government realised that what the Leader of the Opposition put forward was reasonable and was required and we are now seeing the amendment accepted. I just cannot let this amendment pass without putting on the record the misleading information that has been put into the public arena that people on this side were simply filibustering and wasting Parliament’s time.

Ms J.J. Shaw: You did.

Mrs A.K. HAYDEN: With behaviour like that, that is why you are a disgrace as a government, an absolute disgrace as a government.

Several members interjected.

*Extracted from finalised Hansard*
Mrs A.K. Hayden: This is the whole reason —

The Deputy Speaker: Back to the amendment please.

Mrs A.K. Hayden: This is the whole reason I am standing —

Mr T.J. Healy interjected.

Withdrawal of Remark

Mrs A.K. Hayden: Excuse me, member, would you like to withdraw that?

The Deputy Speaker: Excuse me, would you like to continue with your comments, member.

Mr T.J. Healy: Sorry.

The Deputy Speaker: Enough byplay, can we have the amendment, please.

Debate Resumed

Mrs A.K. Hayden: It is nice to see that regardless of what was put out in the public arena and media that we were simply wasting time on grammar and small amendments —

Ms J.J. Shaw interjected.

The Deputy Speaker: Go ahead, member.

Mrs A.K. Hayden: — we have the minister admitting that adding this in is required and needed. If only the government took this place seriously and listened to the real concerns of the people who raised them at the time, we would not be sitting here today, having to accept these amendments, because they would have been done when debating the bill in the first place. I thank the minister for accepting the amendment moved by Hon Nick Goiran, and I thank the minister for admitting that he got it wrong in this place the first time. He went away, reflected and agreed to those amendments.

Mr R.H. Cook: This is a small amendment. I appreciate that members want to make a political point and they are perfectly entitled to do so, but I think that, in this case, the Premier himself was at the table and told the Leader of the Opposition that we would reflect on it and, if necessary, move an amendment in the other place. That is exactly what occurred. The Leader of the Opposition moved three specific amendments, of which one inserted the word “and” instead of “or” and one was in relation to finishing reports about assessments undertaken by the coordinating and consulting practitioner of the patient. It was either those two amendments or the last amendment for which the Premier specifically said, “Let us just have a think about that and we can make the change in the other place if necessary.”

Mr P.A. Katsambanis: I think you were in the chair.

Mr R.H. Cook: No. We just checked the Hansard and it clearly shows that the Premier was in the chair. If we can all turn the temperature down a bit, we are at the final stages of this debate and we can just get through these amendments —

Mrs A.K. Hayden interjected.

Mr R.H. Cook: Member, with respect, this point has been made. I understand that the member wants to make it, but if we could just move through the amendments, we can make sure that we all, as members of Parliament, fully understand them, and that if we are to support them, we do so with that knowledge in mind.

Mr P.A. Katsambanis: I rise because I want to ensure that there is no ambiguity in what is being done here. This is a small change. It is a change of just one word. But it does not mean that it is insubstantial, it does not necessarily mean that it is a grammatical mistake; in fact, it is not. It is actually quite a substantive change. Importantly, it fixes a mistake in the legislation that could have created significant problems in the future. It fixes an inconsistency between the bill as originally drafted and the explanatory memorandum that accompanied the bill. I will not trawl through the specifics because they were outlined, firstly, by the Leader of the Opposition in this place and, secondly, by Hon Nick Goiran in the other place. It is on the record, so I will not trawl through it again. What strikes me — I share the minister’s view that we should tone things down — is that a one-word change, which is substantive and meaningful and actually gives effect to the government’s policy as articulated in its own explanatory memorandum, could evoke such vitriol from the government back bench. When the Leader of the Opposition proposed the original amendment, she was bullied and shouted down by members on the government back bench. Today when the member for Darling Range stood up and pointed out the horrific treatment meted out to the Leader of the Opposition, she was equally abused by similar people. It is unbelievable. It is just extraordinarily unbelievable. We have proven that what the Leader of the Opposition said was meaningful and substantive. Yes, perhaps the government needed a bit of time to reflect — I can give it credit — but do not come back and repeat the abuse on the same issue on the same clause!

I support respect. I think we have all dealt with this respectfully, in the main. Everyone who stood up to speak on the bill, including on the amendments, has been respectful to each other, but it has to work both ways. I am glad that we have got to the stage at which this amendment has not been dismissed out of hand. It has been a difficult
process again, but it has corrected an obvious error that created doubts about the policy intention of the bill. There was a direct conflict between what was in the bill and what was in the explanatory memorandum—not conflict between the thoughts of the government, the opposition, and the proponents and opponents of the legislation, but inherent conflict between the bill and the explanatory memorandum, that that is now corrected. I thank the minister for considering it and supporting it. As the minister said, let us tone down the vitriol and in particular let us stop the abuse of members of Parliament who are trying to make things better.

Mrs L.M. HARVEY: I would like to place on the record my appreciation for the inclusion of this amendment. At the time that I picked it up, I could see by the look on the adviser’s face, Hon Malcolm McCusker —

Mr R.H. Cook: I was going to say you should have seen the look on McCusker’s face!

Mrs L.M. HARVEY: He was sitting opposite me and I could see that what I was saying made a lot of sense to him, hence my disappointment in not having that amendment accepted at the time. However, the beauty of the Western Australian parliamentary system is that we have a Legislative Council. These matters can be considered and given due consideration by the government of the day to allow amendments to be put forthwith in the Legislative Council and therefore accepted to improve the bill.

What the member for Hillarys said was absolutely abundantly clear: the difference between “or” and “and” in the sentence at clause 26(2) is incredibly important. By deleting “or” and substituting “and”, this clause will make sense. With the word “or”, the sentence made no sense whatsoever. It has often been said to me that I would be a very good subeditor because I read every word, particularly in legislation that is very important legislation such as the legislation we have before the house today. I am very pleased the minister has accepted what I considered to be a mistake in the legislation, which I picked up. It is now before the house to improve the bill, and this particular clause will now make sense.

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

Mr R.H. COOK: I move —

That amendment 14 made by the Council be agreed to.

This is one of a number of what we will call “Harvey amendments”. Again, Hon Nick Goiran beat us to the punch on this. It goes to the issue of patients being given copies of the first assessment form and the consulting assessment form. It will not surprise members to hear that amendment 22 is exactly the same as that relating to the consulting practitioner. In both cases, it makes sense that a copy of the assessment form is provided to the patient.

Mrs L.M. HARVEY: Once again, I thank the minister for the inclusion of this amendment. At the time of the debate in this house, it did not make any sense at all to me that the legislation was quite strict about who the application form for access to voluntary assisted dying should be provided to within a certain time frame. Even though, logically, one would assume that the patient requesting voluntary assisted dying might take a photocopy or a photograph, whatever it might be, of the form, it made sense to me that the legislation should require that the patient have a copy of the form. For example, their loved ones might be unaware of the process or the patient may wish to provide the information to them but may not necessarily wish to have a conversation about it. This will ensure that the patient is provided with a copy of their form for their own purposes and records and, should they pass away, for the executors of their will and their estate. It is really important to have that documentation so that family members can understand the process that the terminally ill person has gone through in order to access voluntary assisted dying if they take the poison and end their life. It is very important and I am very pleased that the minister has picked this up and included it in subsequent amendments, so that the legislation is crystal clear that any patient accessing voluntary assisted dying must be provided with a copy of their form. They can read through the form a couple of times and determine whether they really want to continue with the process. It is really important that a person has a written form. They can go over it several times and make sure that they are comfortable with the decision before they proceed to the next stage. Some people need to read things through several times before it clicks in their head that this is what will happen as a result of the VAD process. I think this is very important. As I said previously, this and other amendments have given me comfort that protections are in place to ensure that only those people right at the end of their journey when things are terrible and they have perhaps unmanageable symptoms and pain can access voluntary assisted dying, as is the case in Victoria at present.

Mr P.A. KATSAMBANIS: I want to put on the record that when we debated the Leader of the Opposition’s amendment on 5 September, the Premier was quite unambiguous in making clear that he wanted to use the process between the houses, if you like, for want of a better term, to consider whether it was an appropriate amendment. I quote the Premier’s response from the Hansard —

I do not propose to amend the bill at quarter to one in the morning with some words written on a piece of paper.

We will consult between here and the upper house, which I think is the right way to deal with legislation.

That is fair and good. I want to place that on the record to show that right from the outset the government picked up that this may well be an issue, and good on it. But it reminds us of the ridiculous process we were going through.

Extracted from finalised Hansard
It should also be placed on the record that the person who endured the most through a very, very difficult process was the Minister for Health sitting at the table. He got a bit of a chop out; the Attorney General and the Premier helped him out for a while. I use the term “help” in the case of both of those officers of the Crown rather loosely, but they certainly sat in the chair for a while. It reminds us of what we went through. I would suggest unnecessarily given the paucity of legislation we considered in the few weeks previous to this sitting. We unnecessarily went through the physical toll that it took on all members, particularly the minister and the advisers, who have had an unbelievable workload. The statement I just quoted was right; we should not be considering amendments to the bill at quarter to one in the morning. Hopefully in the future we will reflect on this process and come up with a better process than the one that we went through, but clearly the process between the houses worked. The minister gave his word and he was true to it, so thank you. Again, this amendment improves the original bill without changing the integrity of the bill in any way.

**Question put and passed, Council’s amendment agreed to.**

**Mr R.H. COOK:** I move —

That amendment 15 made by the Council be agreed to.

This amendment is the first of a suite of amendments moved by Hon Adele Farina and assisted by Hon Nick Goiran. It essentially goes to the issue of requiring information about a patient’s language requirements, including interpreter details, to be included in the forms given to the Voluntary Assisted Dying Board. The amendment goes to the issue of details being captured at the first assessment and consulting assessment stage; the written declaration phase, which, to refresh members’ memory, involves a first request, a second verbal request and a written request; the final request and final review; revocation of the request, if that has happened; and the administration decision. This particular suite of amendments includes amendments 15, 17, 24, 26, 28, 29, 32, 33 and 38. Essentially, the government supported this amendment because it will provide for further transparency in the work of the Voluntary Assisted Dying Board and will assist the board to gather information and identify any gaps in health service provision. It is the intent that the Department of Health will capture this information via the database that will be accessible by the board. It is usual good practice for clinical documentation to appropriately record the fact of an interpreter assisting during a clinical consultation. I think members will agree that this is an appropriate amendment that goes to the issue of those for whom English is not a first or, indeed, a second language. It will allow the Voluntary Assisted Dying Board to have a good line of sight over these issues.

**Ms M.M. QUIRK:** The minister will be grateful to know that, as this is a suite of various amendments that deal with the same topic, as he has said, I intend to comment only on this occasion. This amendment certainly has improved the legislation. Clear, concise communication is vital in this area and I think this will improve the situation. However—I mentioned this during the second reading debate and the consideration in detail stage—all these clauses refer to engaging an interpreter in accordance with clause 160(2). Clause 160(2) states that an interpreter must be accredited by a body approved by the CEO, which begs the question: as there is only one accrediting body, why would the CEO be qualified to have sufficient information or background to work out the appropriate bodies? As I said, there is only one body, so it is really just an academic gripe on my part. I think it should be the professional accreditation body, but that is something that the minister might want to consider during the implementation stage. Frankly, I think the CEO will have too much to do under this legislation. I thought this provision could have been more elegantly worded. I do not need a comment from the minister; I am just disappointed that that point was not picked up during the consideration in detail stage.

**Mr P.A. KATSAMBANIS:** I also want to speak on this amendment because it goes to an issue that I am very passionate about. I spoke about this in the context of what I think will, in history, become known as the Buti amendment—the amendment that the member for Armadale moved to add new clause 9A, which was ultimately doomed. However, a different clause was introduced in its place. This is about people whose first language is not English and all the cultural sensitivities that go with that. I commend Hon Adele Farina in the other place for bringing this and the consequential amendments to the public debate and making sure that they were included in the bill. I do not want to labour the point at this stage, but it highlights a genuine lack of consultation with culturally and linguistically diverse communities throughout the process of developing this bill. That is not a criticism of the people who engaged in the consultation; perhaps there was an attempt at engagement without any meaningful response. I do not know; I was not involved in it. But after reading through the bill, it seemed clear to me and to others that there were these sorts of issues around language barriers, interpreters and the more general language issues related to ageing that we are becoming aware of. People who might have functional use of the English language may revert to their first language as they get older. I am living with my parents at the moment, and my father, who I would say has always had a good grasp and comprehension of written English and a functional grasp of spoken English, has practically lost the functional ability to speak the language, although he has retained a good ability to understand what he reads and hears. People are living that experience every day across Western Australia and Australia generally, and we are getting to know more about it as our multicultural communities age in place in Australia rather than in their original countries.

*Extracted from finalised Hansard*
That was clearly missed in the legislation. I do not think it was an error; I just think it is something that happened there. Perhaps, as I said, the people engaging in the consultation tried in good faith, but just did not get much back. Maybe there was not much consciousness about it until it was raised in public after the bill had been introduced into this place and debate had taken place. Clearly, it is something that was missing from the original bill, and it may have led to unintended negative consequences for another vulnerable group in the community. It is a group that we should never forget, especially, as I said, because of that interaction between ageing and reversion to first language. It just slipped through the cracks.

So, with those words, I commend Hon Adele Farina—someone who obviously also grew up in a non-English speaking household, as I did. I wish this amendment good passage and thank the minister and other supporters of this legislation for seeing that this was necessary and agreeing to that suite of amendments.

Mr R.H. COOK: I want to place on the record that the use of interpreters is extensively engaged throughout the health system. In that context, I do not want people to gain the impression that because these issues were not explicitly canvassed in the legislation, the idea of providing health services to people from culturally and linguistically diverse backgrounds is somehow new to the health system; it is something we do every day, and we have an extensive process for that. To settle the member’s concerns about this, the Ministerial Expert Panel on Voluntary Assisted Dying included Maria Osman, who is from a culturally and linguistically diverse background and has extensive experience of consulting CALD communities. I also acknowledge the presence in the Speaker's gallery of panel member Kate George, who is also from the culturally and linguistically diverse background known as the Indigenous communities of Western Australia. She was also on the Ministerial Expert Panel on Voluntary Assisted Dying, and, Kate, can I express my thanks to you for the great work you did.

The MEP consulted specifically with the Office of Multicultural Interests, the Ethnic Communities Council of WA and the Equal Opportunity Commission of Western Australia. This was always intended to be captured in practice. As I said, it was not one of the things that we explicitly stated in the legislation, simply because this is what the Department of Health does every day. I take on board the member’s comments, and I thank him for his support.

Ms M.M. QUIRK: I cannot really let that go without comment. Throughout the debate, when the minister was asked why this bill had to depart from the Victorian legislation, one answer was that Western Australia was much more culturally and linguistically diverse, and, for that reason, we could not use the Victorian legislation. I want to remind the minister that that was the whole rationale behind going in a different direction; rather than saying it was not forgotten, it was certainly sidelined.

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

Mr R.H. COOK: I move —

That amendment 16 made by the Council be agreed to.

Amendment 16 is about referral reports. This is one of a couple of amendments that were moved by Hon Nick Goiran to require that not only the first assessment report and the consulting assessment report form include the outcome of the referral made under clauses 25 or 36 to another practitioner or person, but also a copy of the report of their assessment of the patient’s eligibility be provided by the practitioner or other person. This amplifies the amount of information that will be made available to the Voluntary Assisted Dying Board so that it can be satisfied that the coordinating practitioner or consulting practitioner has furnished themselves with the appropriate reports.

Mrs A.K. HAYDEN: Minister, again it is good to see that another amendment has gone through the other place that will improve this legislation. During the entire debate in here we often referred to the importance of the Voluntary Assisted Dying Board. Obviously, any amendment that provides the board with a bit more support so that it can function correctly and properly, and produce the best outcomes for the patients and people involved, is what we, as legislators, should be always striving to achieve. On that note, I again thank Hon Nick Goiran for this amendment and I thank the government for accepting the amendment. I put on the record that this is another good amendment. It is not one, as we keep hearing in the papers, that was not called for. I know that in this place we are in opposition on this legislation, and it is our role to highlight the amendments that we have fought for and that have been won. This amendment will improve the bill. It will not slow down or stop the bill; it will improve the bill. This is our opportunity to put that on the record. On that note, I thank the Legislative Council and the minister and advisers for accepting this amendment that will support the Voluntary Assisted Dying Board.

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

Mr R.H. COOK: I move —

That amendment 17 made by the Council be agreed to.

Mr P.A. KATSAMBANIS: I am very pleased to support this amendment. I highlighted this issue in the debate during the consideration in detail stage. The amendment provides that a field must be included in the first assessment report form to detail whether a patient has been assisted by an interpreter, and to include the interpreter’s details.
and accreditation. Again, I raised this matter late at night when the Premier was at the table. We had a bit of an exchange and the Premier indicated that clause 28 was not exhaustive, which I had also pointed out, and said that it was just about a series of minimum requirements and that other things could be included. I toned down my rhetoric and rather than asking that a specific clause be included, I suggested that when the minister or the Premier considered the form, they should add the translator field. The Premier indicated, almost by interjection rather than by standing up, that he would consider that.

Clearly, between the houses and at the instigation of Hon Nick Goiran, this has been firmed up into a requirement so that the first assessment report form, in addition to including a series of things, must now also include details about whether an interpreter was used and, if so, the details of that interpreter. Again, that is logical and sensible and it takes into the account the fact that English is not the first language of many people, be they Indigenous people or migrants to this country. It is another built-in protection to make sure that everything is considered and that people act of their own volition and understand everything they agree to. I thank the minister for considering this issue between the houses and agreeing to the amendment.

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

**Mr R.H. COOK:** I move —

That amendment 18 made by the Council be agreed to.

This is another government amendment that requires that when the coordinating and consulting practitioners provide the first assessment report form and the consulting assessment report form to the board, they must include information about the palliative care options available to the patient and the likely outcomes.

**Dr M.D. NAHAN:** This is a very important amendment about which many of us argued, but during our debate it was said that this bill is about VAD, not palliative care. The government wanted to separate the two. Our argument—this amendment picks up that argument—was that as part of the assessment process, it is necessary to consider the palliative care options in the lead-up or perhaps as an alternative to VAD. We spent many hours debating this issue. It was a key issue for me and other members. Therefore I am very glad that the government—this is a government amendment, I believe—has in its wisdom moved this amendment, even though, I might add, it made it clear to us that it was an unnecessary amendment prior to our debate. Again, I emphasise that this is a government amendment. It is one of the issues that we extensively debated in the house, and the government accused us of grandstanding and unnecessarily postponing the passage of the bill. Here we are, back in December, after a record number of hours debating the bill and staying up all night on one occasion. This is one of the issues that we raised, but the government said that it was not necessary. When the bill went to the other house, the government decided to move an amendment. I hope that when the Premier talks about this, he will admit that he played politics with this most important bill for his own gain and did not consider the safe, secure and adequate passage of the VAD bill. Again, it is only appropriate that the consulting medical practitioner assess the palliative care program for the patient and provide them records of that. It was denied as necessary when we debated it in this house, and that is why some of us did not vote for the bill.

**Mr R.H. COOK:** I will provide further information about amendments 18 and 25. This will assist the board to gather data and identify any gaps in the provision of health services and will include information such as whether the patient is currently receiving palliative care; and, if not, whether a palliative care service is available to which they can be referred to assist them; whether the patient has been offered a referral to that service; and whether the patient has or has not been referred to that service.

**Mr P.A. KATSAMBANIS:** I hate to be pedantic. I seek the indulgence of the minister and perhaps his advisers on this. Amendment 17, which we passed a moment ago, inserted in clause 28 on page 20, after line 27, new paragraph (ia). According to the Council’s message, amendment 18 also inserts at clause 28, page 20, after line 27, a new paragraph (ia). To me that looks like there are two paragraphs (ia). I note that the marked up copy of the bill, the blue, if you like, which I was given this morning by the great staff here in Parliament, includes clause 28(3)(i), (j) and (k). I seek some clarity about whether the drafting of the clause, with these paragraphs, is going to be meaningful, because we are inserting two separate paragraphs with identical wording.

**The SPEAKER:** Members, they will be amendments 17 and 18 on the Council’s message. Even though they have the same paragraph lettering, they will be different in the bill. They will be amendments 17 and 18.

**Mr P.A. KATSAMBANIS:** Thank you, Mr Speaker. That answers my query.

**Mr S.K. L’ESTRANGE:** I refer to new paragraph (k) in the blue bill, which refers to the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment. Because the paragraph did not exist before, can the minister inform us, so we can get it on the record, what happens if the care and treatment options are not available? What does the patient or doctor do in that situation?

**Mr R.H. COOK:** They would do what a doctor and a patient do already. The question is about whether those options are available to the person before they access voluntary assisted dying. Ultimately, they may want to access voluntary
assisted dying anyway, regardless of the availability of palliative care, but this was considered to be a policy point about which people wanted more information in the context of the work of the Voluntary Assisted Dying Board. It is about the data collection and basically building an understanding of the extent to which palliative care options are available to people who also wish to access voluntary assisted dying.

Mr S.K. L’ESTRANGE: I go to new subclause (2A), which states —

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

Part of what must be given to the patient is listed in paragraph (k). Notwithstanding the motivations of the patient, if that must be given and, for example, the patient is in remote regional Western Australia and the coordinating practitioner establishes that there are not any palliative care and treatment options available and the likely outcomes of that care and treatment are therefore non-existent, would the minister expect that to be written in the report?

Mr R.H. COOK: What will be written in the report is what the chief executive, through the implementation phase, decides is the appropriate style and form in which information should be provided. Here we are legislating to make sure that that information is captured so that future policymakers at least have a line of sight about how the availability of palliative care may or may not impact on the way in which people access voluntary assisted dying. As the member would be aware, this point was occupying people’s minds in both chambers. We thought these amendments would provide that line of sight to simply make sure that this information is available to everyone.

Mr S.K. L’ESTRANGE: The reason I raise it is that we did not get to debate this, obviously, when the bill was last in the chamber and it is a key aspect of end-of-life choices that people want to understand. I think the minister said in his answer that it is not implied, but if it were thought that the options must be provided to the patient as part of the process of giving them end-of-life choices so that they can choose the palliative care option or the voluntary assisted dying option, and if they are in an environment in which there are very few palliative care options and that is what is given to them in the report, that could steer them to one course of action, whereas, if more options were available to them, they may give palliative care more serious consideration. Is the Minister for Health’s view that a consequence of this amendment could be that if there is no palliative care for someone in a particular region, that could influence the outcome of their decision on end-of-life choices?

Mr R.H. COOK: No, member.

Mr S.K. L’ESTRANGE: If the minister does not think that is a concern, but the patient thinks it is a concern, how will the government respond to it?

Mr R.H. COOK: I assume that if the government of the day could see through the reports from the Voluntary Assisted Dying Board that patients who do not have ready access to palliative care are accessing voluntary assisted dying, that may invite further inquiry about why that is the case. Is there an emerging pattern around this? Do we need to look at these issues more closely? The only way that the government of the day will be able to make that decision is if it has the information in front of it, so this is about the provision of that information.

Mr S.K. L’ESTRANGE: Are you as the Minister for Health satisfied that the palliative care options exist in remote and regional Western Australia to satisfy the writing of this report?

Mr R.H. COOK: Yes, member, I am. It will be not only through the current provision of palliative care services, but also through the funding to which we have committed in both the budget and in recent times. There is a need to make sure that we enhance those services, but palliative care services are available in all rural regions and outreach. We will soon be moving to engaging in palliative care telehealth, so that not only patients but also their carers are in a better position to get further support. This has been one of the aspects of the debate; it has allowed to us have this community conversation about end-of-life choices and for this significant investment of funds to continue to improve palliative care.

Mr S.K. L’ESTRANGE: On that final answer, does the minister envisage that the implementation strategies he just spoke about will be in place prior to the actual voluntary assisted dying process being in place?

Mr R.H. COOK: Significantly so, member. As the member would be aware, the implementation phase for the Voluntary Assisted Dying Bill will take some 18 months. We are on the ground developing these other services and making sure that people in rural and regional communities have good palliative care.

Dr M.D. NAHAN: The intent of this amendment is manifold but includes data collection for the board to review decisions around the provision of voluntary assisted dying. Will it be recorded that a patient simply does not want it; they have palliative care available, which will have a certain outcome, but they choose not to avail themselves of those options? Will that be recorded in this report?

Mr R.H. COOK: The member could envisage that that is the sort of information that will be made available. Just to repeat, we initially anticipate that the sort of information would include whether the patient is receiving palliative care; if not, whether a palliative care service is available to which they could be referred to assist them; whether

Extracted from finalised Hansard
the patient has been offered a referral to the service; and whether the patient has been referred to the service. It is about encapsulating that whole availability of services, whether they have been made available to a patient and, basically, to provide that insight.

Dr M.D. NAHAN: To follow up, it is what services are available, whether patients avail themselves, to what extent, or whether they choose not to do it. I understand that is often an issue.

Mr R.H. Cook: Yes.

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

Mr R.H. COOK: I move —

That amendment 19 made by the Council be agreed to.

This is a government amendment to make clear that the consulting practitioner, when assessing a patient’s eligibility to access voluntary assisted dying, must not adopt the coordinating practitioner’s decision without question, but must independently form their own opinion on the matters to be decided. This is one of the amendments we agreed to following extensive discussions with the Australian Medical Association.

Ms M.M. QUIRK: This is one of the more glaring drafting errors. In a number of places the explanatory memorandum asserted that the doctors were to act independently. Despite questioning that in relation to a number of clauses, that was not expressed in the legislation itself. I think it is a bit cute to say that it was following representations from the AMA. This glaring error was pointed out very early on in the process.

The SPEAKER: Are you happy to answer, minister?

Mr R.H. COOK: I did not think the member was asking a question, but I will put on the record once again that for something not to be in the bill does not make it something that should be excluded from clinical activity.

Ms M.M. Quirk: It was in the explanatory memorandum.

Mr R.H. COOK: Indeed, member. These issues are implicit. We accept that members were seeking more confidence about that. We had the opportunity to reflect on the comments in this place and to observe the comments made in the other place, which provided us with the opportunity to put this amendment.

Mrs A.K. HAYDEN: Just to clarify, this amendment is to make sure that the consulting practitioner is independent and that the coordinating practitioner is not able to sway them or give them opinions. They have to do that themselves. Was any consideration given to extending that? What is “independent”? Can the minister describe what the government means by stating that the consulting practitioner must make the decision independently of the coordinating practitioner? What is it independent of? Is it just the view of the coordinating practitioner or is something else behind that? Can the minister clarify that for me?

Mr R.H. COOK: To provide further context, this highlights that the coordinating and consulting practitioner must make decisions in a clear and distinct manner separate to each other’s assessment. Although both practitioners may look at the same material, such as the patient’s medical history and reports from specialists, they must each make their own determination on each of the eligibility criteria.

Mrs A.K. HAYDEN: Can they be of the same organisation or have business ties? Does being independent go as far as meaning that they do not work together or have a business together, or does it just mean that they do not collude on a result?

Mr R.H. COOK: To provide further context, this highlights that the coordinating and consulting practitioner must make decisions in a clear and distinct manner separate to each other’s assessment. Although both practitioners may look at the same material, such as the patient’s medical history and reports from specialists, they must each make their own determination on each of the eligibility criteria.

Mrs A.K. HAYDEN: Can they be of the same organisation or have business ties? Does being independent go as far as meaning that they do not work together or have a business together, or does it just mean that they do not collude on a result?

Mr R.H. COOK: It means that they make a clinical assessment independent of each other. The issue of the independence of medical practitioners was canvassed extensively both inside and outside the chamber. Western Australia is a big place, but it is a small community. In such a small community, we could get ourselves in all kinds of problems by trying to define what independence would look like. The key element we are looking for is that they make an assessment that is independent. That is why we have explicitly stated that in this fashion.

Dr M.D. NAHAN: I understand the independence of the assessments. They can look at the same data in evidence and reports, which is understandable, and there is no need to duplicate it. Does the consulting practitioner have to go and see the patient, or go through a parallel process of assessing the patient?

Mr R.H. COOK: Yes.

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

Mr R.H. COOK: I move —

That amendment 20 made by the Council agreed to.

This amendment refers back to amendment 11, with regard to the coordinating and consulting practitioner relying upon other information from a registered health practitioner.

Dr D.J. HONEY: I wished to talk on this at amendment 11, but I will use this opportunity to raise the points I wanted to raise then. One of the matters that I debated at length during the second reading debate and in consideration in

Extracted from finalised Hansard
detail was the issue of undue influence. Undue influence has two parts to it in this case. The first one that is of concern is the greed of people who wish to get an inheritance early and put pressure on someone to go down this course of action. The other is observer stress. I think that is actually the more potent one. I have seen this firsthand recently. I will not say who the person is, but it is someone close to me who was in hospital, and it was the distress of the medical staff suggesting a course of action of perhaps someone terminating their life. That discussion was to the considerable distress of that person, who did not think that at all. The person involved had no intention of ending their life until it ended naturally, but the caring medical personnel in that establishment were concerned and distressed, and they were expressing that in ways that, as I said, were quite distressing to the patient.

One of the issues we have here is determining whether there is undue influence on a patient. In this clause, although other information can be obtained, there is no compulsion to do so. One of the concerns raised during the debate was that there is no requirement whatsoever for the person’s normal medical practitioner to have any involvement in this process, or to have any input or any report in this process. Although the coordinating and the consulting practitioner can get reports from the medical practitioner, there is no requirement for them to get that from the person they know, or other people who know the person. How do we determine that undue influence is occurring if these people do not know the patient? Equally, there is no requirement whatsoever for the consulting practitioner or the coordinating practitioner to be an expert in the illness that they are diagnosing. This amendment, which I think is a positive move, allows them to get reports from people who are experts and take that into account, but there is no requirement to do that.

I accept that this amendment confers an explicit ability, if you like—it may have been said that it existed before—to get that opinion. There is no requirement for the practitioners involved to have any knowledge of the patient; hence, it would be very difficult, I would contend, for them to understand whether there are family situations or otherwise that are unduly influencing this decision. Also, there is a risk of practitioners who are not experts in the condition making an expert assessment on the time of death. Pivotal to this legislation is the estimate of the time of death—six months in the case of a physical illness and 12 months in the case of a degenerative mental illness. Again, there is no requirement. The reason for raising this is to highlight that this is a positive step in that the practitioner can get that information, but I believe it is a shortcoming of this bill that there is no requirement for the practitioners to know the patient and, hence, at least understand whether there is undue influence. The other issue is that there is no requirement to have expertise in the area, and that could lead to a misdiagnosis.

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

Mr R.H. COOK: I move—

That amendment 21 made by the Council be agreed to.

This goes back to some of the earlier amendments moved by Hon Nick Goiran that we discussed. It is the fourth in a suite of amendments regarding the independence of a practitioner, by not being a family member or financially benefitting, materially or otherwise.

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

Mr R.H. COOK: I move—

That amendment 22 made by the Council be agreed to.

This is the second of a couple of amendments that the Leader of the Opposition, with the assistance of Hon Nick Goiran, moved regarding the patient being given forms. This is specifically about the consulting assessment form.

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

Mr R.H. COOK: I move—

That amendment 23 made by the Council be agreed to.

This is the second in a suite of amendments moved by Hon Nick Goiran, so that subsequent referrals made under clause 25 or 36 to another practitioner or other person, or a copy of those reports, will also be made available to the board.

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

Mr R.H. COOK: I move—

That amendment 24 made by the Council be agreed to.

This the third in a suite of amendments from Hon Adele Farina and Hon Nick Goiran regarding the use of interpreters.

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

Mr R.H. COOK: I move—

That amendment 25 made by the Council be agreed to.

This the second of a couple of government amendments regarding palliative care information being provided to the Voluntary Assisted Dying Board.

Extracted from finalised Hansard
Mrs A.K. HAYDEN: I just want some clarification. This amendment was moved by the government. Can the minister explain why it had to be put in?

Mr R.H. COOK: This was provided and we discussed this in some detail a short while ago. It goes to the information that is provided to the Voluntary Assisted Dying Board. The first time was under the coordinating practitioner’s assessment. This is under the consulting practitioner’s assessment. They both have to provide that information.

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

Mr R.H. COOK: I move —

That amendment 26 made by the Council be agreed to.

This the fourth in a suite of amendments regarding interpreters.

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

Mr R.H. COOK: I move —

That amendment 27 made by the Council be agreed to.

This amendment, moved by Hon Nick Goiran, is to prohibit the coordinating or consulting practitioner being the person who may sign the written declaration on behalf of the patient. This is an extra safeguard for a patient who has someone sign the written declaration on their behalf. They cannot be a coordinating or consulting practitioner; it must be a subsequent party.

Mrs A.K. HAYDEN: I just want to clarify. Does this relate back to another amendment?

Mr R.H. COOK: No, member. This is about the clause under which the patient makes a first and second request, and a written declaration. There may be circumstances in which the patient cannot sign their own name. In that case, under this legislation, they can have an assistant sign on their behalf. This is just an extra element that Hon Nick Goiran wanted in the bill—that that person cannot be the coordinating or consulting practitioner but must be a third party, or a fourth party in that particular instance.

Mrs A.K. HAYDEN: Is that part of the same changes—that the person is not a beneficiary of the will and so forth?

Mr R.H. COOK: No, not as such, but it will put that extra arm’s length into that process. Obviously, the written declaration is another point at which this person, at a single point in time, says they want to continue with the voluntary assisted dying process. It is just to make sure that that is a fresh declaration. I think the view was—although I was not listening to the debate at that particular point in time—that it would muddy the waters a bit if it was the coordinating or consulting practitioner. It just provides that extra clarity.

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

Mr R.H. COOK: I want to do something now that is a bit audacious and exciting. I would like to seek leave to move amendments 28 and 29 en bloc.

The SPEAKER: Is leave granted?

Mr Z.R.F. KIRKUP: Perhaps the minister could just explain amendments 28 and 29, to satisfy the house?

Mr R.H. COOK: With the house’s indulgence, this is another couple of amendments with regard to the amendments around the use of interpreters.

Mr R.H. COOK — by leave: I move —

That amendments 28 and 29 made by the Council be agreed to.

Mrs A.K. HAYDEN: If I could get the house’s indulgence, I am quickly trying to turn my pages to catch up in time, because we are moving so fast. Proposed clause 50(3)(da) states —

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

I want to confirm that that will all be provided and made clear, so that everyone is well aware of who the interpreter is. I am trying to turn to the page to find exactly where we are at in relation to amendments 28 and 29, because we are dealing with them together, and the words “if the patient was assisted”. I am trying to understand the difference between the two amendments, if the minister does not mind.

Mr R.H. COOK: This is to enshrine the inclusion of interpreters in relation to the coordinating practitioner’s notification to the board of the final request, and also the review by the coordinating practitioner of the final request, on pages 35 and 36. This is to enshrine the role of the interpreter in that process.

Mrs A.K. HAYDEN: Thank you very much. Was this a government amendment?

Mr R.H. COOK: This amendment was originally moved by Hon Adele Farina, and I think Hon Nick Goiran did some quick writing to sharpen it up a bit in terms of drafting.

Question put and passed; the Council’s amendments agreed to.
Mr R.H. COOK: I move —

That amendment 30 made by the Council be agreed to.

This is the final amendment in relation to Hon Nick Goiran’s amendment about the practitioner not being a family member or financial beneficiary. For members’ benefit, this goes to the eligibility of those who can be an administering practitioner and is a further enunciation of that principle.

Mrs A.K. HAYDEN: Am I right in saying that the primary amendment in relation to this is amendment 8?

Mr R.H. Cook: Correct.

Mrs A.K. HAYDEN: Excellent. I want to take this moment to highlight that —

Mr Z.R.F. Kirkup: I thought it was 12.

Mr R.H. Cook: The first was amendment 8, but I think amendment 12 was the larger part. I think the member is on the right number.

Mrs A.K. HAYDEN: It is amendment 8; thank you very much.

I want to highlight, I suppose, for Hansard and for people who will be listening to or reading this down the track and comparing it with the material that was in the public arena about how many amendments were put by the upper house, and that three amendments were needed to make this one amendment work. It highlights that three amendments are needed to make one change to the bill. I want to use this time right now to clear that up. Those who do not live and breathe our world in this place—lucky for them that they do not, and good luck to them—do not always understand the way we work through things. When people read in the media that hundreds of amendments were put by one side—or by one member or by a couple of people—they think they were delaying the debate. I want to highlight that right now we are about to pass amendment 30, which relates to two other amendments. This will happen throughout this entire process today. Although a couple of hundred amendments were listed, of the 55 that got through, there were a number of government amendments. When we boil it all down, probably a handful of real amendments will go through this place, not the hundreds of amendments. For example, amendment 15 reflected proposed amendments 15, 17, 24, 26, 28, 29, 32, 33 and 38 to make one change in this bill. For those who think it is a waste of time, putting all these amendments —

The SPEAKER: Member, are you talking about the clause?

Mrs A.K. HAYDEN: I am talking about amendment 30, which relates to two other amendments that are required. I thought I would take this time to make that note and thank the minister for putting through this amendment.

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

Mr R.H. COOK: At this stage, I would like to announce a swap of policy advisers, if I may.

THE SPEAKER: Certainly, minister.

Mr R.H. COOK: Amanda Bolleter will now be replaced by Lisa Furness.

The SPEAKER: You will still be staying, minister?

Mr R.H. COOK: My word. Thank you, Amanda, for all your assistance.

[Applause.]

Mr R.H. COOK: I move —

That amendment 31 made by the Council be agreed to.

This is a technical amendment not picked up by the thousands of eyes that scanned this document over the course of drafting, proving and legislating, and was clearly missed in this place—that is, in clause 55 by adding the word “dying” to “voluntary assisted” instead of “voluntary assisted substance”.

Mr P.A. KATSAMBARIS: Picking up on what the minister said, this is clearly simply a drafting error where a word disappeared—probably chewed up by the word processor! It highlights again what happens when we come into this place and say, “We’re simply not accepting any amendments”, which is what the government did when we debated the bill—even simple things. This adds the word “dying” after “voluntary assisted” so we get “voluntary assisted dying substance” in clause 55(2), rather than what is printed in the original bill, “voluntary assisted substance”. The term “voluntary assisted dying substance” is defined in clause 7 of the bill. In fact, the division that this clause is in—division 2 of part 4—is titled “Administration of voluntary assisted dying substance”. There is no definition of a “voluntary assisted substance”, and nor should there be. If this slipped through and was never picked up and became part of the legislation, I am sure it would not be a material issue in any proceedings of any sort, but it should have been amended right at the outset, simply for logic and consistency. However, because the government took the attitude that there would be no amendments, we have had to go through this tortuous process. It was clearly a drafting error. I would imagine that at some stage, as I said, the word was probably deleted by accident. Everyone supports this. Let us get it through.

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

Extracted from finalised Hansard
Mr R.H. COOK: I seek leave to consider amendments 32 and 33 en bloc. In seeking leave, I signal to the chamber that these are the third and second-last amendments with regard to interpreters, and go to the issues of revocation of administration decision and coordinating practitioner notification to the board of an administration decision and prescription of substance.

Mr R.H. COOK — by leave: I move —

That amendments 32 and 33 made by the Council be agreed to.

Dr M.D. NAHAN: I want to point out, further to the member for Darling Range’s point, that we have been dealing with 55 amendments. People were repeatedly told that those who were scrutinising the bill had unnecessarily put forward frivolous amendments. However, this amendment, relating to interpretation, actually led to eight amendments.

Mrs A.K. Hayden: Nine.

Dr M.D. NAHAN: There are nine amendments. A very large proportion of the 55 amendments actually deal with something that is absolutely vital; that is, when somebody has difficulty with English, it should be recorded whether that person has had access to an interpreter, which, as the minister pointed out, is standard practice in our health system. However, it was necessary to include it in the bill. It just shows that the number of amendments can be inflated, in that one change can lead to multiple changes in bills such as this. Again, these nine amendments were not frivolous.

Question put and passed; the Council’s amendments agreed to.

Mr R.H. COOK: I move —

That amendment 34 made by the Council be agreed to.

This amendment was put forward by Hon Adele Farina and then amended by the government for the purposes of drafting and scope. It essentially provides that the date, time and location of where the substance was administered, the date and time of patient’s death, the period of time between administration and death, and the details of any complications will be included.

Mr Z.R.F. KIRKUP: Minister, I will be very quick. We raised a number of times in this place the question of what information would be captured upon a patient’s death. I welcome the amendment moved by Hon Adele Farina in the other place to reflect the concerns that we had here; it is a prudent amendment. A lot of the information that should be collated would not necessarily have been reported. This amendment is eminently sensible. I think the minister said that these requirements could have been optionally captured in any case, but I think it is important that they are enshrined in the bill to make sure that these important issues, such as when and where a patient died and the like, are formally captured. I appreciate the government moving the amendment and agreeing to it in this place.

Mrs A.K. HAYDEN: I believe this amendment will also assist in addressing a few of the issues raised by many members in this place, including complications. We all do not want complications to occur, but unfortunately we do not know what the chemical will be, and obviously different people’s weight and reactions can be different. Council’s amendment 34 states, in part —

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

Will an actual process be in place if there are complications? Obviously if they have done it on their own, there will not be a witness, but if a family member or someone else is alongside the patient, is there a process for them to be able to report that complication? Can the minister explain that and how this amendment allows that?

Mr R.H. COOK: Member, obviously we anticipate that this sort of information will be captured. As the member for Dawesville said, we made a commitment that it will be captured. It is the sort of stuff that will be considered during the implementation phase. In the context of the debate in the other place, we thought if that will provide members with further confidence, we are happy to move in that direction. The member is quite right that any complications will be recorded. It is important in providing quality and safety.

Mrs A.K. HAYDEN: Can the minister outline how that will happen? I do not understand. If I have witnessed it, is there a form that I will fill in or will I go back to the coordinating practitioner? How is that information fed back?

Mr R.H. COOK: This is in the context of an administering practitioner. If it is self-administered, obviously there is no opportunity to capture the medical information. There may be opportunities for discussions if there are people witnessing it or a part of it. This relates specifically to the administering practitioner’s responsibilities.

Mrs A.K. HAYDEN: This is for administration only, if someone has taken it home. Quite a few people have told me that their wish is to pass away in their home, surrounded by loved ones. The minister said that he may be able to look into this down the track. Is the minister prepared to make a commitment today that he will look at avenues? If more people go home to die and there are complications, that will be quite a confronting thing for the family who are there. There needs to be a mechanism in place so that if a complication were to occur, there is support for
the family who has witnessed it, and we need to ensure that we get it right because we certainly would not want this to happen again. If there is a complication due to self-administration, that could easily be fixed if the minister and the board were aware of it. As much as I think it is important that we are protecting those who are being administered the substance in hospital or within a medical environment, I really think we need to ensure that the people who are self-administering at home are safeguarded and protected, and being followed up on. The least we could do is make sure that there is support for family members who witness any complications. Will the minister make a commitment that that is something he will look into? We are not moving amendments, but could the minister look into making a commitment that that will happen?

Mr R.H. COOK: Absolutely. I do not want to give the member the impression that these things would happen in isolation, without discussions and consultations, both with the family doctor and other people involved in the care of someone who is obviously at the end of a period of palliation. Those conversations would go on. I will absolutely make sure that part of the implementation phase is that we capture that sort of information, albeit that it would not be medical information. It may not be relied on in terms of time of death and so forth because they are laypeople—that is, not professionals in that field. That is the sort of information I would expect. I am certainly happy to make that commitment.

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

Mr R.H. COOK: I move —

That amendment 35 made by the Council be agreed to.

This amendment was moved by Hon Nick Goiran. It relates to the clause titled “Witness to administration of prescribed substance”. The witness to the administration of the prescribed substance to a patient must certify in the practitioner administration form for the patient that the patient’s request for access to voluntary assisted dying appeared to be—we originally had “enduring”. Hon Nick Goiran sought to include the reference “free, voluntary and enduring”, and we were happy to agree with that. It is consistent with the original clause; it just takes it that little extra step further. It enjoys the government’s support.

Mr P.A. KATSAMBANIS: This is an important amendment. Again, it is small, but it makes the roles of witnesses at various stages of this process equal. Clause 43(3) states that the witness needs to certify—to declare—that the patient appeared to freely and voluntarily sign the declaration. Similarly, the witness to the administration of the prescribed substance previously had to certify only that the person’s request appeared to be enduring. However, adding that it has to be free and voluntary makes the witnesses’ roles equal and analogous in the entire process outlined in the bill. It is also extraordinarily important because, at the end of the day, the policy intention of the legislation is that the patient freely and voluntarily enters into this decision, so there is absolutely no harm in a witness certifying that that was the case.

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

Mr R.H. COOK: I move —

That amendment 36 made by the Council be agreed to.

This is in the context of transferring the administering practitioner’s role if the original practitioner is unwilling to administer. The original text of the bill was that the original practitioner is “unable for any reason”. Hon Nick Goiran moved that we insert the words “or unwilling” after “unable”. Although we believed that “unable” captured the issue of a practitioner’s willingness, we thought that it provided extra clarity, so the government supported this amendment. This will capture circumstances in which the practitioner is no longer willing to participate in the voluntary assisted dying process. This may be because the practitioner may themselves have had a change in circumstances, such as that they no longer want to participate. This amendment is not intended to enable the medical practitioner to simply elect to take on a request for an administering role on the premise that they may then transfer the administering role to another medical or nurse practitioner. Practitioners who are unwilling to undertake the administering role when a first request is made to them should decline participation in the voluntary assisted dying process. In the context that they do not feel they could or are unable to go through the whole process, they should excuse themselves at that point. This amendment will provide an opportunity for them to do that at the final stage.

Dr D.J. HONEY: I think it is a very important addition to this bill. It is critical that at every stage there is no sense in anyone’s mind that there is a compunction on the patient to go ahead with the process, and that has been made clear, but it is, of course, also on the part of the practitioners. Anything that could be seen to be an implied barrier to that would be undesirable, so I very much support the adoption of this amendment. One could say it is a small point of interpretation, but I think it makes it very, very clear that this will be a voluntary process throughout.

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

Mr R.H. COOK: I move —

That amendment 37 made by the Council be agreed to.

Extracted from finalised Hansard
This amendment was put forward by Hon Nick Goiran and goes to the responsibilities of a contact person. The point that was being made was that explicit information should be provided to the contact person about the penalties involved if they do not return any unused or remaining prescribed substance to an authorised disposer. It just makes explicit the penalties associated with their role.

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

Mr R.H. COOK: I move —

That amendment 38 made by the Council be agreed to.

This is the final amendment in relation to the role of interpreters. It goes to the issue in clause 65, “Contact person appointment form”, and includes the same form of words that has been used in the previous amendments.

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

Mr R.H. COOK: I move —

That amendment 39 made by the Council be agreed to.

This amendment provides for the requirement that the person completing the contact person appointment form on behalf of the patient is doing so at the request of the patient and is over 18 years old. This amendment, proposed by Hon Nick Goiran, includes the requirement that a person completing the contact person form must explicitly state that they are doing so on behalf of the patient and also that they are over the age of 18 years.

Mr P.A. KATSAMBANIS: I make the point that this is clearly a regime that is intended for adults only, and this amendment clarifies it. Again, sometimes with these things, we can sit back and think that it is self-evident, but history tells us that what might be self-evident to me, the minister or even the man on the Clapham omnibus, if I go back to my old law school days, may not necessarily be considered to be self-evident by all sections of the community or even by the law itself. Clarifying it is important. It points out again that this is a regime for adults by adults, and that the only people involved in this process will be over the age of 18 years.

Mrs A.K. HAYDEN: Again, unfortunately, I cannot let this one go. This is why we have a bicameral system. This is why we have an upper house. The democratic process needs to take place when we find errors such as this in legislation. It would have been embarrassing for the government if someone under the age of 18 years had been able to sign off on this form. It would have been embarrassing for this state if this bill had passed without this amendment. I am sorry, but I had to stand up; and, if the minister were on this side, he would have done exactly the same thing.

This amendment to ensure that no-one under the age of 18 years is able to sign off is vitally important. I congratulate Hon Nick Goiran for identifying it, the other place for accepting it and the minister for taking it on board.

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

Mr R.H. COOK — by leave: I am going to test the chamber now. Here we go! Amendments 40 to 44 all apply to clause 68, so we can have a big discussion about clause 68. I move —

That amendments 40 to 44 made by the Council be agreed to.

This is a suite of amendments to enshrine in the legislation that particular information pertaining to the voluntary assisted dying substance and the likely effects of the administration of that substance is provided in writing to the patient by the coordinating practitioner prior to the substance being prescribed. These amendments put forward by Hon Adele Farina essentially allow for information regarding the substance to be provided to the patient—for example, the method by which the substance will be self-administered, the expected side effects, the period within which the patient is likely to die from the substance, and the potential risks with the substance, as well as the responsibilities of the coordinating practitioner in prescribing the substance. It goes without saying that it is good clinical practice to provide all this information as part of the prescription process. When people go to a doctor, the doctor says, “I’m going to prescribe you with this; this is what it will do to you, this is how often you should take it, this is how long you should take it for, and these are the likely side effects”, and that is part of the prescribing process. Hon Adele Farina wanted these elements to be made explicit in the legislation, and given that this is what we would expect as part of good clinical practice anyway, the government is very relaxed about accepting these amendments. Members will see that they run throughout clause 68. There is a bit of repetition, because there will be patients who self-administer and other patients for whom the practitioner will administer the substance. Clause 68(2) is about self-administration and clause 68(3) is about practitioner administration.

Dr D.J. HONEY: Could the minister explain the reason for the wording that is repeated with regard to schedule 4 and schedule 8 poisons, and the meanings given under the Medicines and Poisons Act? What was the argument or debate behind having to include that specific definition?

Mr R.H. COOK: The member will remember that when we debated the bill in this place, we talked at length about the role of the Medicines and Poisons Act in the legislation. This is, I guess, another element of explicitly stating what

*Extracted from finalised Hansard*
poisons would be used. As we said during that debate, it will be schedule 4 and schedule 8 drugs, or combinations thereof. It was considered appropriate to reference them in the context of the Medicines and Poisons Act to provide clarity around the definitions.

Dr D.J. HONEY: Just to clarify, is the minister saying that it is to make sure that we keep the types of substances that are used within quite a tight range, if you like, and that this cannot be expanded into a broad, experimental range of substances?

Mr R.H. COOK: Spot on, member, yes.

Mr Z.R.F. KIRKUP: I am curious about what will become clause 68(2)(aa), which provides for the schedule 4 poison or the schedule 8 poison, or a combination of those poisons, constituting the substance. The patient must be informed of that in writing. There is obviously a range of penalties in place for any person who publicly discloses what those schedule 4 or schedule 8 poisons might be. I assume they might also apply to the patient, up to the time at which they administer the substance. What is the intent of providing that information to them? I realise that it is out there, online, and that it is relatively accessible, but we asked this question a number of times during debate and there was quite a lot of pushback. The minister will appreciate that I support the bill, but there was quite a lot of pushback on making sure that that information would not be made public. I am curious about why there was a determination to include this. I realise there is a desire to inform the patient what they will be administering, taking orally, as there is with any other prescription, but of course this is something unique. Is it going to be provided with broad information, without the dosage amounts? What does that mean? Of course, there is a risk that revealing the combination of poisons could lead to people copying that in some way, shape or form. They might have X amount of the drug in their medicine cabinet at home and all they would need to do is take enough of it and they would go through the same thing. I am curious to understand this. We obviously have tried to contain this as much as possible—there is a very clear process of containment—yet it now seems as though this is going beyond that.

Mr R.H. COOK: Ultimately, the patient will have the right to know what the voluntary assisted dying substance is and how it is constituted in their particular case. In the scheme of things there is still an obligation on the patient to not disclose that to members of the public and there is an obligation on the contact person to safeguard the substances, as such. This is simply an expression of the right of the patient to know exactly what the substance they will be taking is. I accept the point the member has made. He is right: we did make a bit of noise about making sure that the information loop is kept fairly tight because we do not want this information to become widely known and, as the member equally observed, the internet can provide us with all manner of information nowadays, but this will formalise the right of the patient.

Mr Z.R.F. KIRKUP: I appreciate the minister’s response. Does he anticipate that the patient will be provided with only the generic name of the poison rather than the dosage or something like that? Is that what we will see here? Will it specifically have the dosage? I appreciate that anything that we take can be lethal in a high enough dose, but will the information be very bland or will it say specifically, “You’re a 68-kilogram male. This is what you will be taking; this is the dosage”? That is very specific information. Or will the patient be given, broadly, the poison’s name and it will be left at that? Does the minister have any insight at this time how detailed that information will be?

While we are on that, the minister referred to clauses 68(2)(g) and 68(2)(h)—the expected side effects of self-administering the substance, the period within which the patient is likely to die, and also paragraph (i), the potential risks of self-administration. I assume all that will be provided in writing, as well as the expected “period within which the patient is likely to die”. This is relatively untested ground in the Western Australian jurisdiction. How will the period within which someone might die be established? I realise there are international studies and anecdotal evidence, but part of this amendment is asking for a lot of certainty, and I am curious how that will be established in Western Australia.

Mr R.H. COOK: Ultimately, the information on the poisons and the way that the substances will be used will be determined by the clinical panel as part of the implementation period. Considering that we have not undertaken this process before, we will know by looking to the clinical evidence that informs the particular drug. Obviously, we will also be looking at the information that is provided by the manufacturer. That evidence will be there. We will not be able to point to a specific period of time, but we will be able to say that within a period of time the patient will feel this or that, and there is an expectation that this will happen. That stuff, ultimately, will be determined by the clinical panel during the implementation phase.

Going back to the member’s point about the specificity of information, it essentially will be simple information so that the patient is informed about what they will be getting; it will not be the full recipe and so on.

Mr Z.R.F. KIRKUP: Mr Speaker.

The SPEAKER: Member for—I have had a blank!—Dawesville. How could I forget the best looking man in the house—so you have told us!

Mr Z.R.F. KIRKUP: Thank you very much, Mr Speaker.

Several members interjected.

Extracted from finalised Hansard
The SPEAKER: You missed the last bit. I said as he has told us.

Mr Z.R.F. KIRKUP: I appreciate that it has been a long year, Mr Speaker.

Mr R.H. Cook: He has become very fond of you in that time!

Mr Z.R.F. KIRKUP: Indeed!

Minister, for what it is worth, I feel the least level of comfort about this amendment when it comes to revealing the identification of the schedule 4 and schedule 8 poison. The government has put in place very severe and heavy penalties if any information like that is revealed. A lot of safeguards have been put in place to effectively say, “We’re not going to tell you this, but this is what you’re taking.” I appreciate that a patient has to be informed of what they will be self-administering—I totally understand that—but I very much worry that the patient will be provided with a detailed breakdown. I am not comfortable with that at all. The level of information provided should not go beyond, “You’re going to be taking this particular poison.” I appreciate the intent of the government’s other amendments, but I place my concern on the record that I do not necessarily like the idea of the dosages being included.

Mrs A.K. HAYDEN: I disagree with my colleague. We debated this issue quite a bit; I think it was quite early in the morning. My main issue is that we did not know what the substance would be and how it would be self-administered. I am delighted to see this amendment. I congratulate Hon Adele Farina on getting this amendment through. Given that information will now be given in a document about the effects of self-administration, the potential risks of self-administration and the substance that will be used, is the minister any closer to knowing what the substance will be, and will that information be brought back to Parliament so that we, as legislators, can understand how it will be self-administered, what the poison will be and the potential risks and side effects? We asked about this issue quite a lot during the debate but we were told that it had not been decided and that it was not for us to know. It sounds as though the minister is a bit closer to knowing what that will be.

Mr R.H. COOK: The answer to that question is no, we will not provide information to Parliament about what the substances are, potential side effects and things of that nature. The substance will vary from patient to patient and will depend on the medical protocols in place for the particular patient at the time. This will be part of the implementation phase and will be oversighted by the clinical panel in a very careful manner. It is not for Parliament to delve into these matters. Obviously, some important information will be provided to the patient because it is the patient who will experience the substance. Important information will be provided to Parliament via the annual report of the Voluntary Assisted Dying Board, which will provide good insight into the way the system is working, how it is being administered and the other elements that go with that. But we will not be providing the information that the member just outlined.

Mrs A.K. HAYDEN: My second question was: is the minister any closer to knowing what substance will be used and how it will be administered?

Mr R.H. COOK: That will be part of the implementation phase. I will not be seeking that information. That will be the responsibility of the Department of Health. I am not a doctor so I would not be able to tell the member whether a substance was good anyway. We will leave it up to the experts. They have provided us with a world-class health system and I am sure they will continue to do so.

Mrs A.K. HAYDEN: Just one last question. I am not trying to be difficult, it is just that we debated this at length. The minister is saying that the other patient will be able to get that information. At what stage would they be provided that information—at the beginning or in a certain time frame? Once they seek advice and they want to go down that path, when are they provided with the information?

Mr R.H. COOK: Clause 68(2) says —

The coordinating practitioner for a patient who has made a self-administration decision must, before prescribing a voluntary assisted dying substance for the patient, inform the patient, in writing, of the following —

That is the point at which they would undertake that. It is the same then for the coordinating practitioner in the case of an administration decision.

Question put and passed; the Council’s amendments agreed to.

Mr R.H. COOK: I move —

That amendment 45 made by the Council be agreed to.

This amendment corrects a technical error in the bill and regards who is obliged to return any unused substance. It removes the words “patient to whom it is supplied or their contact person” and substitutes the words “contact person for the patient to whom it is supplied”.

Mr P.A. KATSAMBANIS: I seek some clarification from the minister about why this amendment is necessary. I note it was moved by the government but I do not know its genesis. On first reading, the amendment seems sensible because this is about labelling requirements and what is done with any unused or remaining substance after it has been given to a person. The label must say that the substance must be given to an authorised disposer by the patient.

Extracted from finalised Hansard
Mr R.H. COOK: I thank the member. I think it is an appropriate question to ask. As currently drafted, the subclause requires that, amongst other things, the label or statement—that is, what is included on the label—attached to the container of the prescribed substance must state that any unused or remaining substance must be given to an authorised disposer by the patient or a contact person. However, only the contact person is obliged under the legislation to return the substance to an authorised disposer and faces a penalty for failing to do so. Although a patient may also return the substance, they are not obliged to do so under this legislation, nor do they face penalties for failure to return it. In most circumstances it is unlikely that the patient will be in any physical condition to return the substance if unused, but this explains why it would have been explicit in this context.

Mr P.A. KATSAMBANIS: That is a good explanation. It reinforces the important role that a contact person plays in this regime and, as the minister pointed out and as we will discuss in some subsequent amendments, the penalties that would apply to the contact person if they did not follow the legislation. I thank the minister for clarifying that.

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

Mr R.H. COOK: Amendment 46 relates to information relating to medical practitioners and, in some respects, it concerns four amendments.

Mr P.A. Katsambanis: Do you want to do 46 to 49?

Mr R.H. COOK: I move —

That amendments 46 to 49 made by the Council be agreed to.

They all relate to the role of the administrative tribunal and the naming of practitioners.

This was a range of amendments moved by Hon Nick Goiran. Amendments 46 and 48 ensure that personal information on a former coordinating or consulting practitioner who is not a party to a State Administrative Tribunal hearing is not made public. Amendments 47 and 49 ensure that personal information on an administering practitioner who was transferred into the role is not made public. Obviously, it is a requirement under the bill for the State Administrative Tribunal to provide reasons for its decision. This is about explicitly stating that the reasons for its decision removes information that would expose or provide the identity of the former coordinating or consulting practitioner or a person to whom the role of administering practitioner is transferred under section 62(2). These are fairly technical amendments and it is not surprising that a member like Hon Nick Goiran, who has much experience in this, moved these amendments, and it is even less surprising that the member for Hillarys with his experience is nodding furiously to these amendments.

Mr P.A. KATSAMBANIS: I think they are logical and sensible amendments. I commend Hon Nick Goiran for moving them. It again highlights what good scrutiny brings to legislation. The provisions that are being amended concern what parts of decisions made by the State Administrative Tribunal can be published, and there is a presumption of anonymity of all the parties involved in the publication of those decisions. It is a bit like cases in the Family Court and Children’s Court and some other protected matters that happen in our courts. We want the State Administrative Tribunal to publish the flavour of the debate or the argument for the sake of precedent and informing the public without naming the participants, because they are irrelevant to the public discourse. It gives them that protection. The original clause failed because it did not take into account the fact that all these roles, the coordinating practitioner and the administering practitioner and the like, can be transferred during the process either because of death, incapacity or unwillingness, as we have added. Those former practitioners who transferred out of the role could inadvertently have been named simply because they were not one of the parties listed as specifically protected by the cloak of anonymity. That has been fixed up here. I think it is worthwhile and it is another exercise in good scrutiny between the two houses.

Question put and passed; the Council’s amendments agreed to.

The SPEAKER: Before we move on to the next amendment, I wish to advise members that I have approved the presence of media to take photographs and footage of the Legislative Assembly concluding with the Voluntary Assisted Dying Bill 2019.

Mr R.H. COOK: I move —

That amendment 50 made by the Council be agreed to.

This government amendment removes the penalty of $10 000 for a medical practitioner who fails to report a first request to the board. This amendment was inserted after extensive discussions with medical practitioners.
would be aware that not all doctors are alike. There are interns, junior doctors and some very experienced doctors. It was considered unfortunate that a junior doctor, who might be fresh to the scene, may be confronted with an initial request and have to discharge their duties as a doctor—a fully-fledged doctor, but nevertheless a doctor with little experience—and inform the Voluntary Assisted Dying Board. In actuality, that junior doctor would probably liaise with more senior doctors or consider the patient as part of a team, and, ultimately, that initial request would be notified to the Voluntary Assisted Dying Board, but it would be more likely to be by a senior doctor. We considered this very carefully and wanted to be able to capture that scenario. It was very difficult to identify and chop up the doctors depending on different levels of skill and experience. We thought it more appropriate to make sure that there was simply an obligation under the act that the doctor notify the board of the first request, but there not be a penalty. Amendment 50 removes the penalty of $10 000 for a medical practitioner who fails to report a first request to the board.

Ms M.M. Quirk: My question is about the table. It is an administrative thing because of various other insertions having to change the section numbers; is that correct?

Mr R.H. Cook: Yes. My understanding is that the amendment is—

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

s. 21(1)

Dr D.J. Honey: Just to be clear, I appreciate that this will remove the fine of $10 000 if the form is not submitted within 48 hours. I thought that was an especially egregious part of the bill. Will the medical practitioner still potentially be subject to a charge of professional misconduct and unprofessional conduct if they do not submit the form?

Mr R.H. Cook: That is correct.

Dr D.J. Honey: In the time, I should say.

Mr R.H. Cook: The practitioner can still be held accountable by clause 10 of the bill. Contravention of the act is still capable of constituting professional misconduct or unprofessional conduct.

Mrs A.K. Hayden: I want to again congratulate the minister on making another amendment to this perfect piece of legislation. The last thing we want to do is get our medical providers caught up in unnecessary consequences that were not intended. It is good to see the removal of the $10 000 fine. I think the minister’s consultation with the Australian Medical Association was one of the main drivers behind this, so it will be very happy with this amendment.

Mr R.H. Cook: I thank the member. That is the case. This clause was amended following concern from medical practitioners that doctors who are otherwise ineligible to participate, or inexperienced doctors such as junior doctors, would inadvertently fail to lodge a first request form. It simply clarifies that.

Mr P.A. Katsambanis: For the same reasons outlined by the member for Darling Range, I fully support what this amendment does in substance. I think it is a good outcome. We had the debate a moment ago about Hon Nick Goiran, myself and others in this place who are legal practitioners. This is not a criticism of the minister, but when we draft legislation that we expect members of the public, who are not legal practitioners, to use and that will apply to the general public, I think the current form of legislative drafting, which is exemplified in clause 107, is a real failure. Originally, 18 provisions, including 21(1) and 32(1), were included as penalty clauses. It will now be 17 because 21(1) is being taken out. When we read those clauses on their own, they create obligations, but there is absolutely no indication that there is a penalty attached to those obligations. Some of these penalties apply to good Samaritans, just members of the public, in relation to being contact persons for returning unused substances and the like. This is not a criticism of the minister or the people who drafted this specific bill, but to expect a member of the public, who is not a legal practitioner and may never have read a piece of legislation before, to then check to see whether there is a table, or a section including a table, at the back of the legislation, is really poor. It would have been very simple, in each of these clauses, to add a subclause at the bottom stating that a person who contravenes this provision commits an offence with a penalty of a fine of $10 000. It just would have been better. As I said, I am not going to labour the point. It happens in a lot of pieces of legislation, but this one is really important, and we do not want people to be caught out unnecessarily, not understanding the gravity of the penalty for contravening an obligation that is placed upon them by this bill.

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

Mr R.H. Cook: I move—

That amendment 51 made by the Council be agreed to.

This is a government amendment to specifically address concerns that a doctor should not be protected from civil or criminal liability when they act negligently—that is, without reasonable care and skill. The existing clause implicitly provided that negligent conduct would not be protected, but this amendment makes it explicit in the bill.

Mr Z.R.F. Kirkup: I am assuming that this amendment was suggested by the Australian Medical Association, in consultation with the government.

Mr R.H. Cook: Yes, it was explicitly raised by the AMA, and on its request we included these words.
Mr P.A. KATSAMBANIS: Just for completeness, I point out that although this amendment was sought by the AMA and the minister listened and has included it, the clause that has been amended applies to all persons under this bill, not just doctors. It goes without saying, but it is good to put on the record, that the standard to which each individual will be judged as having exercised reasonable care and skill would be commensurate with their profession and their professional obligations, so if it is an individual who is simply going to be the contact person—the example used in the previous clause—to return the remaining substance, they would not be held to the same standard of reasonable care and skill as a doctor would be. All professionals, including doctors but also extending to nurse practitioners and the like, would also be subject to professional misconduct rules et cetera. This is a good provision. It was requested by the AMA, but it will apply to a broader range of people than just doctors.

Mr R.H. COOK: That is correct. A number of provisions of the Criminal Code make something unlawful unless it is done in good faith and with reasonable care and skill, or exempt a person from criminal liability if they do something with reasonable care and skill. As such, the proposed amendment reflects the language used in other WA legislation.

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

Mr R.H. COOK: I move —

That amendment 52 made by the Council be agreed to.

Members will recall from earlier in today’s discussions that a range of amendments were proposed by Hon Martin Aldridge about the impact of voluntary assisted dying on regional patients and their ability to access voluntary assisted dying. Amendments 52 and 54 are two of the amendments he moved. They form a suite of amendments to address regional residents. It has always been the intent of the government that the Voluntary Assisted Dying Board collect comprehensive statistics on voluntary assisted dying, including statistics pertaining to access to voluntary assisted dying by residents from regional, remote and metropolitan areas. The amendment to clauses 151(1) and 154(2) enshrined this intent. This will assist the interpretation of the bill when specific reference will be made to regional residents such as regarding collection of data by the Voluntary Assisted Dying Board.

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

Mr R.H. COOK: I move —

That amendment 53 made by the Council be agreed to.

All the amendments to clause 154 go to the issue of the content of the annual report of the Voluntary Assisted Dying Board. Obviously, we pulled up a list of issues that must be on there. We never saw it as an exhaustive list, but again, members of the other place sought extra information to be included in it as part of providing them with the confidence to support the legislation. Amendment 53 was moved by Hon Nick Goiran to require the board to include the number of referrals it makes under clause 117(c) in the annual report. For members’ information, clause 117(c) goes to those issues that are referred by the Voluntary Assisted Dying Board to either the office of the Commissioner of Police, the Registrar of Births, Deaths and Marriages, the State Coroner, the CEO, the chief executive officer of the department of the public service principally assisting in the administration of the Prisons Act 1981, the Australian Health Practitioner Regulation Agency, or the director of Health and Disability Services Complaints Office. To underscore that point, this is about making sure the Voluntary Assisted Dying Board reports on those instances it feels compelled to refer matters to another authority for further investigation or inquiry. Hon Nick Goiran wanted that explicitly stated; we were happy to comply.

Mr Z.R.F. KIRKUP: I assume that as part of the annual report process, there would be a breakdown of the referrals made. Would that be right? If not, would the minister make an attempt for that to be the case, with a breakdown of matters referred to police, HADSCO and the like?

Mr R.H. COOK: It is fair to say that we are not going to be talking about a large chunk of instances each year. Ultimately, it would be essentially qualitative advice that will not come in a table form: “20 this, 50 that”. It would be information that would explicitly state the actions that the board took on those referrals.

Mr Z.R.F. KIRKUP: Just to clarify, I appreciate that the number would be relatively small, but we would hope it was not a number. I imagine it would still have to say specifically, “X number was referred to police, X number to the coroner and the like.” Is that the minister’s expectation about what would be represented in the annual report?

Mr R.H. COOK: That is correct.

Mrs A.K. HAYDEN: I am sure the minister is not surprised that I cannot let this one go to the keeper.

Several members interjected.

Mrs A.K. HAYDEN: We were doing so well until you all heard the cameras were in here, and then you came in. Where have you been all day?

Several members interjected.

Extracted from finalised Hansard
The SPEAKER: Members! Can you talk to the clause please and cut the rest of the stuff out.

Ms S. Winton interjected.

The SPEAKER: Member, we got this far. A lot of you were not here for the whole lot, so let us just finish it off as quickly as possible.

Mrs A.K. HAYDEN: Thank you, Mr Speaker. As we said at the beginning, and at a few other amendments, this was debated at length for quite some time during our time debating it in this chamber when we were forced to sit until 5.30 in the morning.

Several members interjected.

The SPEAKER: Members!

Mr P. Papalia: You’re embarrassing yourself.

Mrs A.K. HAYDEN: Are you saying I am embarrassing myself?

The SPEAKER: Member, if you do not talk to the clause, I will sit you down.

Mrs A.K. HAYDEN: Thank you, Mr Speaker. I will seek your protection, but I will be heard in silence, like everyone else has been during this debate.

The SPEAKER: Yes. Could you just get onto the clause, and I will protect you.

Mrs A.K. HAYDEN: As we have raised a few times, this was debated at length, yet the minister and the government sat there and said that they would not even entertain this amendment. I would like to know what debate turned the government in the other house to bring on this amendment. As we have been talking about, this is a life-and-death bill. We did ask that if any referrals to the board went off to another authority, they would be reported on. It would be greatly appreciated if the minister was able to say what caused him to change his mind. We are pleased that the amendment is here, because we need nothing but transparency in this legislation. This legislation is not a joke. It is to be taken seriously, and that is what we have tried to do through this whole process. I am delighted to see this amendment. But, again, like with so many other amendments, we had an opportunity to do that when we debated the bill in this chamber, but we did not, and we are now back here again today, having been called back after Parliament last sat and after the government removed a week of the parliamentary sitting because we had nothing to do.

Mr R.H. COOK: This issue was not raised in the Legislative Assembly. This issue was raised solely in the Legislative Council and goes to the —

Several members interjected.

Mr R.H. COOK: Members, please! It was about the number of referrals made by the board. We did have an extensive discussion in this place about the powers of the board to undertake an inquiry, during which we clarified that it basically had referral powers, but this particular amendment was not raised. It was raised by Hon Nick Goiran. We are happy to support it. As I said repeatedly during the debate in this place, this is not a list that constrains the board. The board can report on whatever it feels necessary under this bill. In the context of wanting to see the bill receive the support of those in the other place, we were happy to endorse the amendment, because, as I said on a number of occasions, it explicitly states what we said we believe was implicit.

Mrs L.M. HARVEY: I would like to put on the record that I think this is a very good amendment. It goes to providing better accountability of the operation of the legislation. That will certainly put my mind and other members’ minds at ease on the management of the legislation and the potential problems with the legislation, or problems with people potentially accessing voluntary assisted dying in an inappropriate way. I commend the minister for including this in the legislation. Better accountability is what we are all about. Indeed, that is the advantage of having a Legislative Council that is able to do its job appropriately, interrogate the legislation and make sure protections are in place for vulnerable people, which is what we were all about at the outset.

Mr P.A. KATSAMBANIS: I am really glad the minister supports this amendment, because it was moved in this place. It is interesting that when it was debated and voted on in the other place, it was passed by 18 votes to 17, and the government members voted against it. I am glad it was agreed to in the other place, and that with the message that has come here, the minister has seen fit to agree to this small, but important, amendment that will add to the quality of the statistics that will be provided on an annual basis to not just the minister but also the Parliament. Remember, the Parliament is the chief accountability mechanism of the public of Western Australia in holding the executive and the bureaucracy to account, especially in this sort of bill, which deals with the most vulnerable people at the most difficult time of their lives. The more transparency we have and the more statistics we have available, the better. I thank the minister for agreeing to that amendment. That will stop us, of course, from having to continue to bounce messages from this place to the other place. I am sure that will make the Premier happy as well, because we will meet his deadline 15 days early.

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

Extracted from finalised Hansard
Mr R.H. COOK: I will move —

That amendment 54 be agreed —

An opposition member: Go on, move both of them.

Mr R.H. COOK: No; I cannot; they are different. Well, we possibly could.

Several members interjected.

The SPEAKER: Members; we are doing amendment 54.

Mr R.H. COOK: — by leave: I move —

That amendments 54 and 55 made by the Council be agreed to.

The final amendments go to the work of Hon Martin Aldridge in wanting to make sure that regional residents have access to voluntary assisted dying. In particular, he moved two amendments, one of which was the extent to which regional residents who have access to voluntary assisted dying is included in the statistical information provided by the Voluntary Assisted Dying Board’s annual report. That is to be pursuant to new clause 154A, also moved by Hon Martin Aldridge, which goes to denoting an access standard. Essentially, the chief executive officer will have a responsibility to set an access standard, setting out how the state intends to facilitate access to voluntary assisted dying for persons ordinarily resident in Western Australia, including how the state intends to facilitate those persons’ access to the services of medical practitioners and other persons and prescribed substances and information about accessing voluntary assisted dying. The access standard must specifically set out how the state intends to facilitate access to voluntary assisted dying for regional residents. The chief executive officer may modify or replace the standard. The chief executive officer must publish the access standard on the department’s website. Members will understand what Hon Martin Aldridge is trying to achieve with these two amendments. One requires that the chief executive officer state how he will make voluntary assisted dying available to all Western Australians, particularly regional Western Australians, and to make sure the Voluntary Assisted Dying Board provides information by way of its annual report about how that access standard has been brought to bear. From that perspective, I think these are well considered words and from that point of view, the government was very happy to support them.

Are there any other speakers on this?

Ms M.J. DAVIES: Yes. As the minister has indicated, this was part of the work Hon Martin Aldridge undertook. I will put on record my thanks to the minister and his staff for going through the process with the member. We started from a slightly different point, and I think this is a demonstration of us working through some of the concerns that the member had, particularly from the Nationals WA’s perspective around capturing information on regional access and making it very clear to those who are seeking to access voluntary assisted dying that there would be a clear published pathway and it would be measured by the board and part of the statistics that are collected.

From our perspective, the amendment does not restrict or prescribe the form that the standard has to take. There was not an appetite for a prescription for how that might be done within the legislation. However, it must be set out as part of the standard. Although there is no penalty for not meeting the standard, it seeks to establish what might be expected of the government as the provider of last resort when we are assuming that in regional areas there will be some challenges in accessing the service.

We thank the minister for taking the honourable member’s concerns on board. I understand that during the debate in the other house and in writing to Hon Martin Aldridge, the Minister for Health confirmed it was his intention to direct the Department of Health to establish a charter of patients’ rights to illustrate what all Western Australians can expect as part of this legislation and how to access it and the accessibility.

Mr R.H. COOK: Yes, member, that is right.

Mr D.T. REDMAN: This is the only amendment that I have spoken on today, but I think it is a reasonably important one. To start, I want to put on the record my general support for the bill, which I have supported right the way through. In my second reading contribution, I talked about the importance of palliative care, as many members here have done so, and as it applies to regional Western Australia’s access to voluntary assisted dying. The point that I made at the time was that as we go out to the far reaches of regional Western Australia—I point to the east of Halls Creek, for example—services deplete. That is just the reality and the nature of our geography in Western Australia. The reality is that it is almost impossible to prescribe or define the services that we can get to those people, and put it down in writing. Hon Martin Aldridge put clauses in the bill that will allow a level of public scrutiny of the statistics about regional access to these services and that lay out a defined standard that is open and published. I think that has been a really good step, although it would not have been a show stopper for me. The bill would have had my support, but I pay tribute to Hon Martin Aldridge for what he has achieved in trying to have something that gives members of the public an opportunity to look at what is happening and, if necessary, through their elected politicians, to change it or have some influence on it.

Extracted from finalised Hansard
I would also like to congratulate the Minister for Health for the carriage of this bill. This bill is the most significant bit of legislation that I have dealt with in 15 years as a member of Parliament. Today is a massively significant day. I think the way that everyone has dealt with it, in both this place and the other place, has been outstanding.

[Interruption from the gallery.]

The SPEAKER: People in the gallery—we love having you here, but you are not allowed to be part of the show.

Ms M.M. QUIRK: Minister, I know the natives are restless, so I will be very brief. It is consistent with what we have said all along—that in the framework of this bill the CEO has too much discretion. A lot of this stuff should have been prescribed, as it was in the Victorian legislation. This New clause 154A is yet another example of this. As much as members of the Nationals WA might like to congratulate themselves, they have delivered absolutely nothing additional for their constituents, because, as the minister conceded earlier today, the statement about everyone in Western Australia having access to voluntary assisted dying was a statement of principle and unenforceable. I make the point that the Law Society of Western Australia—unfortunately, very belatedly—issued a number of concerns about the bill. One concern was that the making of guidelines should be subject to being tabled in Parliament and in the case of regulations be subject to a disallowance motion. This access standard does not have that status. It is not a disallowable instrument. The idea of publishing something on the website and not tabling it in Parliament is also anathema to me.

Before I sit down, I commend the minister’s very professional, diligent and hardworking staff who have had to bear the brunt of numerous requests on numerous issues from all of us. I thank them for their efforts and wish them a restful festive season.

Members: Hear, hear!

Mr R.H. COOK: Before we conclude the discussion around amendment 55, I would like to take the opportunity to make some further remarks, if I may. We are at the end of a very long process—a momentous moment for the Western Australian Parliament and, indeed, the Western Australian public. To paraphrase Otto von Bismarck, “If you like laws and sausages, you should never watch either being made!” I appreciate this has been a very long process and one that is essentially the culmination of extensive community engagement over the past two years. I just want to take the opportunity to commend my parliamentary colleagues for having the courage and determination to support the Voluntary Assisted Dying Bill 2019. I would like to thank members in this place and the other place for their valuable contributions, and careful and thoughtful consideration of this legislation.

It has been a long debate—over 175 hours. I believe that the amendments made in the other place and agreed to today in this place do not in any way undermine the fundamental policy intent of the bill and, indeed, as I have said on a number of occasions, if everyone can see a little bit of themselves in this bill, all the better. We would not have reached this milestone without the overwhelming support of the Western Australian community. I want to thank everyone for their numerous letters and emails, attendance at community events and consultations, and the many conversations. The carriage of this bill through both houses of Parliament is a testament to their commitment to expanding WA’s choices at end of life. In particular, I want to thank the Joint Select Committee on End of Life Choices that paved the way for this legislation. I would also like to thank the members of the ministerial expert panel whose work has ensured a safe and compassionate bill. I want to thank the member for Morley and Hon Colin Holt for their extraordinary leadership on this debate. I am privileged to stand on the shoulders of those who have gone before me, including Hon Robin Chapple and Norm Kelly before that. Hon Alannah MacTiernan has campaigned extensively for this, but if it were not for the leadership shown by the member for Morley and Hon Colin Holt in the last two years or so, we would surely not have been in this place. I am a very lucky minister to be able to acknowledge their work.

Laws are difficult things; they take us to difficult places. They put intolerable workloads and pressure on the public servants who support us in this place. I want to acknowledge all those people, including the clerks who have been responsible for drafting the legislation. Members, I know this is tough stuff. Things have been said to make sure that we get to this particular point. I accept that the Premier, in providing leadership to this community, as he said, sometimes had to crack a few eggs to make this particular omelette. I think we owe it to him to acknowledge the leadership he has provided to basically get us to this point.

I have had the privilege of being able to work with members from all sides of Parliament to get the bill to this point. I am thoroughly proud of this legislation, but I am overwhelmed by the support I have had from the Attorney General, the Premier, the Joint Select Committee on End of Life Choices and all those who have been involved to date. I want to thank my office and all those who have contributed to this debate in both this and the other place. This is an extraordinary piece of legislation.

Western Australia is not known for its progressive social reform. I would like to think that we have come a respectable second on this occasion in leading the nation in respect of this important legislation. It is not a moment for jubilation. Everyone understands what this legislation is about. It is a time for reflection—to reflect that we have chosen compassion and a right to choose. I thank members for their support of the legislation.

[Applause.]

The SPEAKER: No; we haven’t passed the bill yet!

Extracted from finalised Hansard
Mr M. McGOWAN: Mr Speaker, I would like to take a moment to reflect on the historic decision this Parliament will shortly make. Beyond the fact that Western Australia is the second place in Australia to legislate a regime for voluntary assisted dying, beyond the fact that all members, regardless of party, were offered a conscience vote and beyond the marathon length of this debate inside and outside this Parliament, we have done something amazing. We have passed laws that end the needless suffering of Western Australians at the end of their lives, should they choose to do so. We have acted to give Western Australians genuine choice about the end of their lives. We have given so many in the community hope as we go into Christmas.

I said in my second reading contribution that we do not like talking about death; we all find it hard. But this Parliament rose to the occasion. We have had the hard conversations with our electorates, with each other and with ourselves. Many members came to this debate genuinely not knowing how they would vote. I would like to acknowledge the hard work they undertook in grappling with not only the detail of the bill but also the emotional and moral questions that they had to answer for themselves. It is an incredibly difficult question to grapple with if you have not given it much thought before. I would also like to acknowledge those who were and are still opposed to this bill. I understand that their issues with these laws are deeply personal and sincerely held and shared by many others in the community; however, I reiterate that there are over 100 safeguards in this legislation and it is based on the fundamental premise that it is voluntary for those who are terminally ill and in pain.

I would like to acknowledge those who have worked tirelessly for this to become the law in Western Australia—your hard work has achieved something historic. I would like to acknowledge some people by name, as a reform like this has many, many parents. Firstly, the Minister for Health for his excellent handling of this bill. It is a credit to him and to his staff. We saw that just now. Also, to the Attorney General for his hard work both in the chair and behind the scenes. To Hon Stephen Dawson for the carriage of this bill through the upper house. That took an incredible amount of patience and attention to detail. I believe he won universal praise for the role he played. I would also like to acknowledge Hon Sue Ellery and Hon Alannah MacTiernan for the role they played in managing the business of the upper house so we could get to a vote in a timely manner. I make special mention of the member for Morley for her essential role in shepherding these laws from the Joint Select Committee on End of Life Choices through to passing both houses. I would like to acknowledge the other members of the select committee for the essential work they did in both setting the policy basis for these reforms and their continued advocacy for them, especially across the party divide. I am thinking about Hon Colin Holt, Hon Robin Chapple, Hon Dr Sally Talbot and the member for South Perth, as well as other members across the Parliament, who were the most staunch advocates for the bill and other important end-of-life choices reforms, from advance directives to palliative care. I take a moment to acknowledge the role played by the Leader of the Opposition, Liza Harvey, and Hon Peter Collier in ensuring that this bill came to a vote in the Legislative Council this year. On behalf of the supporters of this bill, I pass on our thanks to you.

Outside the Parliament, I thank the Ministerial Advisory Panel on Voluntary Assisted Dying and its chair, Malcolm McCusker, for their hard work, the Parliamentary Counsel’s Office for drafting these laws, and the advisers on the bill who were outstanding despite being sleep deprived. I acknowledge their encyclopaedic understanding of the legislation. I acknowledge the advocacy and campaigning from organisations like Go Gentle Australia and Dying with Dignity Western Australia. In particular, Andrew Denton, Rhonda Taylor, Belinda Teh, Lenda Oshalem and Joey Armenti. There are far too many campaigners for me to name you all. I thank the Western Australian media for its mature coverage of and deep interest in this issue, as well as its support for what we have done.

This is something that has been talked about and attempted for decades; success was never guaranteed or assured. In fact, I believed there was a good chance of failure. At various times over the last two and a half years, I thought what we have done was something that has been talked about and attempted for decades; success was never guaranteed or assured.

I would also like to acknowledge those who were and are still opposed to this bill. I understand that their issues with these laws are deeply personal and sincerely held and shared by many others in the community; however, I reiterate that there are over 100 safeguards in this legislation and it is based on the fundamental premise that it is voluntary for those who are terminally ill and in pain.

I said in my second reading contribution that we do not like talking about death; we all find it hard. But this Parliament rose to the occasion. We have had the hard conversations with our electorates, with each other and with ourselves. Many members came to this debate genuinely not knowing how they would vote. I would like to acknowledge the hard work they undertook in grappling with not only the detail of the bill but also the emotional and moral questions that they had to answer for themselves. It is an incredibly difficult question to grapple with if you have not given it much thought before. I would also like to acknowledge those who were and are still opposed to this bill. I understand that their issues with these laws are deeply personal and sincerely held and shared by many others in the community; however, I reiterate that there are over 100 safeguards in this legislation and it is based on the fundamental premise that it is voluntary for those who are terminally ill and in pain.

I would like to acknowledge those who have worked tirelessly for this to become the law in Western Australia—your hard work has achieved something historic. I would like to acknowledge some people by name, as a reform like this has many, many parents. Firstly, the Minister for Health for his excellent handling of this bill. It is a credit to him and to his staff. We saw that just now. Also, to the Attorney General for his hard work both in the chair and behind the scenes. To Hon Stephen Dawson for the carriage of this bill through the upper house. That took an incredible amount of patience and attention to detail. I believe he won universal praise for the role he played. I would also like to acknowledge Hon Sue Ellery and Hon Alannah MacTiernan for the role they played in managing the business of the upper house so we could get to a vote in a timely manner. I make special mention of the member for Morley for her essential role in shepherding these laws from the Joint Select Committee on End of Life Choices through to passing both houses. I would like to acknowledge the other members of the select committee for the essential work they did in both setting the policy basis for these reforms and their continued advocacy for them, especially across the party divide. I am thinking about Hon Colin Holt, Hon Robin Chapple, Hon Dr Sally Talbot and the member for South Perth, as well as other members across the Parliament, who were the most staunch advocates for the bill and other important end-of-life choices reforms, from advance directives to palliative care. I take a moment to acknowledge the role played by the Leader of the Opposition, Liza Harvey, and Hon Peter Collier in ensuring that this bill came to a vote in the Legislative Council this year. On behalf of the supporters of this bill, I pass on our thanks to you.

Outside the Parliament, I thank the Ministerial Advisory Panel on Voluntary Assisted Dying and its chair, Malcolm McCusker, for their hard work, the Parliamentary Counsel’s Office for drafting these laws, and the advisers on the bill who were outstanding despite being sleep deprived. I acknowledge their encyclopaedic understanding of the legislation. I acknowledge the advocacy and campaigning from organisations like Go Gentle Australia and Dying with Dignity Western Australia. In particular, Andrew Denton, Rhonda Taylor, Belinda Teh, Lenda Oshalem and Joey Armenti. There are far too many campaigners for me to name you all. I thank the Western Australian media for its mature coverage of and deep interest in this issue, as well as its support for what we have done.

This is something that has been talked about and attempted for decades; success was never guaranteed or assured. In fact, I believed there was a good chance of failure. At various times over the last two and a half years, I thought that we may fail. We had to summon the courage to match that of the public, to meet them along the way. There are far too many campaigners for me to name you all. I thank the Western Australian media for its mature coverage of and deep interest in this issue, as well as its support for what we have done.

This is something that has been talked about and attempted for decades; success was never guaranteed or assured. In fact, I believed there was a good chance of failure. At various times over the last two and a half years, I thought that we may fail. We had to summon the courage to match that of the public, to meet them along the way. There are far too many campaigners for me to name you all. I thank the Western Australian media for its mature coverage of and deep interest in this issue, as well as its support for what we have done.

Finally and most importantly, to all the supporters of voluntary assisted dying, for those of you who watched your mum or dad die in pain, begging for relief from the agony and distress, to those of you who are worried about your own futures and do not want to die that way and to every Western Australian who has lost a loved one who wanted a choice, we thank you for your unwavering support, your contributions, your stories, your consultation and for entrusting us with this task. Thank you for your patience. We did it for you. Have a great Christmas, stay safe and we will see you next year.

Question put and passed; the Council’s amendments agreed to.

The Council acquainted accordingly.

[Applause.]