Second Reading

HON STEPHEN DAWSON (Mining and Pastoral — Minister for Environment) [12.30 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 that 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 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, Amber-Jade Sanderson, the member for Morley, and also Hon Colin Holt, MLC. 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.

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, the Minister for Health hosted a palliative care forum on 24 August this year. This was an important event that brought together consumers and health professionals to share their thoughts and experiences surrounding end-of-life and palliative care. Access to palliative care and education for the community and health practitioners were key issues raised by some of the participants. The government is committed to improving and strengthening palliative care services for all Western Australians. In the context of this debate, members will not be considering voluntary assisted dying instead of palliative care; we will be 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 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 statewide policy direction for quality end-of-life and palliative care.

The 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; two 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 honourable members of this place who will share with us experiences about their loved ones and what they witnessed in their love ones’ 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 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.

Belinda Teh was present for much of the debate in the other place. Belinda walked 3 500 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.”

Extracted from finalised Hansard
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 around 10 per cent of suicides in Western Australia 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, and the distress for their families unimaginable. The Joint Select Committee on End of Life Choices 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 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 a voluntary assisted death is not a 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 from those in Victoria due to our geographical size and location. Western Australia is the most culturally diverse state in Australia, with Aboriginal people, migrants and refugees accounting for nearly 30 per cent of our 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 or older, an Australian citizen or permanent resident, and have been ordinarily resident in Western Australia 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 that 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 chief executive officer of the Department of Health and the Western Australia Police Force 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 that 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 in this bill between the safeguards necessary to ensure the integrity of the model, and to ensure that it will not prevent those who are eligible and who genuinely wish to access voluntary assisted dying from doing so.

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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 to continue.

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 patient-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.

This 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.

Extracted from finalised Hansard
It is clear that practitioner administration should not be limited only to circumstances in which people 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.

**Sitting suspended from 1.00 to 2.00 pm**

**Hon STEPHEN DAWSON:** 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 chief executive officer, 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 WA 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 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 must 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 will allow 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.

Madam President, 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 honourable members acknowledge community concerns and the calls for compassion to support people at the end of their lives—to provide dignity, to provide choice, because Western Australians are ready for voluntary assisted dying.

Voluntary assisted dying has huge public support. Newspoll, Vote Compass and other surveys over the last 10 years consistently show 80 to 88 per cent support. This includes support of around 70 per cent from people who identified as members of major religions.

Extracted from finalised Hansard
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 honourable 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.

I commend the bill to the house and table the explanatory memorandum.

[See papers 3203 to 3205.]

Debate adjourned, pursuant to standing orders.

Legislative Council

Tuesday, 15 October 2019

[page 7533]

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from 26 September.

The PRESIDENT: Before I give the call to Hon Nick Goiran, I will remind members that we have in front of us a very complex, complicated and contentious bill. Obviously, members will be speaking about very personal matters and, at times, it will be emotional. It is a bill on which their respective parties have given all members a conscience vote. All I ask is that we treat each other with respect during this debate and note that there is a difference of opinion around the chamber.

HON NICK GOIRAN (South Metropolitan) [2.20 pm]: I rise as the lead speaker for the opposition on the Voluntary Assisted Dying Bill 2019. The Liberal Party’s position on this bill is to grant each of its members a free vote. Of course, it is always the case that Liberal Party members are able to vote in accordance with their conscience on any legislation, but from time to time our party takes a particular position authorising its members to have a free vote and, therefore, not to have to advise the party room of their position on a piece of legislation. This is one such bill. As you have already foreshadowed, Madam President, I understand that the other parties have taken a similar position on this matter. At the outset, I urge members as we consider this legislation to block out the noise and collectively—all 36 of us—wrestle intellectually with the matters before us. If I do nothing else during this speech today, I appeal to members to collectively reason through this process. Conscience votes are very rare in this Parliament. This is not the first time a euthanasia bill has been before the Parliament. In fact, I recall us dealing with a bill in 2010, in my first term, that was brought forward by my parliamentary colleague Hon Robin Chapple. Members who were there at that time may recall that the second reading of that legislation was defeated 24 votes to 11. On that occasion, any members who wanted to speak were able to do so and a vote was taken. I see no reason that same process cannot take place with the bill before the house.

If this bill is to be defeated after an intellectual wrestle, after members have reasoned through the process, it will not be unusual. In fact, some 50 bills in our nation have failed on this particular topic. I note that as recently as 2017 in the United States of America some 43 bills were presented across 26 states, all of which failed. It is not particularly unusual after an intellectual wrestle and a reasoning process has occurred for a chamber of Parliament to say no to voluntary euthanasia and assisted suicide. As we consider this particular bill, the technical question before the house at the moment is: should this bill be read a second time? However, I put to members that a more important question needs to be considered by members before they decide how they are going to vote on this legislation. The question that I believe every member in this chamber has a duty to answer is: is it possible to design and implement a safe euthanasia regime? That is the threshold question for every single member in this place before they cast their vote.

As members consider that question, it is not acceptable, it is unsatisfactory, and it is not becoming of a member of this place, a lawmaker, a person who has the responsibility on behalf of Western Australians of having the final say on legislation, to simply say, “Yes, I think it is possible”, because anything is possible. That is not an acceptable answer to that question. If members believe that it is possible to design and implement a safe euthanasia regime, there is a duty to identify the jurisdiction that has done so. If it is the case that a member in considering this process and reasoning through the process is unable to identify a jurisdiction that has designed and implemented a safe euthanasia regime, that does not automatically mean that they are unable to answer that question in the affirmative, but they then have a responsibility to set out the parameters, the framework, for which they say it is possible to implement and design a safe euthanasia regime. For reasons that I will outline in a moment, it will surprise no-one, because I have said this previously in this place, that I am of the view that it is not possible—that it is impossible—to design and implement a safe euthanasia regime. Other members may be able to identify a way in which a safe euthanasia regime can be implemented and, if they can, I look forward with interest to hearing what they have to say.

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say. At that point, if after wrestling with this process and reasoning through the process they are able to identify a safe way to do this, they have a second question they must consider. They have a duty to answer this second question before they cast their vote in the affirmative: is it appropriate to introduce euthanasia and assisted suicide prior to addressing palliative care accessibility in Western Australia? I will speak more about that later in my contribution today.

It is reasonable to say that there has been a fair amount of discussion outside this house about the decision by my party to appoint me as the lead speaker on this bill. From our party’s perspective, there is absolutely nothing peculiar about that. I am the member who has been entrusted with the responsibility of speaking on health portfolio matters and, of course, this government bill was introduced by the minister representing the Minister for Health. I might add that my background and experience on this issue include the following. This is my tenth year in the Western Australian Parliament—a great honour it is to serve in this place—but prior to that my profession was a litigation lawyer. During the course of that time I had to deal with a number of areas of law that are pertinent to the matters before us for consideration. One of those areas was medical negligence law, and I will speak about that more in due course. The other area pertinent to our consideration is contract law and, again, I will discuss that in due course.

In addition, as I outlined earlier, this is not the first time a bill of this sort has been before the house. When the last bill that was brought forward by Hon Robin Chapple was defeated I recall saying to some of my colleagues that there was something a little dissatisfying about defeating the proposal of a person who brought it to the house out of good intent and in good faith. I know that the views held by the honourable member are held in good faith. There is something a little dissatisfying about defeating a proposal that is otherwise intended for the good. I asked some colleagues what we could do collectively in a positive sense on a bipartisan or tripartisan basis. The answer to that was the formation of the Parliamentary Friends of Palliative Care. It is a position I have held effectively since shortly after the last debate and it is an honour for me to have been able to do that with my co-chair, the member for Girrawheen and learned friend Hon Margaret Quirk, MLA. During that time we have had the opportunity to organise briefings for members on a range of issues dealing with palliative care.

I will speak more about that in a moment but, in addition, I have served, on behalf of this chamber, on the Joint Select Committee on End of Life Choices, which the government has indicated is the foundation stone of the bill before the house. I note for the record that, of the eight people who served on that committee, I was the only member who attended every meeting and every hearing over the course of that 12-month inquiry, and the outcome of that was the 248-page minority report that members have available to them. In addition, during that time, I was also the co-chair of the Select Committee on Elder Abuse, and I will have more to say about the intersection between elder abuse and the bill that is before the house in due course. That is the background and experience that I bring to this matter, and I am honoured that my colleagues have entrusted me to be the lead speaker on this bill.

The other point that I make is that there has been what I would describe as an element almost of hysteria about the quantity of time that I might possibly take in debating this bill. For that reason, today I deliver my speech, as we would say, ex tempore, and not in a wholly prepared fashion, because I want to put to bed any suggestion that any tricks will be used by any members, least of all me, on this matter. Members of this chamber who are familiar with this debate will know full well what the outcome of that particular legislation has been to date, and the reasons for it, and that this is an entirely different debate.

As I indicated, I was a member of the Joint Select Committee on End of Life Choices, an inquiry that lasted for 12 months. I recall some of my colleagues asking me at the time why I would bother to serve on that committee. I indicated that I was in favour of the establishment of the committee, because it was looking into end-of-life choices for Western Australians and, as co-chair of the Parliamentary Friends of Palliative Care, I knew then, and I am even more convinced now, that there is a great need to improve the accessibility of palliative care in Western Australia. If I could serve on a committee that would make findings and recommendations to that effect, it would be an honour to do so. Members may recall that, when that committee was formed, in August 2017, I moved for the terms of reference of the committee to be extended. The proposal had been put forward by members, in good faith, seeking the establishment of the committee, and I simply asked that the terms of reference of the committee be extended for this purpose. If the committee was going to look into this issue, I said it should look into the risks of establishing voluntary euthanasia and assisted suicide. I was simply seeking to add one extra term of reference for the inquiry. That proposal was defeated. It struck me at the time that a minister of the Crown urged members to vote against my proposal that the committee that ultimately tabled this report would look into the risks of voluntary euthanasia and assisted suicide.

In the same debate, which is the genesis of the bill before us, another member who subsequently served on the committee with me made a very good point. That member said they did not think it was necessary to add this term of reference, because the existing terms of reference would already allow the committee to examine the risks of voluntary euthanasia and assisted suicide. What that member said was true in theory but proved to be false in practice. It is a point of enormous exasperation that the Parliament has entrusted a committee to examine end-of-life choices for 12 months, and that committee has not looked into the risks of establishing voluntary euthanasia and assisted suicide.
I now want to take a moment to compare and contrast the safeguards in the criminal justice system with the safeguards that there will be a casualty rate. 

Safeguards in our criminal justice system are inadequate to justify capital punishment. That is because we know unable to give effect to the aspiration that the acceptable casualty rate is zero. The community believes that the punishment. The community has determined that despite all the safeguards in the criminal justice system, we are

There are not 102 safeguards in this process. I will give members an example. It has been suggested that a person in this bill. It has been suggested, in a very overt fashion, that the bill contains some 102 safeguards. That is false.

will be required to have any specialty or experience in the condition that the patient is said to have. Therefore, it

I turn to the first question that I have asked members to consider during this debate; that is, is it possible to design and implement a safe euthanasia regime? In order to answer that question, we first of all need to define what is safe. If we are going to ask the question whether it is possible to design and implement a safe euthanasia regime, we first need to agree, or at least discuss, what we mean by safe. I have heard in this place, and in the other place, and from people in the community, talk about the need for safeguards, so that seems to me to be an indicator that there is a broad consensus that if a regime is to be brought in, it needs to be safe. What is safe? In order to answer that question, members will need to be able to determine what is the acceptable casualty rate. I say, at the outset of debate that, for me, the answer is zero. That is not a particularly unusual position to take. I remind members, and I am sure they have seen it themselves, that there is an advertising campaign at present dealing with road safety. Members will recall the vision of the gentleman in the advertisement who is asked effectively what would a regime be like? As I recall the ad, he talks about a figure in the region of 70, I think it is. However, when he sees his family coming around the corner and realises what 70 means in practice, he changes his mind and says that the acceptable casualty rate is zero. I hold that same view on this issue. I know from the research that I have conducted into this matter over the last 10 years that to design and implement a safe euthanasia regime is a legal impossibility. Again, that should not really surprise us as we examine our conscience and reason through this process. It is for exactly that same reason that Western Australia does not allow capital punishment. The community has determined that despite all the safeguards in the criminal justice system, we are unable to give effect to the aspiration that the acceptable casualty rate is zero. The community believes that the safeguards in our criminal justice system are inadequate to justify capital punishment. That is because we know that there will be a casualty rate.

I now want to take a moment to compare and contrast the safeguards in the criminal justice system with the safeguards in this bill. It has been suggested, in a very overt fashion, that the bill contains some 102 safeguards. That is false. There are not 102 safeguards in this process. I will give members an example. It has been suggested that a person will be able to access this regime only if they have been given a prognosis of six months to live. That is not a safeguard. That is a requirement. There is a difference between a requirement and a safeguard. The truth is that neither of those doctors

There is so much more that I would like to say about the conduct of that inquiry, as the only member of the eight who attended every meeting and every hearing. There was not even a staff member who lasted the entire inquiry. I am the only person who started from the beginning and attended everything until the end. There is more that I would like to say about the inquiry but, as we know, a decision has been made not to release the minutes of that inquiry. It is a debate that we have had previously, and I have indicated that, for the reasons I have mentioned previously, that is unusual and unnecessary.

I compare and contrast that with the criminal justice system. I put to members that the criminal justice system contains a plethora of safeguards. The community has determined that those safeguards are inadequate to justify capital punishment. I ask members to consider those safeguards and whether they could be implemented into this proposed regime. The criminal justice system begins with a complaint. The independent office of the Western Australia Police Force is charged with determining the extent of the investigation of the complaint. During the course of the investigation, WA police can call in and interview the suspect. The suspect is required to give only their name and address; other than that, they can stay silent. That is the extent to which they have to cooperate with the investigation. Western Australians are very concerned about the possibility of abuse in the criminal justice system. Therefore, we ensure that any person who is subject to an investigation by WA police is supported by a legal expert, who is taxpayer funded, through legal aid if necessary. If it is a particularly heinous crime and the police decide to lay charges, the police do not prosecute the case. We implement another safeguard by ensuring that the independent office of the Director of Public Prosecutions prosecutes the offence. The Director of Public Prosecutions is obligated

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to reveal all the evidence, including evidence that might assist the suspect. The suspect is provided with legal representation throughout that process. After that independent investigation and independent prosecution, the final decision is made by another group of independent people—namely, the jury. In Western Australia, the suspect does not need to have a reason to object to a proposed juror; the suspect can object just because they do not like the look of that person. That is another safeguard to ensure that the independent investigation is followed by an independent prosecution and is decided by an independent jury. A specialist in the law, namely a judge, acts as umpire to ensure that everybody follows the rules and nobody abuses the safeguards that are in place. The community of Western Australia has determined that even though all those safeguards are in place, if a guilty verdict is handed down, there may be the possibility of casualties; therefore, we will not allow for capital punishment. An additional safeguard is that people are allowed to appeal to the High Court, if necessary. Throughout this process, the prosecution is required to prove the case not on the basis of any old evidence, and not on the balance of probabilities, but beyond reasonable doubt.

I ask members to compare and contrast that plethora of safeguards with two general practitioners signing off on voluntary assisted dying. In due course, members may put to me that there is a distinction. Members may say that it is not right to talk about the safeguards in the criminal justice system, because that is the equivalent of involuntary euthanasia—of course the suspect did not volunteer to be investigated and prosecuted. I want to tease that out in two ways. First, I remind members that it is not outrageous to compare and contrast the two. It is possible, and has happened, that a suspect pleads guilty. If a person pleads guilty, despite all the safeguards that are in place, we would be pretty confident that the person was guilty. We need to remember that the person is entitled to be given taxpayer-funded independent legal advice, and to be independently investigated. I remind members that in this fortieth Parliament, the Joint Standing Committee on the Corruption and Crime Commission, of which Hon Alison Xamon and Hon Jim Chown are members, tabled a report dealing with the case of Mr Gibson and the unlawful death of Mr Warneke. In that case, the suspect pleaded guilty. We now know that that was wrong. Thank goodness that despite all the safeguards in the criminal justice system, we do not have capital punishment in Western Australia; otherwise that particular individual would have been executed. This person had pleaded guilty. Therefore, members, please do not say to me that this situation is different, because this is voluntary euthanasia. I do not know how many times during this debate emphasis has been put on the word “voluntary”. Let us have a debate about what “voluntary” means. It is all very good for us to use the language, but what does it mean in practice?

For there to be a valid consent—this is a legal principle—three elements have to be present. Firstly, the person has to have capacity; secondly, they must have knowledge of the matter to which they are consenting and agreeing; and thirdly, there needs to be a voluntariness of their decision. These legal principles apply in every other situation, and they also apply in a voluntary assisted dying regime. These are fundamental principles of law.

What could possibly go wrong in this situation? I ask members to consider the lessons that can be learnt from medical negligence. Members will be aware that medical practitioners in Western Australia are obliged to hold medical indemnity insurance. Why is that? It is because doctors make mistakes. I would be reasonably confident that most members in this place, if not all members, would know of a doctor who made an error in diagnosis; in other words, they told the patient that they had a particular condition only for that later to be found not to be true.

Something fascinated me, and I have still never really understood why it happened. As I say, I am still somewhat constrained in what I can say about the conduct of the inquiry. A case has been hidden from members in the committee report, but it is found and referred to in my minority report. I cannot answer the question about why this case was hidden from members in the committee report, but it was the case of an individual who had been told that they had a terminal condition only for that not to be true. This individual was then sent on a course of palliative care treatments only for those later to have been found unnecessary. That is just one of dozens, if not hundreds or thousands, of examples of an error in diagnosis, as happens from time to time. It will require only one error in diagnosis under this legislation by those general practitioners, or whoever the two doctors involved are, for there to be a Western Australian casualty. We know that has happened in the other jurisdictions.

Medical negligence law is not simply limited to errors in diagnosis. There will also be errors in prognosis. The bill before the house contemplates a doctor coming to a decision, a consideration, that the person has six months or fewer to live, and in certain circumstances that is extended to 12 months. Could a doctor say a person has six months to live only for that not to be the case? Have members ever come across that situation in which a person has been told that they had six months to live, but in actual fact they had many more years to live? That is what we call an error in prognosis. The medical profession accepts that practitioners routinely make errors in prognosis, yet it will require only one error in prognosis by the two safe-guardians under this legislation for there to be a Western Australian casualty.

Another matter I ask members to consider while we are thinking about the impact of medical negligence law in any voluntary euthanasia or assisted suicide regime is the existence of doctor bias. Some proponents will say to us that it is okay, because we can trust the two doctors who have to make this decision. Could the doctors who have been entrusted with this task and duty have a bias towards voluntary euthanasia and assisted suicide? We already know that in Western Australia we even have at least one doctor who, if you like, boasts about her treatment of

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some patients at end of life and how it has been inconsistent with the laws of Western Australia. She then says that is the reason that laws need to change. Are these the people whom we will trust to make these decisions? In a moment I will talk more about the Northern Territory experience, where there is a doctor with a very well known and overt bias for euthanasia and assisted suicide. Could those doctors who have a bias steer patients towards this outcome? That is all that needs to occur for there to be Western Australian casualties at the end of this process.

The other lesson I have learnt from my experience in practising medical negligence law is the ease by which doctor shopping occurs. The so-called safeguard in this legislation is that two doctors will have to agree. Members, in my previous profession, it was routinely the case that people could shop until they got the opinion they needed from a doctor to support their case. Doctor shopping occurs routinely already, and this will be the easiest and simplest way to pierce the veil of the safeguard. If the safeguard is two doctors, GPs or otherwise, a simple excursion of doctor shopping will pierce the veil of that safeguard.

I now turn to consider the lessons we can learn from contract law that teach us that it is impossible to design and implement a safe euthanasia regime. Two of the contract law principles that confirm that for us are duress and undue influence. I want to give a couple of examples. My learned friend Hon Pierre Yang, who is a former family lawyer, has more experience in this field than I do, but he, and perhaps others who have practised in family law, will be familiar with binding financial agreements. Binding financial agreements were previously referred to as prenuptial agreements. In law, if a person enters into a prenuptial agreement under duress or undue influence, after the event, the courts will set aside that agreement and say they will not allow the terms of that binding financial agreement to be adhered to because it is wrong that the person entered into it under duress or undue influence, or maybe some unconscionable conduct was involved. This happens, and we have had cases, including in the High Court of Australia, setting aside those types of agreements.

In this instance, there will be a contract between a doctor and a patient. Unlike a binding financial agreement, if that contract is entered into under duress or undue influence, it will be a legal impossibility for that person to claim redress after the event. This situation in contract law is not simply limited to these family law agreements. Indeed, I remind members that banks routinely require people to sign guarantees. If those guarantees have been entered into under duress or undue influence, courts will not hesitate to set those guarantees aside. It is all well and good when we are talking about binding financial agreements, bank guarantees or other forms of contract to be able to provide some redress and restitution to a person who has been wronged, but it is impossible to do that for a dead person. It is the case that if a Western Australian enters into a voluntary assisted dying regime under duress or undue influence, they will be a casualty as a result of the legislation before us. It is yet another example, just like those in medical negligence law, that tells us why this type of regime ought to always be prohibited, because it is an impossibility to design and implement a safe regime.

I pause for a moment to consider: what impact does the existence of elder abuse in Western Australia have as we contemplate the particular regime that is before us? As I indicated at the outset, during effectively the same 12 months that I served on the Joint Select Committee on End of Life Choices I also served on the Select Committee into Elder Abuse. One of the many things that inquiry into elder abuse found is that different forms of elder abuse take place. Psychological and emotional elder abuse is in competition for top ranking with financial elder abuse as the most prevalent form. That was the consistent evidence the committee received in that 12-month inquiry. I encourage members to look at the report to that effect.

Contemplate for a moment what that means. If psychological and emotional elder abuse is prevalent in Western Australia, how easy is it for a person to be steered towards a voluntary assisted dying decision in circumstances of psychological and emotional elder abuse? This is why I have said previously that this notion of steering is the elephant in the room. We need to intellectually wrestle with that realisation as we consider this bill and reason our way through that process. This is one of a number of reasons why I say to members that it is impossible to develop, design and implement a safe euthanasia regime when lessons in medical negligence law exist, when we know about the contract law principles and when we know that psychological and emotional elder abuse is prevalent in Western Australia.

Members who may be familiar with my minority report will know that it has three chapters. The first chapter looks at current end-of-life choices in Western Australia, including palliative care. The second chapter looks at the theory; that is, what are the risks in implementing a euthanasia or assisted suicide regime—that very thing that I asked the committee to be particularly mindful of? Incidentally, if someone later, during the course of the debate says, “We did look at what happened in other jurisdictions”, what they really mean by that is that we looked at the legislation. It does not mean that we looked into any of the wrongful deaths in those jurisdictions; we simply did not do that. That is evident from the content of the report. It is not the case that we took evidence from those in international jurisdictions with respect to wrongful deaths—no, not at all. I will give members an example. When the committee looked at the Swiss model, who did we call? We called Dignitas, which comprises individuals who execute this act in Switzerland. When the committee was looking at the Northern Territory experience, we spoke to Dr Philip Nitschke and to the then Chief Minister, who was a proponent of the legislation. That is the true extent to which we looked at the wrongful deaths in the other jurisdictions during a 12-month inquiry.
As I say, the second chapter of my minority report looked at the theory; that is, the different risks that could occur—the thing that the committee did not want to look at—but then I finished the minority report by looking at the lived experience in those other jurisdictions. I ask members to turn their mind to this: to what extent, before we pass this particular piece of legislation, do we have a duty to consider the lessons from those other jurisdictions? Members might say to me that it is all well and good to talk theory but we want to know about the real experience. What has actually happened in the few jurisdictions where this has occurred? That is what chapter 3 of my minority report was devoted to. It is the case that when one looks at the European experience, for example the Netherlands, my general practice is not to try to debate with members on matters that are necessarily in contention—I am quite happy to have a minimal facts approach to this—in other words, what matters are simply undeniable? There is often a discussion around the “slippery slope” and whether it exists and so on and so forth. I say that that is just a red herring; let us not even bother having that discussion.

Let us look at the facts in the Netherlands. It is a fact that there has been an incremental expansion in the practice of euthanasia in that jurisdiction. Whether members want to describe that as a slippery slope is a red herring; who really cares what the description of it is? As we intellectually wrestle through this particular debate and reason through the process, let us ask ourselves whether there has been an incremental extension in the practice in the Netherlands. It is intellectually dishonest to say otherwise. It is no wonder that that is the case because if a regime sets a particular bar and says, “Voluntary assisted dying—euthanasia or assisted suicide—is only going to be available for these particular people”, as this bill does, certain Western Australians will be able to access this particular regime and others will not. It is inevitable that people will want to push up against that barrier. Indeed, I suspect that most members in this place, if not all 36 of us, will have already been lobbied or have had advocacy suggesting that this bill does not go far enough. It is certainly on the public record that proponents have said, “We need to get something through at this particular point.” “It is a good start” is sometimes the language that is used. A start to what, members? Where are we going with this?

This is no mere theory. Firstly, these are the words articulated by proponents in Western Australia; and, secondly, we know from the lived experience in the Netherlands that there has been an incremental expansion in the practice. Because the European experience is often too uncomfortable for proponents to stick with that debate, my experience over the last 10 years has been that we quickly move away from the European experience. Why? Because they have allowed euthanasia for the mentally ill and for children, which makes us uncomfortable. I am thankful that that makes us uncomfortable in Western Australia. What happens as a result of that uncomfortableness is that we quickly shy away from that debate and start to look at other jurisdictions. That is fine. I am the first to accept that is not what the proposal before us is at this time. I simply raise it now because I am sure that it was not the proposal in the Netherlands some 20-plus years ago either. Let us not deny the actual lived experience in the Netherlands and Belgium. I might add that Belgium went one step further than the Netherlands with its legislature changing the law. The Netherlands has continued to incrementally expand the system by way of practice and judicial determination and interpretation. What normally happens then is that it suits proponents to shift the debate. It is very uncomfortable talking about the European experience, so they shift to the North American experience. We have already seen the same push for an incremental expansion in Canada, which has a fairly new system. An election is taking place at the moment and one need only look at the rhetoric in Canada to see that that is what is taking place. In fact, just recently there was a court decision to that same effect looking for an expansion. That does not surprise me because, as I said, if we set a particular bar and say that some Western Australians will be able to access this, we can expect people to continue to push against that bar. Why is it that only some Western Australians will be able to access voluntary assisted dying and not others?

Because the Canadian experience has tended to morph towards that experience in Europe of an incremental expansion, I find that the debating ground that is most comfortable for proponents is the Oregon experience. Usually that is where we end up. Usually people say, “Let’s not talk about the Netherlands anymore. We are too uncomfortable talking about euthanasia for the mentally ill. We’re too uncomfortable talking about the experience in Belgium, which has seen children euthanased. We are not comfortable with what’s going on in Canada because of the very overt expansion of the system. Let us talk about Oregon because it has had decades of experience.” There is the suggestion that its regime is the safe one. Is it? Before members cast their vote in favour of the Voluntary Assisted Dying Bill 2019 on the assumption that the Oregonian experience is somehow safe, they should test it and check whether that is true. They should find out whether there have been any wrongful deaths in that experience. There is no point looking for it in the committee report because not one paragraph deals with the wrongful deaths in Oregon. They will find it in the minority report and I encourage them to look at it. If they do, they will see from the data—not my data, but data from the Oregon Health Authority—that there have been medical errors in prognosis countless times. What does that mean? Under the Oregonian model, it is necessary that there is a prognosis of six months to live before someone can access euthanasia. Why is it then that people have taken the lethal substance sometimes years after the initial prognosis? It is because there has been an error in prognosis. The medical errors in prognosis are there to see in the Oregonian data. We are about to embark upon a similar regime that allows for a prognosis of six months to death. The only rational explanation that we can use to justify that is that Western Australian medical practitioners are magnificently superior to Oregonian doctors in diagnoses and prognoses.
In addition, we know now, as a result of a couple of decades of experience in Oregon, that doctor shopping is frequent—to the point of it now being what I would describe as a commercial exercise. If people do not like a decision, they can continue to shop until such time that they get the opinions they want and can access voluntary assisted dying. Oregon does not have voluntary euthanasia; it has assisted suicide.

The third point I make about the Oregon model and one that I ask members to consider is the complication rates. An interesting element of this debate is it seems that because a medical practitioner is involved and because we are talking about the use of a needle or swallowing a poison or substance that somehow we feel that that is a safe regime. There is an excellent line in a documentary entitled Fatal Flaws: Legalizing Assisted Death in which a US doctor says something to this effect: “I wonder if the debate would shift if instead of using the needle as a symbol, we used a gun? I anticipate that if we did that, transculturally around the world we would say that that is wrong.” I think he is right on that point. The question that members need to ask themselves is whether it is reasonable to make that substitution. Are we now simply arguing about the method, implement or tool, or are we talking about the risks of what could go wrong? The Oregonian data confirms that there have been significant complications. Sometimes after a person has taken a substance, they have taken days to die, which was contrary to their expectation when they entered into that arrangement and contract with the doctor. That is not my data. Members should check the Oregon Health Authority’s data. That is the complication rate. The complication rates for the use of lethal injections has resulted in some states in the United States of America saying that it is not humane to use that as a form of capital punishment and they have abandoned it. The same thing applies with this issue.

Usually during a debate about the various jurisdictions, I find that what happens is that people in Western Australia, indeed Australia, say, “Look, honourable member. It’s all very good to talk about the Netherlands and the mentally ill and Belgium with the children, the complication rates, doctor shopping and medical errors in prognosis and diagnosis. It is all very well to talk about that but we wouldn’t do that.” That is usually the line that comes out—“We would not do that. We have confidence in the medical practitioners in Western Australia. We hear your concerns, but we don’t think that that’s going to happen in Western Australia.” I ask members to consider the Northern Territory experience. If they do not want to consider the lived experience in those other jurisdictions because they do not think it is relevant—I put it to them that it is relevant—and are in that particular space, I ask them to consider the Northern Territory experience, which saw doctor shopping at its worst. There is nothing in the bill before us to prevent the same thing from happening here. Let me explain that. I will give members one example of what happened in the Northern Territory. A patient had mycosis fungoides, which is a cancer of the blood that affects the skin. In the Northern Territory scheme, a person needed two doctors to sign off on their illness. The first doctor was Dr Philip Nitschke. I leave it to members’ conscience to consider that if Dr Nitschke was the first doctor, how much confidence would they have in the assessment of the first doctor—that everything that should and could have been done was done properly. To what extent will they examine their conscience and say that that particular doctor did not have a bias towards voluntary euthanasia and was not looking to achieve a particular outcome? I leave it to members to consider that. Be that as it may, a second doctor was to be involved. The law in the Northern Territory, unlike our bill before the house, said that the second doctor needed to have some kind of experience or qualification in the underlying condition. The problem for Dr Nitschke, or Mr Nitschke, as he is now, at that time was that the dermatologist and the oncologist would not agree to be the second doctor. Why not? Because the patient was not diagnosed as being terminally ill. The doctor shopping experience then took place and resulted in an orthopaedic surgeon being the second doctor to sign off on this particular patient’s death. For those who are unfamiliar with this, an orthopaedic surgeon has neither the qualifications nor the experience in anything whatsoever to do with mycosis fungoides. This is how it was treated in the Northern Territory experience. We are not talking about the Netherlands, Belgium, Switzerland, Oregon or Canada; this occurred in our country. This is how voluntary euthanasia was delivered in the Northern Territory. Members, ask yourselves why it would be any different in Western Australia. Who is going to be Western Australia’s Dr Nitschke? People with a bias towards a particular outcome will run around and continue to shop until they get the outcome that they want. Why? Because the bill before the house requires only two doctors to sign off on this.

I hope in some way that the explanation I have given over the last 60 minutes or so demonstrates to members why I so passionately say that it is impossible to design and implement a safe euthanasia regime. I say that because of the theory and because of the lived experience. Ultimately, after all that, if members still disagree with me, they still say that there is a safe way in which this can be done and that it is possible, and after intellectually wrestling with the issue and reasoning through it, they can articulate what that safe system looks like and why it is a safe system, and say, “Therefore, we would like to support this”. I move to my second and final question, which is: is it appropriate to introduce euthanasia and assisted suicide prior to addressing palliative care accessibility?

Associate Professor Richard Chye is the director of palliative care at St Vincent’s Hospital Sydney. I have never met this particular doctor but he said something that really went to the heart of this question. According to my notes, he said that no terminally ill Australian should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide. I ask members: Would that not be an interesting proposition for us to vote on? If we substitute the word “Australian” with “Western Australian” and say that no terminally ill Western Australian should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide. I ask members: Would that not be an interesting proposition for us to vote on?
palliative care but able to access assisted suicide, how would we vote? I put it to members that that is exactly the question that is before the house now. The question may be whether the bill should be read a second time, but as we examine our conscience on this matter, we need to ask ourselves: should any terminally ill Western Australian ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide?

On what basis do I say that that is the question before the house at the moment? I draw to members’ attention the findings in the report of the Joint Select Committee on End of Life Choices. Fear not, I am not referring to the minority report, which the government has not responded to. Not one finding or recommendation of that 248-page minority report has been responded to. I am referring to the committee report. I take members to findings 9, 10 and 11, which deal with this particular point. I emphasise that these are the findings of the committee, not the findings of the minority report. It states —

Access to inpatient specialist palliative care in Perth is limited.

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

Silver Chain is providing community palliative care to more patients than for which it is funded.

The committee recommends —

WA Health should conduct an independent review, from a patient’s perspective, of the three models of palliative care in Western Australia: inpatient, consultative and community. The review should examine the benefits and risks of each model and the accessibility of each across the state as well as the admission criteria for hospice care …

Where is the independent review, members? The government said that it agreed to the recommendations in this report. We are embarking on a regime that will give Western Australians ready access to lethal injections at end of life. The committee has made these findings and has recommended that WA Health conduct an independent review from a patient’s perspective. Where is the report on the review? I note that the committee then goes on to say, in findings 12, 13 and 14 —

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.

More can be done to promote understanding of palliative care in the community and with health professionals to ensure that more non-cancer patients who could benefit from palliative care are receiving it.

There is inconsistency in the data regarding the number of patients with conditions amenable to receiving palliative care. This is perhaps reflective of the uncertainty regarding which diseases or conditions are appropriate for palliative care.

As a result of those findings by the committee, not the minority report, it makes these two recommendations —

WA Health should implement a process to determine the unmet demand for palliative care and establish an ongoing process to measure the delivery of palliative care services with the aim of making those services available to more Western Australians.

Has it been done? Recommendation 11 states —

To improve understanding of palliative care in Western Australia, WA Health should:

- establish a consistent definition of palliative care to be adopted by all health professionals;
- provide comprehensive, accessible and practical information and education services about palliative care to health professionals and the community;
- encourage knowledge sharing by palliative care specialists with their generalist colleagues; and
- establish a palliative care information and community hotline.

What is the number of the hotline, members? They are not my recommendations; they are not my findings. They are the findings and recommendations of the Joint Select Committee on End of Life Choices. This is the foundation stone for this bill. This is what the government has said it has agreed to. Do we have answers to these questions before we lead the community to having ready access to lethal injections?

I return to my original question: should terminally ill Western Australians ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide?

*Extracted from finalised Hansard*
Finally, on this point, I note that findings 16 to 20 state —

Access to hands-on specialist palliative care is limited for metropolitan and non-metropolitan patients.

Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population.

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.

There is limited access to palliative care medical specialists in regional Western Australia.

There is limited medical oversight, coordination or governance of medical palliative care services across WA Country Health Services.

The committee makes three recommendations about palliative care. Recommendation 12 states —

The Minister for Health should prioritise policy development and improved governance structures for the delivery of palliative care by WA Country Health Services.

Has that been done? What is the new governance structure? Recommendation 13 states —

The Minister for Health should ensure regional palliative care be adequately funded to meet demand.

It concludes with recommendation 14, which states —

Once a consistent definition of palliative care has been established by WA Health in accordance with Recommendation 11, the Minister for Health should appoint an independent reviewer to audit:

- The level of palliative care activity actually provided in Western Australia’s hospitals and compare it against the level of recorded palliative care activity.
- The actual spend by WA Health on palliative care on a year-by-year and like-for-like basis, across all aspects of palliative care provision, including community service providers, area health services (including WA Country Health Services) and delineating between inpatient, consultancy and community care.

Has that been done? What is the name of the independent reviewer?

If none of those things has been done because the government has instead decided that since that report was tabled in August last year, over the following 14 months the higher priority has been this legislation before us, that is wrong. As I suspect, when most members examine their conscience, they would feel very uncomfortable if any Western Australian should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide. It is in this context, not in respect of my findings and recommendations in the minority report, but in the committee’s findings and recommendations on palliative care—findings and recommendations that the government has accepted—that I ask: how can it be appropriate for us to introduce voluntary assisted dying, whether we want to describe that as voluntary euthanasia or assisted suicide or otherwise? In many parts of Western Australia, this will mean no real choice at all.

I conclude with these five statements. Firstly, the desire of a significant proportion of confident people for ready access to lethal injections ought never override the rights of the quiet vulnerable to safety and protection. I feel sufficiently passionate about that to say it again: the desire of a significant proportion of confident people, confident Western Australians, for ready access to lethal injections ought never override the rights of the quiet vulnerable to safety and protection. Secondly, if we are intellectually honest and reason through the theory of an euthanasia regime, we should conclude that it is inherently unsafe. The insufficiency of the criminal justice safeguards informs us of this. The prevalence of medical negligence informs us of this. The ease of doctor shopping informs us of this. The existence of elder abuse informs us of this. The reality of doctor bias informs us of this. Thirdly, when we engage with the lived experience of the few jurisdictions that have legalised euthanasia or assisted suicide, we know that the theory of an inherently unsafe regime has resulted in casualties of wrongful deaths. In other words, the theory has translated into practice and wrongful deaths have ensued; there have been casualties. Fourthly, there is another way; there is a better way. There is a safe approach to end-of-life choices; however, it will require all of us to persistently insist that quality palliative care is made available to every Western Australian and that until we, the 36 of us, have exhausted ourselves in fulfilling this duty, we should not contemplate a euthanasia regime, let alone this bill, which is more dangerous than the Victorian legislation and more dangerous than the now inoperative Northern Territory legislation. Finally, I oppose this bill because the risks in legalised assisted suicide are simply too great, not the least of which is because the consequences are final.

Extracted from finalised Hansard
HON SUE ELLERY (South Metropolitan — Leader of the House) [3.35 pm]: I support the Voluntary Assisted Dying Bill 2019. The questions that each of us need to satisfy ourselves about are actually going to be different. The questions Hon Nick Goiran posed that he wants to be satisfied about or the questions that he suggests we need to satisfy ourselves on are different from the ones I need to satisfy myself about. For me, it is about this: do we agree that for those Western Australians already diagnosed with a terminal illness, who have between six and 12 months to live, we provide a medical and legal framework for them to determine the timing of their death? For me, this is about people who are already dying. Hon Nick Goiran also invited us to block out the noise as we proceed to get on with this. I urge members to listen to and manage that noise, because that noise is democracy and Western Australians want voluntary assisted dying.

The principles and precise safeguards that are set out in the bill before us provide the safety net that members of the community would rightly expect to be part of any legislation on this matter. They are found in part 1, division 2; in the interpretation provisions in part 1, division 3; in the operational provisions in parts 2, 3 and 4; in the review provision in part 5; and in the offences in part 6. A number of safeguards have already been canvassed in the public debate. For me, some of the most important ones are around access: that the request for access is voluntary and without coercion; that it is restricted to those who have reached 18 years of age; that it is restricted to those who meet specific residency requirements; that it is restricted to those who have decision-making capacity for voluntary assisted dying; and that it is restricted to those who are diagnosed with a disease, illness or medical condition that meets a specific and limited set of criteria.

With regard to the request process, the person must make three separate requests. Requests must be initiated by the person themselves, and requests must be clear and unambiguous. Requests cannot be made by a substitute decision-maker. Requests cannot be included in an advance health directive. The person must make a written declaration of the request with two witnesses present. The witnesses must not be beneficiaries, must not be family members, and must not be either the coordinating or consulting practitioner for the person. The person has no obligation to continue and can withdraw at any point in the process. Eligibility is assessed by medical practitioners. The person must have two assessments of eligibility undertaken by separate and independent medical practitioners and assessing medical practitioners are restricted to those who meet the specific registration and experience requirements. The coordinating medical practitioners must complete a final review that confirms that all eligibility criteria and process requirements have been met. The State Administrative Tribunal can review certain decisions. The Supreme Court’s jurisdiction remains preserved and health practitioners may refuse to participate in voluntary assisted dying.

The majority of Western Australians have expressed the view that they want voluntary assisted dying legislation; they say yes. They have told us that, as their representatives, they want us to legislate to that effect. They are also telling their doctors, nurses and other health professionals. They are telling the media; they are telling their families, their children and grandchildren. They are telling palliative care providers. They are telling their neighbours and their friends. They are having conversations. They told me at a forum that I held, and I will talk about that in a minute. Complete strangers have come up to me at my local shopping centre and said that they want me to vote yes. In the conversations I have had, many people have expressed surprise, and, I guess, some frustration, at the public commentary that there may be enough members in this chamber who do not support the principle of voluntary assisted dying, or who do not support the detail of this bill, to mean that the majority of the chamber may vote against the bill, despite the clear will of the majority of Western Australians. I think Western Australians are fearful that the opportunity might be lost.

I want to touch a little on some of the measures of public opinion on this matter. Members will be well aware of the article in The West Australian of 26 August this year referring to a poll that the newspaper had conducted. It stated —

Nine out of 10 West Australians support euthanasia and the State Government’s bid to legalise voluntary assisted dying, a poll conducted exclusively for The West Australian reveals.

... The survey of 656 people, conducted by Painted Dog Research’s Social & Health Unit in co-operation with rewardingviews.com.au, found 88 per cent of them back voluntary assisted dying and the Government’s Bill to legalise it.

... Only 12 per cent of people said they did not support the voluntary assisted dying Bill.

An overwhelming 93 per cent of people aged 50 to 59 said they would want to be allowed to end their own life with medical assistance if they were terminally ill with a condition causing intolerable suffering.

That particular age group is where I sit, and I think the number is so high in that group because of what I know about my generation. We are assertive consumers of all services, and we want to be in control of everything to do with how we live our lives and, indeed, how we end our lives. Over the years, many polls have been taken, and I will refer to some taken over the last 10 years. In 2016, in the ABC Vote Compass, on the question of whether terminally ill patients should be able to legally end their own lives with medical assistance, 75 per cent said yes.

Extracted from finalised Hansard
In 2015, an Ipsos MORI poll asked what people thought of doctor-assisted dying. They were asked whether it should be legal for a doctor to assist patients aged 18 or over to end their life, if that is the patient’s wish, provided that the patient is terminally ill, when it is believed that they have six months or less to live, are of sound mind and express a clear desire to end their life. In response to that, 73 per cent said yes. I can go back further to Newspolls over the years. In 2012, the question was: thinking about voluntary euthanasia, if a hopelessly ill patient experiencing unrelievable suffering, with absolutely no chance of recovery, asks for a lethal dose, should a doctor be able to provide a lethal dose? Of those asked that question, 82.5 per cent said yes. I could go back to the Newspoll in 2007 on the same question. On that occasion, 80 per cent said yes.

The detail of the medical and legal framework will be examined in detail, and I urge all members who support the principle to work together to ensure that a bill is passed by December that gives real effect to that principle. To those who do not support the principle, I respect that, and it is their right, and indeed their obligation on behalf of those in the Western Australian community who share their opposition, to oppose the bill. If members believe that no matter what changes are made to this bill they will never support it, I ask them to make a judgment call about the point at which, and how, they demonstrate that they also respect the majority view of Western Australians. Please do not misinterpret this as me disrespecting every member’s individual conscience vote on this bill, and every member’s right to satisfy themselves on the detail of the bill—I do absolutely respect those rights. But I have been a member of this place for 18 years, and I have been the Leader of the Opposition. I have seen used, and have used myself, every procedural method to delay a bill that I want to oppose. I know how to slow down the committee stage to the point that no or limited progress is made. I know how to ask for information that is actually irrelevant and will not change the way that I vote. I know how to refer a matter to a committee when in fact nothing that the committee recommends will change how I vote on the second or third reading.

I just make the point that, unlike much of the legislation to which I have applied those tactics, the genesis of this bill has been an extended and extensive period of public consultation and debate. The genesis and development of this bill so publicly has meant that every stakeholder with a view has been able to get those views to each of us, whether by the hundreds and sometimes thousands of emails sent and received, other correspondence, face-to-face briefings or meetings, the range of seminars organised by various proponents, or other forms of representations and forums. Any of us wanting additional information have been able to find stakeholders of all persuasions to assist us. Ultimately, the 36 of us in this place with a vote will have to decide ourselves. We have to weigh up the advice that we sought ourselves, that we were provided with, or that we stumbled across. There are experts on both sides of the debate, good people who hold genuinely formed views, who can assist, hinder or confuse, but ultimately our democratic system says that it is down to us. Procrastinate or not, filibuster or not, we still have to make the decision ourselves, and our community is saying yes, and asking us not to delay.

My motivation for supporting this bill exists at several levels. Firstly, I guess, it is for myself. Not unlike many of my generation, I want to be in charge of my life and I want to be in charge of my death. I want to know that I have the choice. I have spoken before on legislation in this policy area, and I said then, and I will say again now, that if I find myself in a position in which this legislation applies, I do not know what I would do and I do not know what choice I would exercise. Knowing my personality, I may well fight, fight and fight to stay alive. But if I know death is inevitable, I may well want to know that I have the choice to exercise the timing of my death. I may well exercise it, and I may well not exercise it, but I want to know that I can.

I am also highly motivated by the experience of others, most recently that of my friend Deborah Walsh, who died on 20 October 2017. Some members may have known her father, the late Senator Peter Walsh, who was the federal Minister for Finance in the Hawke government. Some members may know her husband, Gary Gray, who was national secretary of the Australian Labor Party and a former member for the federal seat of Brand. I knew Deb for the person she was in her own right. Deb and I were foundation members of the highly uninfluential cross-factional redheads caucus. That was started in the early and mid-1980s when factions were formalised in the WA Labor Party. Deb, Ruth Webber, Deb’s sister Anne, a few token blondes in Kate Ellis and Lois Anderson, and I used to meet in the Court Wine Bar after state executive meetings. We provided character analysis of those we liked and the many we did not like. We drank a lot, we resolved much, but none of it related to anything of significant political standing, and we did not influence a single preselection, but we enjoyed ourselves. We told great stories, and some of them were occasionally true. We took the proverbial out of the many terribly, terribly self-important blokes who were around us at the time.

Eventually, our lives took their inevitable different paths career and family-wise, and we all moved on, crossing paths every now and again. For example, I was at Deb’s wedding to Gary. Two years ago this month, I saw some of those people at Deb’s funeral. She was 54 when she died, following breast cancer. In August 2017, Gary rang me to tell me that Deb’s time was limited. They had been told she might last until Easter 2018. They were hoping she would last until Christmas 2017. Deb wanted the opportunity to make a submission to, or even appear before, the Joint Select Committee on End of Life Choices. I was keen to help Deb do that if I could. However, she did not get the opportunity to do that, because although her mind remained sharp to the end, she was physically frail. She was militantly in support of legislation to give effect to real choice for people with a terminal illness.

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In preparing my speech for today, I asked Gary whether I could refer to Deb’s views and circumstances. A few weeks ago, I caught up with him to take some notes. I want to thank Gary for sharing with me what was, and remains, obviously, a very significant tragedy in his life. This is what he told me. In early October 2017, Deb made the decision that no more investigations and invasive procedures would be conducted. She was strong in mind, but physically frail. She put Gary in charge of her dying, and she put her sisters, her mother and her friends in charge of her living. It was a constant open house and party. She picked the coffin. She picked the funeral proceedings. She wanted only the boys and Gary to speak. She was very, very strongly in favour of voluntary assisted dying. She wanted a system that would work. She had watched her sister deal with her father’s death, and she had watched Gary deal with his father’s death. She saw and was of the view that voluntary assisted dying laws would provide a map and a pathway for everyone. Her biggest fear was a painful death, and that it would be painful for her loved ones and might have a damaging impact on her boys. She was the mother of three sons. She could see how death could break some people, and she could see how death could make others stronger, but only if it was managed well. In the hospital, she had really good people look after her and her family. Those good people, including oncologists, were confident that she would live beyond the time that she lived. The night before she died, her oncologist said to her, “I’ll see you in the morning.” Deb said, “I don’t think I’m going to be here past tonight”, and she was not. She died at 7.50.

Deb wanted to give evidence to the committee, and I gave her, through Gary, a commitment that I would do whatever I could to help her do that. However, in the end, she could not do that. Therefore, I wanted to make these comments in my speech to honour my commitment to her, and to use her example to demonstrate to members why I so strongly believe that this is important legislation that needs to be passed.

When Deb died, her three sons were holding her. Her mum was holding her hand. Her sisters were around her. Gary was in the room, within her line of sight. Gary said that she wanted to express the view that the system as it is now is not an evil system. He said that she would have wanted me to express the view that there were thoughtful, courageous, caring, kind and highly professional staff who worked really hard to keep her alive. At the end, she had managed so well that she had the capacity to know when she wanted to let go, and she did. She knew how to be her own best advocate, but she also knew that plenty of others could not.

Deb’s death was beautiful, gentle and easy, and support was provided for those around her. One of the most poignant things that Gary talked about was the level of her decision-making. She had asked one of her nieces to paint the coffin that she would be taken out in. Equally, a kind of maturity, I guess, was exercised by her sons, the youngest of whom, Toby, was only 14 or 15 at the time and in year 10. The boys made the decision to carry their mother’s coffin into and out of the service, because they wanted to physically feel her weight in that coffin. Gary said that Deb did all the planning that needed to be done, with humour and good grace. She was bossing Gary to the end, and then she let go. She was gracefully in control, she was powerful and she was generous. But our culture does not do death well, generally. Deb wanted to know that everybody would be given the opportunity to exercise control and make decisions about how their last days, weeks and perhaps months, would be spent.

It is interesting that as part of the public debate, we have heard from health professionals on both sides of the argument. We have heard from two of the largest groups—nurses, through the Australian Nursing Federation, have publicly expressed their support for this legislation, and the Australian Medical Association, representing doctors, has taken an opposing view.

When I was deciding what I would rely upon in my comments, I read a lot of material. Some of that material came from the voluntary assisted dying debate in Victoria. I refer in particular to a document titled “Assisted Dying: Setting the Record Straight.” It provided a summary of some of the issues raised in the Victorian parliamentary inquiry. I thought it summarised those issues quite well, as did our own parliamentary inquiry here. It crystallised for me that every year, and in fact somewhere in Western Australia right now, families are struggling with how to best manage the end-of-life choice of one of their loved ones. Every year, desperate terminally ill Australians are ending their own lives, often in horrific circumstances. Some of the circumstances that were provided to the Western Australian parliamentary committee inquiry demonstrated that families are being traumatised after witnessing the bad deaths of loved ones.

Some of the mythology, perhaps, that has been expressed during the course of the public debate is that predicting whether someone is expected to die within a specified time is not entirely accurate and therefore we should not rely on doing it at all. “Terminal” is already a legally recognised term in Australia. Insurance companies accept whether someone is expected to die within a specified time is not entirely accurate and therefore we should not rely on doing it at all. “Terminal” is already a legally recognised term in Australia. Insurance companies accept
everybody. No matter how much money we put into the operation of palliative care as it operates now or even into research for better palliative care, it cannot meet the requirements of everybody. I think it is possible to chew gum and walk at the same time. It is possible to improve palliative care and provide additional resources, while at the same time putting in place a legal and medical framework that gives effect to voluntary assisted dying. It is not the case that we must do the first before we can do the second. I do not accept that argument, and I do not accept that most Western Australians accept that argument either. Not all terminally ill people view palliative sedation, whether it relieves the pain or not, as a satisfactory alternative to being able to make decisions themselves in those circumstances about the timing of their death.

The point I made earlier about what I might choose to do was I think well illustrated by Andrew Denton. In 2016, he made a speech at the National Press Club. In his investigations, when he looked at policies that applied in other jurisdictions, he described discovering a golden rule that applies the world over; that is, most people do not want to die. They will do just about anything to stay alive, to be with family, to celebrate a grandchild’s birthday or to wake up and marvel at the beauty of the sunrise, and I agree with that. I also think people want control and choice. The conclusion Andrew Denton reached was that if we do not give them that control and choice, desperate people will take desperate measures, and that people are dying awful, awful deaths when their deaths could be so much more dignified.

This debate has also been good because it has raised the issue of how we deal with death more generally. I refer to the section on end-of-life choices on the Australian Medical Association website. The AMA makes the point that end-of-life care is best managed around a conversation. The website states —

People do want to live with certainty about the end of theirs or their loved one’s life. It has not been hard to arrive at the conclusion that we are the problem, we the health industry, we the clinicians. We are the death denying industry, we are the death denying profession and until we —

Health professionals —

stand up and lead the way on this subject, our society will continue to suffer.

I quote an article from The West Australian about Scott Blackwell, formerly of the AMA. It says —

Scott Blackwell was a former president of the AMA and a leader in palliative care in Western Australia. He said that his own personal experience of the death of his wife, Naomi, strengthened his view that end-of-life care is about a person, not their tumour marker score.

The best indicator to measure the success of that process is how well the family grieves after their relative has died.

Further in the article he says —

“In my conversations with families of residents, I stress that hospitals are where you go to get fixed, not where you go to get care,” he says.

“If there is nothing that can be fixed, the best care you can get is in the residential care facility or at home.”

The article continues —

Doctors can be too busy trying to treat or cure, when sometimes the most humane approach is to step back and have a different conversation …

Dr Blackwell said —

“It’s about minimising suffering and maximising life … Alleviating suffering is the most important thing I can do, and I’m proud to say I work in a team that is really good at that.”

I held a forum in my electorate. I held only one; I wish I could have held more. I held it in Rossmoyne. It was in a smaller facility than I wanted, but it was the only one I could get with the amount of time I had to organise the event. It had the capacity to hold about 100 people. I sent out letters around the area of the hall inviting people to the forum. Within 24 hours of that letter hitting letterboxes we had a full house and we had to start taking extra names of those who wanted to come but who we could not fit in at that point. Eventually, when the forum was held, we had about 120 people in the venue. To a person, they thanked me for holding the forum. Three people out of that 120 stood and spoke against voluntary assisted dying, but they did so respectfully and politely. They were vehemently opposed to it. My judgement of people in the room was that the vast majority were in favour and the keywords they kept saying to me when I spoke to them over a cup of tea after the forum were “choice” and “control”. I had some emails from people who could not attend, and I want to share them with the house. The first is from Ted McEvoy, which I got, I think, the day after we sent out invitations. Ted lives in Bull Creek. He said —

Greetings Sue,

Thank you for your invitation to attend forthcoming the VAD forum.

I would have enjoyed attending the forum but I will be out of the country.

Extracted from finalised Hansard
I’ll be in the process of ticking off one of items in my bucket list by travelling on the TransMongolian Express.

I’m sure you would be aware of other similar situations but this is my personal circumstance. I have/had two daughters both born after my service in Viet Nam 1967/68. My elder daughter (Fiona) was born on 9th October 1969. Fiona’s younger sister (Brianna) was born 31 January 1973.

Around 20 years ago, Fiona was diagnosed with Crohn’s disease—she was urgently transported by the fantastic RFDS to Fremantle Hospital for emergency surgery. As a consequence, she lost her bowel.

Five years ago she contracted breast cancer and was treated by the excellent Prof Arlene Chan. Following a regime of aggressive chemotherapy, a double mastectomy and reconstruction, her cancer went into remission.

However, late last year, Fiona noticed a large lump in her abdomen. The cancer had spread into her vital organs. She was admitted into Hollywood hospital in early January this year. The prognosis was terminal.

Fiona’s parents, her close and extended family, her many friends witnessed her struggles to remain alive whilst suffering absolute agony and pain.

She passed away on January 2019—she was 49yo.

After being directly involved with the death of Fiona, I am absolutely convinced as to the proposed VAD legislation.

I’ve copied this email to my local MLA … to ensure he is aware of my strong opinion. This issue transcends petty politics—I would hope that all members of the WA Parliament will carefully examine their individual consciences and make a concerned decision.

Sue … with this email, I give you the rights to use it as you see fit, although with my express approval to do so beforehand publication.

I confirmed to him that I would use it. I received two other emails. I will not name the people who wrote these two emails to me, because I do not have their specific permission, but I will read them. The first says —

Good afternoon Sue

I am a 67-year old resident of Murdoch, Western Australia.

Over the years, I have witnessed family and friends become seriously ill, incapacitated and distressed about their frailty, medical issues and quality of life. For the last six weeks of my grandmother’s life in hospital, she kept repeating “I want to die” to every visitor. She was mentally alert but she had no hope of leaving hospital. It was awful to watch her decline. She had no control over her future.

If you are monitoring your electorate’s support for the Euthanasia Bill, please add my name to that list. I believe the Bill is a humane option for seriously and terminally ill people with little quality of life and no options for improvement.

The last email I want to refer to states —

My Dad died earlier this year. It was one of the most grateful times I’ve had in my life, I was able to give my dad the death he wished for. I nursed him at home and he had his final moments surrounded by us. This was made possible due to; being a nurse, having an understanding workplace and colleagues, a understanding and very supportive husband and supportive family and friends. All very specific things that aren’t available to everyone.

We had left the hospital the final time, after spending what had seemed like the last several years in and out of hospital, this was the final time. The nurses were crying, they all knew this was it and Dad was on his last journey. We had made a pact that we wouldn’t be going back, we would deal with whatever came our way together and at home. For Dad a hospice was not an option. We were given a wonderful palliative care nurse who visited once a week, they were all amazing and this service is completely invaluable in our community.

While this journey was incredibly powerful and special, there were many moments that were scary and uncontrollable. Our last Christmas Day dad spent in agony, the palliative team came and did all they could to control his pain. We all agreed the year before we’d call our final Christmas as that was the last year we were all able to enjoy. Unfortunately the end of his life was marred by uncontrollable pain. There were incredibly special moments but also incredibly scary moments. One of the scariest and painful things was the unknown. What would be next, when is the next? We had been given several scenarios of his potential death and none seemed peaceful and some were completely petrifying. We all lived with this unknown in his final days, hanging over us all, he was scared and vulnerable. He was a proud man his

Extracted from finalised Hansard
entire life and wanted to remain this way. In his final days he shrunk away, there wasn’t a quality of life, he seemed to have already slipped away. He wanted to die with dignity and I fought extremely hard to maintain this for him, but as explained earlier this isn’t always accessible for everyone. Not everyone has a child who is a nurse, who has the ability to take time off, who can move into their parents home. Not everyone wants to nurse/care a person in these final stages, it may be too confronting, too much even or have financial commitments.

I don’t know what may have happened for us had Voluntary Assisted Dying been legal at the time. But I do know that the options for people in the most vulnerable process of their life should be made available to them. That humans have the right to choose their own death with dignity and peace.

This story is incredibly personal and painful to me and my family. We don’t often speak about it and I only share this story with you to encourage you all to support the Voluntary Assisted Dying Bill.

I want to end where I began. This bill is about the timing of the death of those who are already dying of a particular terminal illness. Western Australians want us to give effect to their voice. They want this legislation to pass. They expect us to examine it in detail but they want us to do it efficiently and in a timely way. I know we can do this and I hope we will.

HON PETER COLLIER (North Metropolitan — Leader of the Opposition) [4.13 pm]: All of us know that this is probably one of the most profoundly emotional issues that we will ever have to deal with. I have had to deal with it twice now in this chamber; once with a motion by Hon Robin Chapple back in 2010. Prior to that, it had been dealt with six times. This is the first time it has been by government-sponsored legislation. As I said, it is a highly emotional issue. Given that, the Liberal Party made the right decision to make it a conscience vote, the same as all parties in this chamber. Can I say hand on heart that I have not spoken to one member of the Liberal Party to access his or her views on this legislation. I have not tried to intimidate, cajole or influence any member of the Liberal Party with regard to this issue. We have not discussed this issue in our party room. I want to make that one thing perfectly clear. Every member of the Liberal Party who stands today will base their contributions and views upon their conscience.

As I have said, it is a very, very emotive issue. In anyone’s language, two of the most profoundly emotional issues that any Parliament will have to deal with will be at the beginning of life and at the end of life. By design, in Australia over the last three months, we have dealt with the beginning of life—the conception; the abortion debate in New South Wales—and here in Western Australia we are dealing with the end of life, or euthanasia. The sanctity of life is paramount. Inevitably, those two issues are going to elicit an enormous amount of emotion. They deserve an enormous amount of scrutiny when we decide what is best for conception and what is best for death. We must scrutinise this legislation thoroughly and comprehensively. I make no apology for that. The sanctity of life is wonderful; it is paramount.

I will talk a little later about some personal influences with regard to where I stand on this legislation. I have pretty much been blessed with good health. Although I have seen a number of people around me not in such a situation and who in fact have suffered terminal illness and ultimately death, personally it has not impacted on me. I have come to a decision on where I will vote on this legislation based upon an enormous amount of research and an enormous amount of consultation and also how I feel personally about the sanctity of life.

Having said that, let us look very briefly at where we are at as a community in terms of dealing with the beginning of life and the end of life, and whether we give both elements due respect. Looking at the beginning of life in terms of the resources that we provide from conception to birth and then early childhood, the resources are legitimately phenomenal. Firstly, at the prenatal stage, public or private, there are state and federal contributions towards the pregnancy confirmation and check-up; the first trimester check; the ultrasound; monthly check-ups; prenatal and parenting classes; and full support at the hospital for high-risk pregnancies. In terms of maternity, public or private, state and federal contributions: full support is provided during the birthing process in hospitals of choice—public fully funded/private partially funded via the Medicare gap cover—there is postnatal support in hospital for two to 10 days; breastfeeding support; and postnatal mental health support specifically aimed at postnatal depression.

Child health, local governments, zero to five years: compulsory check-ups at regular intervals with a baby nurse; measured developmental support; ongoing breastfeeding support and ongoing mental health support. Immunisations, local governments, state and federal contributions: the schedule of immunisation starts at birth and goes through to adulthood; it is now compulsory, with no jab, no play. Federal financial support is tied to the immunisation schedule. Financial support, federal government, paid assistance: there is a raft of federal government assistance, including maternity allowance, paid parental leave, family tax benefits A and B, childcare assistance, parenting payments and so on. Support for parents includes family tax benefits, parental leave pay, dad and partner pay, additional childcare subsidy, parenting payments and so on.

The point I am making is that there is nothing more beautiful than the birth of a child and raising that child. We as a community give that child due respect. We provide all that we possibly can so that that child—he or she—can be the best that they can possibly be through nurturing. In some instances, of course, it does not work out that way because of community dynamics, but we as a community do all that we possibly can.

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Of course, there are issues when it comes to the end of a person’s life. The Royal Commission into Aged Care Quality and Safety has heard some extraordinarily disturbing revelations. The end of a person’s life due to a terminal illness is very confronting for the individual and the friends and family of that individual. It must be extraordinarily confronting for a person to go into a doctor’s surgery and be told that they have a terminal illness and limited time to live. We provide support mechanisms for that individual, but do we provide sufficient support mechanisms in all instances? Do we provide the same support services for an individual in Perth as we do in Melbourne, Sydney or Brisbane? Do we provide the same support services for an individual who lives in a remote Aboriginal community in the Kimberley? Do we provide equivalent support services for someone who lives in a mining town 200 miles east of Kalgoorlie—or in Meekatharra, Albany or Bunbury? We do not. Members do not have to take my word on this. The support services, in particular palliative care services, that we provide for individuals are sporadic at best in a lot of instances and non-existent at worst in a number of other instances. To suggest that an individual who has a terminal illness has the appropriate mindset to decide whether they will access the provisions of the voluntary assisted dying legislation and end their life is an issue we need to consider. We should not put the cart before the horse. At this stage, can we as a community put our hands on our heart and say, “Yes, we provide the support mechanisms for every individual who has a terminal illness”?

Members do not need to take my word for it. This Parliament has done an enormous amount in the area of palliative care. “My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices” is comprehensive. One chapter specifically deals with palliative care. Hon Nick Goiran’s minority report, “The Safe Approach to End of Life Choices: License to Care Not Licence to Kill”, also provides a considerable amount of information about palliative care. I will take a bit of time—not too long—to go through the particular recommendations in both the report and the minority report and what they have to say about palliative care. Chapter 3 of “My Life, My Choice” is appropriately titled “Palliative Care” and it states, in part —

It has long been held that palliative care should neither hasten nor postpone death—indeed, this premise can be found in the World Health Organisation’s definition:

*Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening 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. Palliative care:*

  - provides relief from pain and other distressing symptoms;
  - affirms life and regards dying as a normal process;
  - intends neither to hasten or postpone death;
  - integrates the psychological and spiritual aspects of patient care;
  - offers a support system to help patients live as actively as possible until death;
  - offers a support system to help the family cope during the patient’s illness and in their own bereavement;
  - uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
  - will enhance quality of life, and may also positively influence the course of illness;
  - is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is intended to assist in relieving symptoms and would usually commence once a patient has accepted that curative treatments are no longer appropriate. According to the University of Western Australia, palliative care is:

* [...] an approach to care that involves acceptance that the underlying condition is not responsive to curative treatment (or a decision has been made not to treat with curative intent.)*

That is a fairly accepted and appropriate definition of “palliative care”. The report is quite compelling about whether we provide palliative care across Western Australia. For example, on page 64 it refers to where people receive palliative care treatment, and states —

Consistent with access to medical care across Western Australia generally, how patients access palliative care will vary depending upon their socio-economic status and whether they are located in the regions or in the Perth metropolitan area.

That in itself is a problem; people who live in regional Western Australia may be less significant than someone who lives in the metropolitan area. The report goes on to say —

*WA Health provided a list of the 28 services currently accredited to provide specialist palliative care:*

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It lists them, but I will not go through them all. It continues —

The models of care available at each of these facilities differ and it would not be correct to suggest the level of palliative care provided is equal across them all. For example, four of the WA Country Health Service regions only have access to consultative specialist palliative care. Without access to inpatient or community specialist palliative care patients do not have the same level of choice as patients in the other parts of the state.

I emphasise that this is in the “My Life, My Choice” report. Finding 9 states —

Access to inpatient specialist palliative care in Perth is limited.

Finding 10 states —

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.

Recommendation 7 states —

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 understand that in recent times the government has committed to that in the northern suburbs, which is good and wonderful, but we still have a way to go before that facility is established and before we know whether it will be adequate. Finding 11 states —

Silver Chain is providing community palliative care to more patients than for which it is funded.

Recommendation 8 states —

The Minister for Health should ensure that community palliative care providers, such as Silver Chain, are adequately funded to provide for growing demand.

The report then refers to palliative care in the regions, and it is quite compelling. I am sure that most members would have read the report and learnt about the deficiencies in palliative care facilities in the regions of Western Australia. All I am saying is that, at the very least, we have to get to a point at which palliative care facilities in the regions of Western Australia are remotely adequate before we ever go down the path of saying, “This is perhaps your other option.” I hate to think that that will be the situation for some people who live in the regions, particularly those in the remote areas of the state. I will come back to that a little later.

I will briefly touch on the recommendations in Hon Nick Goiran’s minority report, because they pretty much mirror those in the majority report about the lack of palliative care facilities, particularly in the regions.

Recommendation 1 states —

The Minister for Health should consult with the Palliative Care Outcomes Collaboration (PCOC) and service providers to determine a data collection methodology that would set the lowest figures for unmanaged pain symptoms as the aspirational standard for every service provider.

Recommendation 2 states —

The Minister for Health should consult with palliative care service providers to ascertain the current deficit in capacity preventing equitable provision of specialist palliative care across Western Australia.

Recommendation 3 states —

The Minister for Health should assess the recommendations made by Western Australia’s peak body for palliative care and report to Parliament with a plan to:

a) utilise co-design workshops;
b) progress the Compassionate Communities model;
c) introduce shared care models;
d) increase the capacity of the Silver Chain Hospice Care Service model of care;
e) build the capacity of existing outpatient clinics to facilitate Advance Care Planning; and
f) increase the availability and flexibility of Telehealth.

Recommendation 5 states —

The Minister for Health should develop and roll out a community awareness program about specialist palliative care services.

This is another area that has been identified in the “WA End-of-Life and Palliative Care Strategy 2018–2028” and by the Ministerial Expert Panel on Voluntary Assisted Dying in its findings. There is a real lack of understanding about the palliative care facilities that are provided in Western Australia. Not only that, there is an enormous disparity in the palliative care facilities that are provided across the length and breadth of Western Australia.
I turn to the final report of the Ministerial Expert Panel on Voluntary Assisted Dying, which reinforces exactly what was stated in the report.

Debate interrupted, pursuant to standing orders.

Resumed from an earlier stage of the sitting.

HON PETER COLLIER (North Metropolitan — Leader of the Opposition) [5.07 pm]: Before the debate was interrupted for question time, I was going through the “My Life, My Choice” report to identify issues that had been raised about the capacity of Western Australia as a community to provide appropriate palliative care. A number of recommendations in that report and the minority report collectively indicated that there are some serious deficiencies in that area.

I would also like to draw members’ attention to the report of the Ministerial Expert Panel on Voluntary Assisted Dying, particularly the very pertinent dot point under the heading “Guiding Principles” —

- People approaching the end of life should be provided with high quality care, including access to specialist palliative care, to minimise their suffering and maximise their quality of life.

I do not think anyone would disagree with that. It is an identification that we, as a community, must get the order right. I suggest that we must get palliative care right in the first place, before we can contemplate legislation like that we are discussing at the moment.

I would also like to draw members’ attention to the “WA End-of-Life and Palliative Care Strategy 2018–2028”. That strategy was referred to in both the reports that I have mentioned. The vision of the strategy is to improve the lives of all Western Australians through quality end-of-life and palliative care. No-one can argue with that. Under the heading “Why the Strategy is needed”, it states —

End-of-life care is care that affects us all and is not a response to a particular illness or condition. Everyone will die; therefore, the Strategy is relevant and important to all of us. Death is unavoidable; however, we can change the way we talk about/manage end-of-life, death and bereavement and the way we plan, care and support those who are dying, including those who are close to them, such as their families/carer.

It goes on to say —

Delivering equitable end-of-life and palliative care across WA is challenging. This contributes to the need for a strategic, integrated, coordinated and collaborative approach.

Particular challenges include:

- inequitable access to end-of-life and palliative care based on need, e.g. geographical isolation and population groups
- increasing complexity, e.g. ageing and growing population
- ad hoc integration of specialist palliative care into care for people with chronic conditions

I will briefly go through the overview of priorities —

1 Care is accessible to everyone, everywhere.

That is the first priority. It continues —

I have access to good quality end-of-life and palliative care, regardless of who and where I am, or how I live my life.

2 Care is person-centred.

I am seen as an individual, and I have the opportunity to be involved in honest discussions with those important to me about my care. My values, culture and spirituality are respected and taken into account when care is given.

3 Care is coordinated.

I receive the right care at the right time, in the right place, from the right people. My care occurs within a coordinated/collaborative approach, enabling care to be delivered seamlessly.

4 Families and carers are supported.

Those close to me and/or caring for me are supported and involved in my care. The contributions made by my family/carer are recognised and valued by those providing my care, including their need to be supported during and after my death.

5 All staff are prepared to care.

Wherever and whenever I am cared for, all staff involved in my care have expertise, empathy and compassion. All staff provide confident, sensitive and skilful care, before, during and after my death.
Again, no-one can argue or disagree with the vision contained in that strategy. Whether we have achieved that at this stage, considering the strategy is from 2018 to 2028, is very debatable. Obviously, we would not have achieved it in the first 12 months of the strategy. Again, I emphasise the point that palliative care is an essential precondition for the end of life of an individual, and if we cannot provide extensive, comprehensive palliative care for all Western Australians, we should not be considering this bill.

I turn to other views from members of the community. As I said, I accessed the views of a number of people. I went to a number of hospitals and palliative care units and spoke to the specialists and clinicians. Those I spoke to, to a man or a woman, spoke of inadequacies with the current provision of services. I will draw from an open letter from palliative care specialists that I received from Dr Doug Bridge. The letter was written by 21 highly qualified Western Australian palliative care specialists, 16 medical specialists, four nurse practitioner specialists and a specialist pharmacist. The open letter states, in part —

The McGowan Government has invited public comment on its discussion paper Ministerial Expert Panel on Voluntary Assisted Dying.

We write as WA palliative care specialists whose vocation is caring for those who are dying. Between us, we have been privileged to care for tens of thousands of patients and their families. We would like to explain our position regarding the Government’s proposal to legalise euthanasia. In our conversations with our patients, their families, politicians, and even our medical colleagues, we are concerned about the confusion and misunderstanding regarding euthanasia and palliative care.

The confusion starts with the language. The discussion paper uses the term “voluntary assisted dying”. This term is ambiguous. It could be used to describe palliative care: we provide assistance to people who are dying. It would be less confusing if the discussion paper were entitled Ministerial Expert Panel on Euthanasia and Assisted Suicide. The older term “mercy killing” has fallen out of use, but is actually a more accurate description than “voluntary assisted dying”.

The proposal to legalise euthanasia and assisted suicide involves a massive change in the ethics of our society. “Do not kill” is a foundational ethical principle which has been observed by every civilisation for thousands of years.

Euthanasia and assisted suicide are not medical treatments, and most emphatically not part of palliative care.

Most people want to die at home. In Perth we are blessed with an excellent range of palliative care services, whether the patient is in a hospital, a Palliative Care Unit or at home. Sadly, many Western Australians do not have access to these services.

Unlike euthanasia, palliative care aims to provide total care (body, mind and spirit) for patients and support for their families.

With modern medications and procedures, we can almost always control symptoms. In extreme cases, at the request of a dying patient and his or her family, we have occasionally used deep sedation to control symptoms that did not respond to the usual treatment.

Rarely, a patient will say to us, “doctor, I just want to end it all”. Contrary to popular opinion, the reason for such requests is not pain, but despair and loneliness also called “existential suffering”. Euthanasia is not a treatment for despair and existential suffering. Provision of holistic care by a skilled interdisciplinary team of health professionals enables patients and families to acknowledge and attend to distress within themselves and their relationships. The time before death offers unique opportunities for psychospiritual growth and allows for healing even without a cure.

We agree with the discussion paper that, “too many Western Australians are experiencing profound suffering as they die. This is, in part, due to inequitable access to palliative care”.

According to the parliamentary records of 3rd April this year, Western Australia has the lowest proportion of specialist palliative care doctors of any state in Australia. We have 15 full-time equivalents for the state, less than one third the number required to meet national benchmarks.

According to the Honourable Jim Chown, whose motion was supported unanimously, WA needs at least another $100 million per year spent on palliative care for staffing and education, in addition to funding for infrastructure such as palliative care wards and beds.

We do not believe euthanasia or assisted suicide are solutions to suffering. We reaffirm our commitment to our patients: we will continue to care for you to the best of our ability, guided by your choices, but we will not kill you. Although we work in a variety of institutions, these opinions are our own and not necessarily those of our employers.

In addition to that, I have had several meetings with the AMA. It recently released a survey of in excess of 1 500 doctors. The results of that survey are quite compelling. I will not go into the details of the bill at this stage,
but suffice to say that should the bill pass the second reading stage, I will spend quite a considerable amount of time in the Committee of the Whole House dissecting particular clauses—that is on the assumption that it passes the second reading. Having said that, the AMA has raised a number of issues, both with palliative care and also the safeguards contained in the bill. I turn to the question about palliative care in the survey provided. The AMA asked —

Do you think that all patients should be offered accessible palliative care prior to, or at the same time as VAD?

Ninety-one per cent said yes, six per cent said no and two per cent said not applicable. The survey said —

*Bottom line:* Overwhelming majority—palliative care must be accessible, both financially and geographically, and delivery must be timely.

Another question was —

Do you think that the State Government should provide special support to patients outside metropolitan areas to ensure there is equitable access both to healthcare and to VAD services as part of the VAD Bill?

Ninety per cent said yes, six per cent said no and five per cent said not applicable. Beyond those survey results, the document states —

The AMA (WA) advocated for significant increases in spending on palliative care in WA, long before the debate on voluntary assisted dying (VAD) began. Our repeated calls along with those of others in the sector, have gone largely unfulfilled by governments of all political persuasions. However, on the eve of the State Budget 2019–20, the McGowan Government announced a $41 million increase for palliative care and end-of-life choices—spread over five years. With $5.8 million of that funding earmarked for end-of-life choices, this package brings the total investment by the State Government for palliative care services over the next four years to $206.2 million. This is around a third to a half of what we are told we should have.

For example the University of Notre Dame’s Chair of Palliative Medicine Research Professor David Kissane AC says WA needs an additional $100 million a year spent on palliative care over and above the circa $50 million allocated per annum.

It has been reported that Western Australia has:

- the lowest number, per capita, of inpatient palliative care beds in Australia;
- just 15 full-time equivalent palliative care specialists, when we are in need of 50 or more to match Victoria per capita; and
- just one in three Western Australians needing palliative care get timely access to these services in the format of their choice.

It is therefore disingenuous to talk of removing suffering, unless we also fix palliative care. We know that most patients will never access VAD. However, most will need palliation, including those who do want VAD. While GPs form the backbone of palliative care services, they are often reluctant to become involved without the eco-system of back-up that palliative care specialists and community nurses provide. As a result, the regions are especially impacted by the lack of adequate palliative care services.

The WA Palliative Medicines Specialist Group outlines specialist support in the regions:

- Pilbara: one visit a year;
- Kimberley: six one-week visits per year;
- Geraldton: 10 single-day visits per year; St John of God Hospital Geraldton offers in-patient care at an eight-bed hospice for both public and private patients.
- The Wheatbelt: 12 single-day visits per year;
- Kalgoorlie: one day per month;
- Esperance: once every three months;
- Bunbury: two specialists run a 10-bed hospice and an outpatient clinic;
- Albany: one palliative care physician funded for six hours a week, with only three hours a week to run an outpatient clinic. Albany Community Hospice is an eight-bed in-patient palliative care service open to both public and private patients.

One of the key concerns is ensuring that long into the future, decision-makers do not view VAD, even subliminally, as more cost-effective, practicable or indeed more compassionate than the adequate provision of palliative and other care services. Properly funded palliative care will continue to serve most patients with terminal conditions very well, and VAD should never be discussed with a patient without the availability of palliative care and other management options being assured first. Patients may not want palliative care, but they certainly need to have that option accessible and it needs to be the government’s priority.
That is quite compelling, particularly those figures that show in some instances in the rural and remote areas of the state people have access, if they are lucky, to one palliative care specialist a year.

There are a number of other examples of the lack of palliative care facilities. In summary, the points made in the reports, the palliative care strategy and the work done by government indicate that palliative care facilities throughout Western Australia are lacking. In a nutshell, the issues are such that access is even further limited in rural areas and almost non-existent in remote areas. For example, in its submission, the WA Country Health Service told the Joint Select Committee on End of Life Choices that there is limited oversight, coordination and governance of medical palliative care services across its services. This, together with the barriers to access across the state generally, must be addressed by the state government. I acknowledge the $46 million that has been put towards palliative care and the $17 million that has been added recently. Quite frankly, there is still a parlous lack of palliative care resources across the state; that is in both the metropolitan area of Western Australia and in the regions.

According to WA Health, public hospices usually accept patients with only very short life expectancies. The average length of stay for a patient is only 10 days. Patients, regardless of their condition, expected to live for many weeks or longer may not be accepted because they will block access to the beds. The number of hospice beds required requires a high level of patient turnover.

Palliative Care WA, call logs and other evidence suggests there are a number of people for whom existing services cannot meet their needs. They are not yet close enough to death to qualify for hospice care, but challenging health or family situations mean they are unable or unwilling to receive palliative care in the home or other community settings. They will likely be accommodated in hospital wards or aged-care facilities. There is no obvious or agreed solution to this problem. Options include the development of intermediary stages or longer term hospice facilities; increasing the capacity in existing hospices to ensure there are enough beds; and developing new hospices in geographically dispersed areas outside current localities with a high concentration of hospice beds.

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. It is expected that over the next four years $600 million will be needed, and medical specialists in the field need to increase from 15 to 50.

I feel that the evidence presented and tabled in this chamber is compelling in that palliative care facilities are simply inadequate in Western Australia. I do not want it to be seen as an option between euthanasia and appropriate palliative care. I would like to think we can have both so that if someone is at the point of their terminal illness where they cannot think of an option, at least we know that we provided that individual with the care, support and mechanisms to ensure that they had the appropriate mindset to make that decision, and not before. Can we really say at the moment that we are in that position? As I said earlier, can we say to terminally ill people in the Pilbara, the Kimberley, the midwest, the goldfields, in the south west in particular, and in the northern suburbs of the metropolitan area that we are doing all we possibly can to ensure they are surrounded by people who love them and that they are surrounded by clinicians in medical facilities who are appropriate to ensure their decision is based on that premise, and not that there is no alternative?

As a member of the Legislative Council for the North Metropolitan Region, a number of people have spoken to me about this. A number of people have also written, which I will speak about in a moment. A number of members in the other place spoke of personal experiences. When people speak or write to me, they will frequently—I can understand it; I am not offended—base their comments on the assumption that I do not understand and that I have no idea what it is like. Personally, I do not; I simply do not. I do not understand what it must be like to have a terminal illness. But I have experienced it. I do know what it is like to surround someone you love, and no matter what you say and do and no matter how much you love them, you cannot do anything. In both instances, those two very important people in my life never, on any occasion, expressed a desire to end their life. They were fortunate.
pass away, but the manner in which my father drew his last breath was as dignified as anyone can imagine. It really was dignified. I love him so much and I miss him so much. I hate the fact that he died, but that he died in the way that he did gave us some comfort.

I am not quite sure whether I will get through telling members about the second person but it is important that I talk about her. I lost my soulmate on a cold June morning in 2009 after she had been diagnosed with multiple myeloma four years prior. If members know anything about multiple myeloma, they know that it is one of the most hideous forms of cancer one can imagine. She underwent full blood transfusions and by the end, she was having them every few months, which in themselves were extraordinarily painful. I had just become a minister and I had mixed emotions; it was a terrible time. I would leave here to visit her. More often than not in her last 12 months she was in either St John of God or Hollywood Private Hospital. A lot of the time she was unconscious, but I would lay there with her. She never once indicated any desire to go early. She was surrounded by a wonderful loving family and magnificent health facilities in the palliative care unit. She was the most beautiful woman in the whole wide world. Towards the end, she came good. Three weeks before she passed away, we were sitting there and it was the first time she showed any emotion. She said, “This isn’t fair. But I wouldn’t change a thing for quids.” The last few weeks were traumatic because we knew she was going. We had been told that she was going and that it would be only a matter of weeks. As I said, she slipped away on a cold June morning and the world lost the most beautiful woman in the whole wide world. She had magnificent care during that time. I personally saw the staff afterwards and both the family and I sent them flowers. In a very unfortunate situation, she was one of the fortunate ones because she had the care and support that a lot of people do not have access to. It really pains me that we as a society are not talking about an alternative to death to support someone through the process as much as we possibly can. I am not saying for a second that anyone in this chamber does not want to do that, but we simply do not. The evidence I have provided over the last half an hour and that members have read is stark evidence that we have to do so much more to ensure that what my Cherry and my father were provided with is provided to every Western Australian. Until we reach that position as a community, I do not see how we can go down the path we are considering today.

I will talk about one of the most vulnerable groups in our community—I have talked about it indirectly—which is Aboriginal people. As I have said on numerous occasions, I am a proud Kalgoorlie boy. I grew up with the Wongi people and I have deep personal regard for Aboriginal people. It pains me that one of the groups that is very vulnerable and susceptible to a lack of palliative care facilities is Aboriginal people. The former government put in place regional services reform and the current government has continued it. I would like to think that the quality of life of Aboriginal people in remote communities will ultimately benefit significantly, particularly in the area of health, but we are nowhere near that at the moment. I draw on the comments of an Aboriginal man, Senator Pat Dodson, who stated —

First Nations 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 Nations child is at higher risk of contracting life-threatening bloodborne diseases. Last year, six First Nations babies died of syphilis. Our 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.

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 Nations people are already living with kidney failure, without sufficient access to dialysis. The burden of disease and disability in First Nations communities is far higher than it is in the general population. First Nations people are more likely to live with a severe or profound disability. They also die younger. On a national basis, First Nations men can expect to live to an average age of 69, while non–First Nations men can expect to live to 80. First Nations women can expect to live to an average age of 73, while non–First Nations women can expect to live to 83 …

With so many of our people suffering complex health conditions at an early 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 that First Nations people are receiving palliative care within their communities.

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. Paving the way for euthanasia and assisted suicide leaves First Nations people even more vulnerable, when our focus should be on working collectively to create laws that help prolong life and restore their right to enjoy a healthy life.

He concludes —

In the broad sense, we are part of a common humanity. If we give one person the right to make that decision—that is, to assist in committing suicide—we as a whole are affected. If we give one family that right, we as a whole are affected. If we give one state or territory that right, we as a country are affected. If we give one nation the right to determine life, our common humanity is affected.

Extracted from finalised Hansard
I could not have said it better myself. In addition to Senator Dodson’s comments, I draw from one dot point from the 2016 review of palliative care, which was done for the Department of Health. It states —

There remain significant barriers to access to palliative care services for a number of people within the population, particularly for Aboriginal and Torres Strait Islander peoples. While some progress has been made in raising awareness of palliative care services in culturally appropriate ways, the cultural security of palliative care services varies significantly. The Strategy does not focus on groups which have traditionally not accessed palliative care services; developing culturally-specific activities to address the needs of Aboriginal and Torres Strait Islander peoples may help to improve access to services for those who need it.

Having said that, I do not want to continually repeat myself. I will conclude with some figures but, suffice to say, I am conscious of the fact that the government has provided additional funds for palliative care. I am concerned, first, that the amount is insufficient and, based on the comments that I have articulated today, it is seriously deficient; and, second, it is sporadic at best and non-existent at worst. We cannot go down the path of looking at the alternative before we provide that option. Comprehensive palliative care is an absolutely essential prerequisite before any consideration is given to voluntary assisted dying or euthanasia.

To conclude, I have listened to the views of the community. I am very conscious of the views of the community as per published opinion polls. An opinion poll of 656 people was printed in The West Australian of 26 August and it revealed that nine out of 10 of those polled want euthanasia. I would be interested to know what question was asked on that particular occasion. Was it do you support euthanasia or was it do you support euthanasia before appropriate palliative care is provided? I would be very interested to know what that question was. Suffice to say, that view has pretty much been seen across the board with published opinion polls. I have received in excess of 1 100 emails, most of which were received in the last few days after our phone numbers were published. Around three-quarters of the writers said no. It has gone down to about two-thirds saying no now, with people being prompted into action. Of those 678 people who wrote to me, 525 were against and 53 were for the legislation. That is completely filtered. It is unambiguously truthful. That is where it is at. That is what I have been provided with. That is a consideration of course. I also acknowledge the fact that publicly presented polls consistently show that the majority of people are supportive of the legislation. I am conscious—I will repeat this—of whether the questioning in that area necessarily provides the option of palliative care. I feel very strongly about this. I am very conscious that a significant number of people with a terminal illness desperately want this legislation, along with a lot of families and older people. I am also conscious that a lot of people who are in that frame of mind do not have the adequate palliative care that they so richly deserve. Until we as a society and until this house can say that every single Western Australian has appropriate, comprehensive palliative care opportunities, I cannot support this legislation, so I will not be supporting the second reading.

HON ALANNAH MacTIERNAN (North Metropolitan — Minister for Regional Development) [5.41 pm]: I have to say how pleased and in a sense surprised and almost a bit unbelieving I am to be here today and have the historic opportunity to legislate to give Western Australians control over how they die—to provide for our citizens the right to choose to have medical assistance to end unbearable pain and suffering at the end of their life. I have always supported this cause. I have always very firmly had the conviction that people should have this choice. It is essential for human dignity that each individual has the right to make that choice.

I have been involved with Dying with Dignity Western Australia and its predecessor, the WA Voluntary Euthanasia Society. I want to take this opportunity to really pay tribute to that group, which has been battling away at this for 40 years. I acknowledge people such as Murray Hindle, who led the group for so long, and Dinny Laurence, who have really kept this cause alive.

I regret to say—it is to my shame—that until five years ago, I never made this cause a priority. I remember Hon Robin Chapple contacting me in about 2009 when he first started rounding up the numbers. I said that I would support a bill. I did not do anything to progress the cause, even though I felt very strongly about it. When I was travelling to Canberra one Sunday afternoon in 2014, I was reading an article in The Monthly. It was asking why this right for medical assistance to die was not legislated anywhere in Australia even though the cause had the overwhelming support of the public for many decades. It asked what that said about our politicians and questioned how disconnected they were from the wishes and aspirations and space where the community was at. I felt deeply ashamed because I was one of those people who supported it, but it was a complex and messy issue. We knew that the people who opposed it opposed it with such passion that it always became a complicated issue. I had not really pulled my weight in this regard during the many years I had been in public life. When I arrived in Canberra, I rang around and found that Richard Di Natale from the Greens and Sharman Stone from the Liberal Party were strong supporters of this cause, and together we became the joint conveners of the parliamentary friends of Dying with Dignity in the federal Parliament. We tried to explore what we could do in a federal sense to promote this cause. We did quite a lot of work highlighting the need for these issues and supporting the territories to have the right to determine legislation in that regard.

When I finished up in federal Parliament, I remember the then Leader of the Opposition, Mark McGowan, approached me and asked if I would be interested in coming back into state Parliament. I told him that he needed
to know before he made the offer that I was very committed to this cause and I would want to pursue it if I got back into Parliament. He obviously had no problem with that. We saw a build-up of community interest in and pressure for action on this issue. In the lead-up to the highly contested 2017 state election, for the first time we saw many politicians getting off the super six and honestly answering how they intended to vote on legislation of this type. There was a big campaign by the Dying with Dignity group and also doctors for choice. Many people from both sides of Parliament, and often in very marginal seats, were prepared to stake out their position. I do not think any person was disadvantaged by supporting this cause during that election. It has been observed by many members that this was really the first election in which this issue was at play in Western Australia.

Having moved this legislation forward, our government has done the right thing. It has given the Parliament not only the right, but also the obligation to make a determination on this issue for the people of Western Australia. I understand and respect the wide diversity of views in this place. It is absolutely important that we vote on this legislation and bring this issue to a conclusion. That is what the community expects of us; it wants us to make a decision. We understand that with legislation such as this, there will be a great deal of scrutiny. We are all expecting that, and we think that is right and proper. At the end of the day, it is important that before the end of this year, we as a Parliament stand up and be counted, make a decision and vote on this issue. I hope with great passion that we make the decision that the vast majority of the community wants us to make.

We have gone about this process with great thoroughness and rigour. I was very impressed with the work of the Joint Select Committee on End of Life Choices—it was extremely thorough—and then the work of the ministerial advisory group and the decision to have a government bill to ensure that all the complex matters could be properly dealt with. As I said, it is now up to us as members of Parliament, as people representing our community, to make the decision.

Like the Leader of the Opposition, I believe in the sanctity of life. I think that is absolutely essential and is at the very essence of our civilisation. However, I truly believe that having a good death, to be able to face dying without fear, is integral to a good life. This whole legislative package is life-affirming. It is about giving people the opportunity to have the comfort that in those final days, they are not going to have a horrible exit from this world. To me, that is honouring life.

Quite rightly, we talk a great deal about palliative care services as part of the suite of end-of-life choices that must be available to people. The government acknowledges that the services are not perfect and that they are not always even across the state, but we rank well by world standards. There has been investment in this area. We also know that jurisdictions that have end-of-life choices legislation generally invest more in palliative care. We have acknowledged that all this examination of palliative care has highlighted some shortcomings in WA. We have invested an additional $60 million to address some of those shortcomings. The critical issue in this state is that clear evidence exists that there are hundreds of cases each year of people who are beyond the reach of palliative care, not in a geographic sense, but because the nature of their condition is such that it cannot reasonably be alleviated by palliative care. Those stories abound. They abound in the reports that have been presented and they abound every time we have a forum. I have personally participated in 10 forums in the four or five months leading up to this legislation being introduced. Many cases that simply cannot be alleviated are listed in the report—for example, bone cancer, neurodegenerative disorders and many of the lung disorders. I note the Leader of the Opposition’s very moving account of his father’s condition. It is estimated that around 500 Western Australians are currently suffering in these ways. This is not just a theoretical problem; it is a real, present problem. No matter what we do in developing and expanding palliative care services, and as important as that is, there are probably 500 people, maybe more, in Western Australia at the moment who are suffering from conditions the pain and suffering of which cannot be alleviated by palliative care.

We know the terrible reality is that around 10 per cent of suicides in Western Australia, and indeed in many advanced countries, have been attributed to a person taking action to alleviate a terminal illness. We know from many of the stories from our constituents and matters on the public record that many people end their life early by suicide because they want to take action while they are still physically capable of doing that. Hon Robin Chapple will know well the case of Clive Deverall, who was head of palliative care in WA, and such a leader with the Dying with Dignity campaign early on. I remember Clive telling us how angry he was that action was not being taken, knowing that there were hundreds of people suffering in pain; we could relieve it, but we were not doing it. We then heard on election day that Clive, who had been diagnosed with a terminal illness, went to a polling booth at a school and then took his life. He shot himself. He shot himself because he wanted to do two things. He wanted to have control while he was still physically able, but he wanted to make the point that this was something that had to be dealt with. I hope that Clive, from beyond, and his lovely wife, Noreen, will take some comfort from the fact that his inspiration, his work and his advocacy have been part of a great movement that has led to the historic legislation that is here today.

After the dinner break I will talk a little about some of my personal experiences and some of the experiences of my constituents and people around the state. There has been some contention about a couple of aspects of the bill that I think are really important. One is the obligation of a doctor to set out all the options for a patient who has a terminal illness. The Victorian legislation contains a provision that prevents a doctor from raising this issue with
their patients. I find it an extraordinary proposition that we would not want people to know what their options are. I think this is really underestimating the sense and desire of our community to be in control. To me, the idea that there should be an option there, but people are not allowed to talk about that option unless they have the knowledge, or indeed it might be the case that they raise it with a doctor, is a very unfortunate provision in the Victorian legislation. I urge members to think about this, to think about the importance of a person being given all options. I think it is thoroughly misleading to have a situation in which they have a doctor advising them about their options, but there is one that they are not allowed to tell them about. It is almost as if this is a studied misinformation campaign because presumably a person will take the view that they have been presented with all the options, but in fact one is missing. I know there is a bit of debate going on around that particular aspect, but I urge members to respect the right of people in the community to know what options will truly be available to them should we manage to proceed with this legislation.

One of the constant themes at the forums on voluntary assisted dying is that this legislation does not go far enough and that many people want to be able to make an advance health directive in the event that they are suffering dementia and are not capable of going through the process that we have laid out, which is underpinned by an active request. It will absolutely not be possible to do that. At the very heart of this legislation is that question of conscious choice. It is us saying that it is the person at the heart of this who must be the person who has the right to choose. It is not the doctor. It is the patient; it is the person whose life it is. Any advance directive would require intervention by a third person who interprets that advance directive and says that this is the point now.

_Sitting suspended from 6.00 to 7.30 pm_

_Hon ALANNAH MacTIERNAN_: I want to now go on and talk a little about some of the personal experiences I have had that I think illustrate some of the dichotomies and issues that we need to deal with. I will then move to the stories from people in my electorate and around the state who have contacted me.

When my mother died some 11 years ago on my birthday, it was the best present I could ever get, because I had felt so immensely guilty about her suffering. She had asked me many times whether I could kill her, because she was at the point at which there was no enjoyment of life whatsoever. Both physically and mentally, her life was incredibly challenging. There is no doubt that the pain, and the suffering in particular, that she was going through meant that this was a life of virtually no quality. On the other hand, my father-in-law came to live with us in his 90s during the last weeks of his life, to be at home surrounded by family. Even though his death was quite challenging—he had massively fantastic care by Silver Chain—I never got any sense that he would want that life to be finished early. People are different. It is very important for us to understand that this is about choice. If this legislation is passed, that choice will still be available to people.

In the last 20 months, I have watched two deaths very closely. One was of a very, very close friend of mine, Jennifer Harrison, who had been my very, very good friend for over 40 years. When Jennifer got her diagnosis of metastasised cancer some two years before, she made sure that every possible moment was as full and as rich as possible. She was someone who absolutely wanted to seize every opportunity that life still had to offer—to be surrounded by friends and family and to go off and have new adventures. But when the time came, when her pain was so great and her mobility had been so compromised, she had the benefit, again through massively excellent palliative care and negotiation with the palliative care service, of terminal sedation. I was with her for eight of the last 12 hours of her life, during that time when she was receiving palliative sedation. I am confident that those 12 hours were not a cause of distress for her and that she passed from life looking as fabulous and gorgeous as she always had. It was peaceful; it was a good death.

Some six months later, I was dealing with an elderly relative, and the story is the exact opposite. This was someone who wanted to die. She was in her mid-80s. She had stopped eating for quite some weeks—she was really just skin and bone—and she was kept on a regime of very light sedation in a nursing home for around 14 days. I watched her go through enormous distress. Every day I visited the nursing home I would ask them to provide more relief, but it was done in such a way that it just strung out her death for weeks. Her death was eventually caused by massive organ failure. This was not a good death; it was a good death.

Some people say that we already have terminal sedation or palliative sedation, but that depends very much on what the doctor is prepared to do. What we are asking for here is that the patient, the person whose life it is, be the one who makes the choice—that they have the sort of choice that my wonderful friend Jennifer had to have a decent and not too protracted end to this experience, so that they are not kept for weeks in a state of semiconsciousness and with no real relief from that suffering. I know that many people have had a variety of experiences, but if we drill down, what they are telling us is that we need choice to reside not with the doctor, but with the person. That is the essence of this legislation. It does not mean that we are denying those people who believe that they want to fight on to the end and that there is dignity in that suffering; we want them to have that choice. We want everyone to be able to make those decisions for themselves.

I will spend most of the rest of my time going through some of the submissions and letters I have received in the last couple of weeks. As I said, we have run 10 seminars around Western Australia. Overwhelmingly, people have been
telling us stories that reinforce this message that palliative care is not the solution for everyone—that there are many cases that are beyond the reach of palliative care. I will go through a very small sample, believe me, of stories from Western Australians, who are telling us why we have to get this right. Professor Ian Hammond from Subiaco said —

I retired from clinical practice as a Gynaecological Oncologist in 2012, and since then have been involved with the Federal Dept. of Health, Chairing national committees that have led to the renewed National Cervical Screening Program …

In my 30 years as a Gynaecological Oncologist, there were several occasions when women who had end stage gynaecological cancer, and who had accessed Palliative Care, but were unable to get relief from intolerable symptoms, usually bone or nerve root pain, and asked me if there was anything that I could do to ‘end their suffering’. This request came from the women, not their relatives, and sadly I was unable to offer them anything apart from ‘terminal sedation’ which for many was just temporally inappropriate.

I fully recognise that Palliative Care services will provide relief for the vast majority of the WA community, but there are occasions, probably about 3–5% of cases, where Palliative Care cannot provide complete relief, and this is generally accepted by the specialist Palliative Care community.

…

There is a much better solution and I believe our society must be humane and treat ‘ourselves’ as well as we would treat animals who are suffering. We can, and must, do better. Currently we do not, but the VAD legislation once enacted will lead to a significant improvement in end of life …

Wendy Hewitt has written to me. She said —

I watched my mother dying of pancreatic cancer and pleading with my father to end her life. You can just imagine what an impact that had on all of us especially my Dad. I realise that not everyone agrees with my stance, however as an active member of the Wembley Downs Church of Christ my experience is that many members of the congregation have already signed a petition to be presented to support the legislation. We believe this in line with the compassion of Jesus.

Trevor Bordas from Girrawheen has said —

My input to this debate comes from six years working in the aged care industry as a Carer. It was the most rewarding work experience of fifty years. In the six years, I was able to share with Residents and their families their end of life experience. Palliative care figures high in the debate. It has it’s place but is not an experience that defines a better exit to life. If we are all honest, voluntary assisted dying already exists in society, in a form I have witnessed. I have witnessed the end of life experience of perhaps one hundred people and in most instances it has been distressful to the individual and not deserved. In my own instance, I live with three types of cancer within my body, one of which is Stage Four and probably will be the cause of my eventual demise. I appreciate my life but do not want to experience end of life torment and fear that I have observed.

Helen Swale from Mosman Park says —

Many of us who support this end of life Choice have a story to tell as to why we do so, having experienced first-hand what it is like to see a loved one die a painful death despite the best that palliative care could offer. Here are mine.

My father, having been diagnosed with Motor Neurone, indicated to us in the family that at some point he would take his own life—at the time of his choosing. My mother did the right thing—got rid of the shotguns he hunted with and any drugs around the house as she tried to keep an eye on him generally. He had been a strong man physically and mentally and found the wasting of muscle, difficulty swallowing and lessening ability to perform basic tasks devastating as it robbed him of any quality of life.

He had asked a Canadian friend to bring a large bottle of aspirin when next visiting … This childhood friend wishing to kind and helpful to his childhood mate innocently fulfilled that request. A few weeks later, my mother heard my father vomiting in the bathroom and discovered that he had mixed a large number of the pills in a glass with water which he stirred with a toothbrush and swallowed. He was rushed to hospital where he told medics that next time he would “do the job properly”. Well, he didn’t need to try as he’d done enough damage to end his life when re-admitted two days later and died two days after that. I wasn’t there but according to my mother, it was pretty awful.

Helen goes on to talk about her mother’s very painful death. She says —

I’m not afraid of dying but I’m very afraid of how I die. I don’t wish to go through what my parents went through and more importantly, I don’t wish for my children to have to see or experience anything similar, particularly when there is the possibility of doing things a better way. I wish to have Choice. And Choice is what we who support VAD are asking for.
Jeff Rose from Scarborough writes —

My viewpoint has been strengthened by the suffering of my 70 year old … twin Andrew during the last years of his fight against cancer.

His medical treatment failed him as it was too late due to him being wrongly diagnosed with a primary lung cancer when he was actually in the grip of stomach cancer … The outcome of this negligence was that treatment including removal of the lobe, chemo and radiation, found him free of lung cancer but a negligent delayed scan of his body found the source which was stomach cancer and by this stage he was too weak, depressed and disillusioned … that he decided to hasten his own death at home.

He called in his wife son and daughter and told them of his decision to deny more rounds of chemo and radiation, then contacted Silver Chain who transported a bed equipped with a morphine pump to the lounge room of the family home where his wife had shifted her bed to and denied food and sucked ice blocks until he died an emaciated skeleton quite a few months later.

Andrew, his wife, children and grandchildren and myself suffered indescribable anguish at the spectacle of him fading away more each day over an extended period.

By the time Andrew had decided to take his own life he was too weak to do anything but his mind was still active to the end and he was acutely aware of not only his own suffering but the suffering of his loved ones.

Andrew’s family, my family and many friends as a result of suffering with Andrew support the VAD Bill and I ask that you also support this overdue humane legislation …

Vivienne Overton of Carine wrote —

I watched my mother die slowly and painfully, although she asked many times why someone couldn’t help her end her suffering. I now have Stage 4 lung cancer which has metastasised into my bones and now my brain. So far the treatments I’ve been having for the last two years … have helped enormously and no-one is prepared to put a time limit on my life span, but there IS no cure and it’s just a matter of time before I become severely incapacitated …

Why shouldn’t I be able to decide for myself when I’ve had enough? PLEASE support the VAD Bill before the Upper House so that I, and those in my position, have this choice.

Yvonne Bowey from Kulin wrote —

I have taken to writing this email as I feel so strongly about the urgent need for the VAD legislation … I am currently living and breathing the palliative care system, with my Dad in a regional hospital in the palliative care room. This is on top of watching my Grandmother in Law, battle and lose the same fight recently.

The care that is being given to my Dad is fantastic, but it cannot keep up with his pain levels. We are constantly being told that he should not be in pain and the aim is to make him comfortable, but the medication is not keeping up. There is a constant demand for increased medication, which comes as a reaction to pain, not as a preventative. Dad is of very sound mind and it breaks my heart that he is begging to die, his last wish, and we cannot accommodate this. For someone who has worked and volunteered all his adult life, he deserves the right to choose to end his suffering.

And this is really what this is about—choice. When (and I hope sincerely this is a when), the legislation exists, people still have choice, whether to use VAD or not. Currently this choice is not available and so many of our loved ones are suffering needlessly. I am tired of legislation being enacted for the minority and not the majority.

Hillary Whyte of Scarborough wrote —

I am a nurse with seventeen years of experience in the field of oncology, Haematology and terminal care in a private hospital. I have witnessed so much grief around the manner in which many of my patients have died. I am sixty years old. I have nightmares about dying in a hospital where someone else controls my death. I beg of you, please pass the voluntary assisted dying laws.

Fiona Harris from Dalkeith wrote —

I was diagnosed with Stage 4 Bowel Cancer 4 1/4 years ago. Since then it has returned 4 times—most recently I was told by my oncologist today. I am still hoping to beat this dreadful disease, but I watched my mother-in-law die from it some 7 3/4 years ago.

If and when my time comes, I want to be able to decide when enough is enough. Let me assure you it will not be a decision that I will take lightly, but having had the number of surgeries and chemotherapies that I have had, I believe it should be my right to be able to say when I do not want my life unnecessarily prolonged.

So I support the VAD legislation … It has been well thought through by some of our finest minds, and already incorporates appropriate safeguards.

To be clear, this law is not about life and death—it just gives those who are already dying, and suffering more than they want, the right to choose a peaceful death.

Extracted from finalised Hansard
Maureen Duckett from Greenwood wrote —

I have worked in a hospital. I have had family who have died an awful death—in hospital and in nursing homes. I would like to be able to decide how and when to die—I’m not asking anyone else to die—just me. I can’t understand why someone I don’t know would like me to suffer. So many people, a great majority, want this law to pass so I don’t understand why some elected members put their reasons ahead of mine—they will be remembered for not taking any notice of their constituents.

Please vote for this law.

Trevor Hay from Nannup wrote —

I am a 66 year old, conservative voting atheist. I also have multiple myeloma … an incurable blood cancer. 18 months ago I experienced a level of pain I never thought possible as a result of my cancer (which had ‘eaten’ my bones). I wouldn’t want to live with that. A palliative care doctor prescribed a drug regime that had me in ‘la-la’ land. I wouldn’t want to live like that. I don’t think that anybody has the right to force me to do either if I choose to take an alternative route. That choice should be mine alone.

Brenda Cuthbertson of Trigg wrote —

After watching my father —

Die —

by starvation, as there was no other way for him to stop living. He had no quality of life, no dignity, was in constant pain and was going to get progressively worse. I would ask you to support this bill.

Jane Bell of Middleton Beach wrote —

Please support the assisted dying proposal. I am 58 years old and have progressive advanced breast cancer for which I have been undergoing treatment since 2012.

I have been fortunate to be under the care of Professor Arlene Chan whose expertise has enabled me to live confidently and comfortably with the disease as it progresses. I still live an active healthy life cycling, walking, swimming, sailing and valuing every minute of my life.

My greatest fear is prolonged suffering with deterioration. It would be of great comfort to know that when the suffering from the disease cannot be contained, that palliative care will allow me to choose to cease ineffective treatment and choose a course of action that gives me control over the situation.

Please vote to introduce laws that will provide people with an incurable illness the right to choose assisted dying medication to avoid prolonged suffering which will ultimately result in death.

Honourable members, I could have gone on for hours with these stories; this is just a small sample of the stories that have come in. They clearly demonstrate the reality. This is not theory; this is the reality—that there are many hundreds of people out there each year who are beyond the reach of palliative care, no matter how much we invest in it and no matter how good our professionals are. More than 80 per cent of the people in our community are asking for choice—choice about their lives, not choice about anyone else’s life. I urge members to listen to this painful reality and dignify our community and give each and every one of our citizens the right to make that fundamental choice at the end of their life. Thank you.

HON SAMANTHA ROWE (East Metropolitan — Parliamentary Secretary) [7.55 pm]: I rise to make my remarks on the Voluntary Assisted Dying Bill 2019. I would like to commence my contribution to this debate by very clearly stating that I am in full support of the current bill that is before this place. I intend to vote for this bill when the time occurs, hopefully within the coming weeks.

It is my belief that a secular society should seek to alleviate suffering wherever it may exist. I also believe that no-one should suffer for somebody else’s beliefs. I think the debate in the other place was an example of parliamentary democracy at its best with, by and large, considered contributions, very insightful questions during the committee stage, and expert responses from both the Minister for Health and his advisers. It should also be noted that, for many of us who are fortunate enough to be elected representatives in this place right now, at this point in time, this will possibly be the most important piece of legislation that we will consider.

The bill provides a safe and compassionate approach to voluntary assisted dying and a workable legal framework that will address an issue that a majority in the community is asking for and has consistently expressed support for over many years. I will note the key elements of the eligibility requirements; I think it is important that we note and remember them. Firstly, at all stages, this is a voluntary process for people and health practitioners. The person must be 18 years of age or older and an Australian citizen or permanent resident who has ordinarily resided in WA for the past 12 months. The person must be diagnosed with a disease, illness or medical condition that is advanced, 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 neurodegenerative illnesses. The person must be experiencing suffering that cannot be
relieved in a manner that they consider to be 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.

Under this bill, it will be a crime to induce or coerce another person to participate in voluntary assisted dying. The bill provides robust and rigorous safeguards to ensure that access to voluntary assisted dying will be for only those assessed to be eligible. The government will also provide an implementation phase for the law, which will take approximately 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 in the bill. However, perhaps most importantly, voluntary assisted dying will allow for a person to make a choice and to have autonomy over their own deeply personal end-of-life decision. This can be discussed and disclosed with others, but, like all medical treatment for consenting adults in our jurisdiction, ultimately the only view that should be carried out is that of the patient. As the member for Morley in the other place stated, the days of “doctor knows best” are probably long gone. Beyond the ancient Hippocratic oath and its mantra of first do no harm, modern medicine and patient care has developed contemporary ethical frameworks that are more reflective of our longer lives, advanced medical practices and our prolonged decline in later years. Importantly, these frameworks and the practical clinical efforts that are made in someone’s final days are more often aligned to a principle of dignity and protection from undue suffering.

It is also important to note that sometimes no amount of palliative care will eliminate the potential for someone to suffer horrendously when a terminal illness has taken hold. However, most importantly, palliative care is not always a choice that patients wish to make when considering their own end-of-life choices. I would like to refer to a story by a palliative care nurse on the Go Gentle Australia website. It states —

As a palliative care nurse, I am asked to end a patient’s life about twice a year—about 40 people so far. I consider it a privilege that these people felt safe and comfortable enough to ask me this difficult question. I have never done so as I do not think it is my place, I do not have the right medications and it is not legal.

I have cried with people that it was not part of the holistic care I could provide. Sometimes I remember the faces and situations of those requesting assistance. You never quite forget the yearning in their eyes. They in turn have often comforted me that I could not do any better for them. I do believe people should have end-of-life choices, such as Voluntary Assisted Death. We can and must advance our response to this issue, through discussion, open debate and compassionate laws.

I have spent 16 of my 36 year nursing career in palliative care. This includes international, interstate, regional, metropolitan, community and inpatient settings. I have been privileged to work in gold-standard palliative care teams, so the requests to end patients’ lives were not related to gaps in service. Such gaps and lack of access do occur but that is not the issue at hand.

The truth is that even with the very best palliative care service in the world, there will be a certain percentage of patients who do not achieve a peaceful death.

I think 90 per cent of the time palliative care teams do a really good job of easing someone’s physical pain. But it is very hard to relieve somebody of emotional or spiritual pain. Their level of suffering depends partly on their tolerance for their quality of life. A growing number of people are seeking alternatives, which I believe should be legal and regulated. I have also nursed the failed suicide victims seeking some autonomy with a terminal illness. Many first responders have witnessed both successful and non-successful suicides.

In my career I have seen a lot of community education about pain control and palliative care, but there has been little debate about voluntary assisted death. Palliative care teams shy away from talking about it, but it is time for a transparent discussion. Many other countries have achieved good, well-regulated legislation.

I have seen doctors increasing pain medication to ease the end of life. I have seen terminal sedation, and I have seen people withdrawing from food and fluids. There have been hundreds of peaceful meaningful deaths. But there are still a number deaths that have stayed with me because they were not peaceful. For these people, the ability to make a choice about when to die, and to do it on their own terms, would have made a huge difference.

The best end of life care I ever saw was the vet who compassionately put down my beloved dog, with dignity and compassion. Just as we plan for birth, there should be options for death, with well-regulated legal avenues that protect the vulnerable.

It is really important to note that there are times when the very best of palliative care is still not enough for some patients. That is what this bill is about. Clinical interventions and innovations have provided an almost unbelievable level of care and an ability to care, treat, sustain and, in many cases, prolong life. However, in doing so, we are acutely aware of many members of our community who are now kept alive only through substantial and sometimes
very invasive clinical interventions. Often these instances are in contravention of prior desires or requests for how a person’s death is to be approached. Let me clearly state that voluntary assisted dying is not a substitute for palliative care, nor is it an extension of palliative care. The bill before this house notes that voluntary assisted dying is proposed to be available to those with a terminal illness. That illness needs to be advanced and progressive and will ultimately cause death. Let us be very clear that this is for those in our community who will die imminently due to a terminal illness and no amount of medical treatment or intervention will reverse that prognosis. For some, it may well include palliative care, while for others it may not be a viable option due either to their own condition and circumstances or a very personal choice. Whether it is palliative care or voluntary assisted dying, we must retain the primacy of personal choice.

I do not think anyone during this debate has, or it is highly unlikely that they will, declined to acknowledge the very important role of palliative care as part of a modern health system. It is crucial. I think it is really satisfying to see that our government has invested in this area. It is critical. I note that apart from the $224 million that has been provided for palliative care services, additional funding has been made available. In the 2019–20 budget, $17.8 million is being invested to enhance palliative care services. There has been an additional 10 inpatient palliative care beds provided, a 15 per cent increase in metropolitan inpatient palliative care beds, $6.3 million allocated to improving metropolitan and regional community-based services, and the provision of an extra 61 full-time employees in regional areas to support palliative care.

However, I think we as a society have to improve how we discuss death, because no-one wants to suffer needlessly or in a prolonged fashion. For an event that is probably more certain than taxation, often a psychological barrier appears when we consider the ways in which we may want to face death. I think this bill has created a really important community discussion, and it is inclusive of our parliamentary debate about the way we talk about death in our community. In conjunction with our current world-class health system—a system that promotes wellbeing—the effective and appropriate provision of palliative care and voluntarily assisted dying can provide for the two central desires that we all retain, I think, in our subconscious, which is to have a good life and a dignified death.

The work undertaken by the Joint Select Committee on End of Life Choices was exceptionally thorough. The many safeguards that have been recommended and put in place in this bill probably make it one of the most contemporary of its kind. Taken on the whole, Western Australians have expressed an expectation that the WA Parliament deals with this bill expeditiously.

In conclusion, I want to express my thanks to the joint select committee and to the Premier and the Minister for Health for their unwavering leadership on this issue, and for the progression of a key election commitment. I would also like to thank the many members of the community—representing patients, families, carers, clinicians and policymakers—who have contributed as a collective and a community voice in the process of developing this bill. The joint select committee heard from a huge number of people in our community, and, I think, in doing so, have formed the evidence base for a really modern, safe and sensible piece of legislation.

This bill provides dignity. This is a bill that is designed to reduce unimaginable suffering and give people a choice. This is a bill that allows us to make a choice, I believe, that is fundamentally human. I commend the bill to the house.

HON ROBIN CHAPPLE (Mining and Pastoral) [8.12 pm]: I rise tonight in support of the Voluntary Assisted Dying Bill 2019. I do so as the nominated lead speaker for the Greens WA, which is a position I find somewhat bemusing, considering we all have a conscience vote. As this is a conscience vote, I will leave it to my colleagues in the Greens WA to individually give their evaluation and commentary on the legislation before us. I support the voluntary assisted dying legislation on four fundamental grounds. Before I go into that, I wish to acknowledge former Australian Democrats member Hon Norm Kelly, who started this journey on 16 October 1997 when he introduced his first bill in this chamber, the Voluntary Euthanasia Bill 1997. Here we are today, some 22 years later, dealing with the Voluntary Assisted Dying Bill 2019. I thank Hon Norm Kelly for commencing the journey as we work toward its conclusion.

I will not labour long on the many reasons for supporting this legislation. I have participated in two second reading debates on this matter, and I am sure that if people want to hear my extensive views, they can go back to Hansard and read what I have said previously.

In December 2016, prior to the last election, a dying with dignity working group, with Liberal MP Tony Simpson, MLA, Hon Alannah MacTiernan and me, gave a commitment to jointly introduce dying with dignity legislation should we all be re-elected. The quote we came up with stated —

We really want to present a bipartisan view—a Liberal, Labor and a Green moving forward in something the public genuinely wants and is long overdue.

Unfortunately, as we know, Hon Tony Simpson did not get re-elected. An interesting point is that as there was no provision in the WA Parliament to jointly sponsor a bill, we decided that once we had to come up with a bill that we all agreed on, we would all attempt to introduce it on the same day at the same time and work out who was going to be the winner after that, so to speak. But it was a genuine attempt at bipartisanship.

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Firstly, I believe this to be valid legislation insomuch as it will give peace of mind and succour to some of those people who will face unbearable suffering at the end of their lives. I am led to this belief as a result of having watched my mother suffer a very terrible end-of-life journey, and I will talk more on that shortly.

Secondly, it will fulfil a goal of mine that I expressed in my maiden speech on Thursday, 4 June 2009, when I stated —

I intend to continue my support for the introduction of voluntary euthanasia legislation in Western Australia.

Thirdly, the Greens WA have an endorsed policy of supporting voluntary assisted dying, which is referred to as the Greens WA dying with dignity policy. Again, I will deal with this later in my contribution.

Fourthly, this legislation focuses on the desires and the will of the people we are put here to represent. This is again reflected in one of the views we as the Greens WA hold dear, and that is the notion of participatory democracy.

Starting with the fourth reason for supporting this legislation, I turn to two consistent polls that reflect the views of the constituents of the Mining and Pastoral Region in particular. The most recent one was done by West Australian Opinion Polls. In it, the Mining and Pastoral Region polled the highest support of anywhere in WA—84.1 per cent. It is a very small electorate in numbers, but when we consider that this is a country electorate that I represent, I feel duty-bound to represent the wishes of my community. It had the highest level of support and also, significantly, the lowest level of opposition at 10 per cent, with 5.8 per cent undecided. This polling result was a reflection of a very significant poll by Newspoll in 2009, which must be one of the largest polls that I have ever seen and which polled various states’ positions of support for what was then classified as voluntary euthanasia, and what we now refer to as end-of-life choices, or, in this case, the Voluntary Assisted Dying Bill.

I refer to how we fared as a state. In Western Australia, 86.3 per cent of capital city voters, or 1 072 respondents, and 92.1 per cent of non-capital voters—the country voters—were in support of euthanasia. That is my electorate, and that is one of the major reasons I am supporting this legislation. When the WA votes were compared with the votes in the states of Victoria, New South Wales and South Australia, only one state in a non-capital environment outpolled WA in support of the legislation. Of all the states, WA has always been a most significant state in support of voluntary assisted dying. I think it is important to say that, and the reason I do so is that I received a couple of emails from people who lobbied me saying that the polling is all fake and all the rest of it. However, in my view, with two polls over many years expressing exactly the same numbers, and, in fact, if anything, with the slight diminution of the vote in WA in support of voluntary assisted dying, I think their views are a complete and utter furphy.

I will come to some of the statistics from the current poll. Support for voluntary assisted dying was above 80 per cent in every upper house region, with the highest level of support at 84.1 per cent in the Mining and Pastoral Region and the lowest at 80.1 per cent in the East Metropolitan Region; more than 80 per cent of those surveyed believe that people should have the option of a doctor assisting them at the end of their life; more than 70 per cent believe that, in isolation of all other safeguards, having two doctors assess a person is a sufficient safeguard, even without the other 101 safeguards contained in this legislation; 76.5 per cent expect their member of Parliament to vote in accordance with their electorate’s majority support for voluntary assisted dying, while 17.1 per cent expect them to vote only in accordance with their own personal conscience; 94.8 per cent of the people who strongly support or support the Voluntary Assisted Dying Bill feel very strongly or strongly about the voluntary assisted dying issue; and slightly more than one in two people, or 52.4 per cent, said that they would be less likely to vote for their local WA member of Parliament at the next election if they vote against the Voluntary Assisted Dying Bill, regardless of which political party they are aligned with. Awareness of the Voluntary Assisted Dying Bill 2019 is extremely high at 90.3 per cent.

I have received a number of emails, as have all members. Since the introduction of the legislation, I have received 89 emails in opposition to the legislation, 18 of which came from Dr John Buchanan, the secretary of the Australian Care Alliance, and 44 in support of VAD legislation. I find it quite interesting that the emails we are receiving are not reflective of the polling in any way, shape or form. It is important to note that a significantly large number of emails that I have received were against the legislation.

The Greens WA adopted its Dying with Dignity policy in 2017. Basically, it sets the premise that the Greens WA seek to save and preserve life, but we do not believe in forcing people to prolong their life under conditions of suffering at the end point of life. When people have a terminal illness and are suffering to such an extent that they no longer wish to have their life prolonged, they should be able to seek a peaceful death under medical supervision with their family in attendance, or ask consenting medical practitioners to help them end their life. Clearly, as members will know, policies set out broad, overarching visions, and turning policies into legislation is quite often a complex and difficult process. In this regard, I think the government has done pretty well.

I was indeed honoured to be chosen as one of the members from the Legislative Assembly and the Legislative Council for the Joint Select Committee on End of Life Choices established by motion on 10 August 2017 by the Legislative Assembly. At this point, I would like to thank my colleagues who served on the committee and, like me, learnt so much from that process. Believe it or not, I went into that committee thinking that I was all-knowing, but I certainly was not. The committee members were Ms Amber-Jade Sanderson, MLA, chair; Hon Colin Holt, MLC,
deputy chair; Hon Nick Goiran, MLC; Mr Simon Millman, MLA; Hon Dr Sally Talbot, MLC; Mr Reece Whitby, MLA; and Mr John McGrath, MLA. Although we might have had a number of differences, over that year-long process, we had a very collegiate relationship. I even remember giving Hon Nick Goiran a hug outside a pub in Albany, and I can assure members that there is a photograph of it as well! Anyway, it was a good committee. We were exposed to lots of things. We were offered counselling. Some of the things that we experienced did indeed touch me very deeply, and I know they touched other members of the committee. Certainly, a young lady who is in the public gallery today gave a very detailed presentation about the demise of her mother that took us all to a very emotional point, and I would like to thank that young lady.

We met a number of people who were on that end-of-life journey. We went out with Silver Chain staff and met people. I am reminded of Tex; I think I have mentioned Tex before. Tex was a grumpy old bugger from the Pilbara. Excuse me, but I think I can use that word in this context. Tex was very interesting. He did not want anybody fussing around him, but he had a major problem. He had incredible gout. His legs were in a terrible state and he had compression bandages around both legs. Silver Chain sent us out with people to guide us. The lady who went out with us was not Tex’s normal person. Tex said, “Who’s this woman?” and got all grumpy. She proceeded to remove his compression cast and worked on his leg, but then she could not figure out how to put the cast back on. Luckily, I have some engineering experience, so I stepped in and tightened up the straps and we got him fixed up. He grumbled about her and said, “Bloody politicians—even helping me.” Beside him on his little table was a block of iron. I said, “Tex, that’s a hot iron briquette from Port Hedland” and he said, “How do you know?” and I said that I used to work up there. Suddenly, Tex became quite effusive and we chatted about his experiences up there. At the end of the visit, he said, “I don’t like bloody politicians at all. Don’t like Labor, don’t like Liberal and those”—I will not use the expletive—“Greens I have no time for at all” and I said, “Hi, Tex; I’m a Green.” We kept in communication and when Tex passed away, which is what he was going to do, his friend who had been looking after him said that I should feel very proud that I had made an impression on him, not as a Green, but as somebody who showed some compassion, and that he felt quite good towards politicians in general after that.

I am also mindful of some of the horrors that we experienced. One woman who was in palliative care in Sir Charles Gairdner Hospital was a prisoner. Hon Colin Holt and I remember that to this day. As far as she was concerned, she was not going to die; she wanted out of there. She had just had both hips replaced and was not going anywhere. But at the same time, they had shackled her to the bloody bed—excuse my language. This woman, who could not move and was in the process of dying, was handcuffed to both the base and the side of the bed. We both went to some great length to rectify that situation. It was an appalling situation. Those are some of the things that we faced. I am standing here feeling quite emotional about that. It was not a good experience.

Hon Colin Holt: She has since passed as well.

Hon ROBIN CHAPPLE: Yes. The interesting thing in that case was that everybody knew that she was terminally ill, except her. She would not accept it. So these are the really interesting dynamics that occur.

Then we went to Albany, and we saw what was one of the best palliative care situations I think we have ever seen. The wards and the systems there were stunning. People could open the doors. There was no rail, so they could wheel the bed out onto the verandah, and people had a little garden around them. It was stunning. Then there was that movie theatre.

Hon Nick Goiran: I wouldn’t describe it as a movie theatre, but it was a room to lessen the impact for the patients.

Hon ROBIN CHAPPLE: That is right. They had beautiful scenes of forests and thing like that displayed on this giant wall screen. It was very passive; it was very good.

That was part of the experience on that committee. I think we learnt in all our different ways so much from that committee. Although there might have been different views on the outcomes of the committee, I believe that the committee worked exceptionally well, receiving some 700 submissions and holding 81 public hearings. I do not think there has ever been a committee that has done that many public hearings. Its final report, “My Life, My Choice” was laid on the table of the Legislative Assembly and the Legislative Council on 23 August 2018. The committee’s majority finding went on to form the basis of the government’s decision to draft the legislation we are dealing with here and now. This process was further enhanced by the establishment of the Ministerial Expert Panel on Voluntary Assisted Dying. This committee had a wide representation of people from all legal, medical and social backgrounds, including Malcolm McCusker, QC; Dr Penny Flett, AO; Dr Scott Blackwell; Dr Roger Hunt; Associate Professor Kirsten Auret; Dr Elissa Campbell; Dr Simon Towler; Kate George, an old friend of mine from the Pilbara; Fiona Seaward; Noreen Fynn; and my dear friend Samantha Jenkinson. Its report was finally tabled in Parliament on 27 June 2019.

I would like to mention two particular aspects of the bill before us. Key provisions of the Victorian legislation have already proven to be unworkable. Members are well aware that the Victorian Voluntary Assisted Dying Act 2017 commenced operation only a few months ago. It seems likely that there will be an attempt to amend the bill before this house by incorporating several provisions that appear in the Victorian act, but not in this bill as tabled. Some of these Victorian provisions are highly contentious. In particular, one such provision requires, or at least is being

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interpreted to require, that one of the two doctors assessing the patient must be a specialist in the condition or illness afflicting the patient. Another prohibits doctors from informing patients of the option of voluntary assisted dying. Victoria is the only jurisdiction in the world to enact such a prohibition.

I would like to bring to the attention of the house that the effects of these provisions have recently been subject to a report by Dr Rodney Syme on behalf of Dying With Dignity Victoria. Members may know that Dr Syme is a medical specialist with unparalleled expertise in this field. He has had 27 years’ experience in counselling people about end-of-life issues and has assisted several hundred. This year, he was made a Member of the Order of Australia in recognition of his work. In the opinion of Dr Syme, the immediate effect of the requirement for one of the assessing doctors to be a specialist is to seriously diminish the number of available doctors, especially when combined with the appropriate right to conscientious objection. He states categorically that this is having a disastrous effect on the implementation of the act. He explains that available specialists are hard to locate, especially in regional areas. That is why I come back to the electorate that I represent, the Mining and Pastoral Region, where we have virtually no specialists. He explains that available specialists are hard to locate, and that this creates significant delay in a process when time is critical in reducing suffering. The result is that people are dying before their assessments are completed.

It should be noted that these observations are based on careful documentation on the experience of patients since the commencement of the Victorian act. It is obvious that if these are the results of provisions in Victoria, they would be magnified many times over if adopted in Western Australia. Already, we have rightly had considerable public discussion over the need for more palliative care services in the regions, and in that regard, the limited availability of medical specialists in remote and regional areas has been highlighted. This is especially the case in the Kimberley, the Pilbara and the goldfields. I am personally aware of the shortfalls. It takes no imagination to see that if a dying person is required to see a specialist in the regions and of course is unable to travel, they will simply be shut out of the right to choose voluntary assisted dying, in stark contrast to those in Perth. This would be unconscionable and an outrageous situation. As far as the prohibition on raising the existence of VAD is concerned, Dr Syme states that this is clearly in conflict with medical ethics, which require the provision of full information regarding lawful treatment options, which is a serious inhibition of the informed discussion and consent. I add that it appears to be an extraordinary intrusion into the doctor–patient relationship and the performance by doctors of their professional work. It is very disappointing that the Australian Medical Association is not loudly opposing the provision in Victoria.

The second point I wish to briefly make, and has been talked about here briefly, is the particular importance of my constituents—the Aboriginal constituents. Some have suggested that the mere existence of such a law will have a negative effect on Aboriginal people accessing health services. That is demonstrated by the experience in the Northern Territory. This claim is not borne out by hard evidence; in fact, it is contradicted by it. The 1996 report to the Senate Legal and Constitutional Affairs Committee into the bill that was passed and became known as the Andrews act, considered the evidence about the operation over the Northern Territory Rights of the Terminally Ill Act. The report noted the following in paragraph in 5.65 on page 52 —

The Northern Territory Government denied that there had been any decrease in the use of medical facilities by Aborigines, and provided the Committee with statistics in support of this assertion. This information related to hospital separations, emergency evacuations to hospital from remote communities and non-emergency travel to hospital under the Patient Accommodation Travel Scheme. No clear decrease was shown in relation to any of these categories since 1995.

I seek leave to table “Consideration of the Legislation Referred to the Committee: Euthanasia Laws Bill 1996”.

Leave granted. [See paper 3267.]

Hon ROBIN CHAPPLE: Secondly, and finally, I now wish to talk about my parents’ death. My father died an average death—six hours. That is the average. He died on 11 November 1980 of myocardial ischemia—a heart attack. It took him six hours to die. I was 32 and he was 74. My mother, Dorothy Margaret Chapple, was born in the subdistrict of Stoke Newington in London in January 1914 and died on 27 July 1988 in Sir Charles Gairdner Hospital from a number of contributing factors. Death was not easy; it was over an extensive period. It was not just one illness that caused her death; it was multiple conditions. I was lucky enough because my employer at the time, BHP, gave me leave to come to Perth and I was able to stay with her as much as I could. Eventually, I had to return to the Pilbara and she passed away while I was not with her.

One of the things that my mother died of was aspiration pneumonia. Aspiration pneumonia is a complication of pulmonary aspiration. Pulmonary aspiration is when food, stomach acid or saliva is inhaled into the lungs. Food that travels back up from the stomach to the oesophagus can also be aspirated. The other point is general debility, a state of general weakness or feebleness, which may result in the outcome of one or more medical conditions that produce symptoms such as pain; fatigue; I can never say this word—cachexia—wasting of the body due to severe chronic illness; and physical disability.

She also had an unusual condition, which meant that whenever I met my mother, I had to wear a facemask. She had pulmonary tuberculosis. Pulmonary tuberculosis is defined as an active infection of the lungs. Pulmo is Latin Extracted from finalised Hansard.
for lung. It is the most important TB infection because an infection of the lungs is highly contagious due to the mode of droplet transmission. Her pulmonary TB led to her coughing up phlegm and blood, and led to her having constant fever, night sweats, chest pains and weight loss.

The other interesting point that led to her demise was that she had to have nasogastric feeding, which is being fed by a tube that carries food and medicine into the stomach. That in itself is identified as one of the causes of her death. Another contributing cause was a bilateral obstructive uropathy, a sudden blockage of the flow of urine from both kidneys. The kidneys continue to produce urine in the normal manner, but because the urine does not drain, the kidneys start to swell. My mother also had a number of unknown complications, possibly renal tuberculosis. She was 74 years old; I was 41.

I started this journey back in 2001, when I was first elected. It will give me great succour if we reach the third reading and I can stand in this place and say, “Mum, I did it.” Thank you.

HON DARREN WEST (Agricultural — Parliamentary Secretary) [8.42 pm]: Members, I have long been a supporter of the right to choose the time to end our life. I am unsure whether that is from growing up in a progressive family and a progressive household or from growing up on a farm where, as very practical people, we see farm animals put out of their suffering on a regular basis and I wondered why that courtesy could not be extended to people as well. In my inaugural speech in 2013, I made reference to things I would like to see achieved in my term in Parliament. One of those was something like the Voluntary Assisted Dying Bill before us today. This is a historic day on which members of both houses of Parliament will look back on their time in Parliament and remember when they debated this important bill. It will be a big change in Western Australia should it be passed.

I am a strong supporter of this legislation for three reasons. Obviously, firstly, from my personal view that I have formed over my life. Second, because of the very high level of public support that has been indicated by previous speakers. I suggest that across my area of the Agricultural Region, it would be in the order of four in support to one against. The main reason I think for me is for those people who are affected by a terminal illness, those who have had enough, those who want to choose to end their life because they no longer wish to suffer. This bill is about that choice. This bill is about compassion, kindness and love. It is about families and people suffering, staring down the barrel of a terminal illness, being able to have that conversation about when is the time to go, whether it is at a time of the patient’s choosing to end suffering or the time determined by the illness—that is the patient’s choice, in my view. It should be their choice.

I want to thank all the people in the Agricultural Region who have contacted my office. There have been hundreds if not thousands of people from my electorate and across the state who have engaged in this debate and chosen to email, write, call or drop into the office to share their view. I have not come across anything in my parliamentary career that has engaged the public as much as the Voluntary Assisted Dying Bill has. I note that there have been great levels of respect. The debate in the Assembly was dignified, as it has been in the public, and it has been respectful. It is very emotive and I cannot underestimate the importance of acknowledging everyone’s views, even if we might disagree with them.

We recently held a forum in Geraldton. I thank Hon Alannah MacTiernan and the member for Morley, Amber-Jade Sanderson, Chair of the Joint Select Committee on End of Life Choices, for attending that forum. The view of our community was overwhelmingly in favour to the point at which it was suggested that we could have taken the legislation further. We had some very heart-wrenching stories, particularly from a gentleman who was staring down the barrel of the end of his life and desperately wanted to have a say in the timing of his death. We heard stories from families who are watching and have watched loved ones suffer.

I will not go into detail about all the anecdotes we heard. They are all beautiful stories of love and kindness that people wanted to be able to share with their family members. I respect that not everyone holds the view that this legislation should be passed. I respect also that there will be those who will find fault with the legislation and disagree with the notion that people who are suffering should have the choice to end their life at a time of their choosing. I say to those people, “I respect your opinion as much as I do not agree with it.” I would say to those who are terminally ill and hold that view, “Don’t access voluntary assisted dying; that is your choice. That is the patient’s choice, in my view. It should be their choice.”

Members, I do not see a link between choosing to end your life at a timing of your choice and provision of palliative care. However, I have found that this debate has shone a very bright light onto palliative care provision. It has also turned up areas in my electorate and other parts of the state where we perhaps struggle to provide the level of care that we do in parts of the metropolitan area of the state and in the country generally.

I note that whenever voluntary assisted dying legislation has been debated around the world, there has been an increase in palliative care provision. We see that happening here in Western Australia. Once a light has been shone on that service, we have seen subsequent increases in funding of palliative care across the state. I certainly welcome that because it is a separate matter from voluntary assisted dying, but, naturally, palliation is required for people who are staring down terminal illness and facing the end of their life.

Excerpted from finalised Hansard
This legislation has been developed over the past two or so years. I acknowledge the extensive work that has been put into it, from the health minister right through to the Joint Select Committee on End of Life Choices. I acknowledge the tremendous amount of work that was done by that committee and also by the Ministerial Expert Panel on Voluntary Assisted Dying. Due to the fine work put in by those dedicated people, I am satisfied with the provisions of this bill and I will be supporting it without amendment through the house. The Agricultural Region and its voters want this bill passed, as does the broader community. I think the broader community is satisfied with the bill as presented.

People facing terminal illness often resort to other means of ending their life. I have talked extensively in this place about terrible examples of the lengths that people have gone to because they do not have access to voluntary assisted dying. The passage of this legislation will provide that opportunity, rather than some of the very sad and tragic ends that those facing terminal illness have availed themselves of. I acknowledge the work of Belinda Teh, who is in the gallery today, for raising awareness of the need for people to have the choice to end their life at the time of their choosing. Belinda walked from Melbourne to Perth to raise awareness of voluntary assisted dying. I also acknowledge organisations such as Go Gentle Australia and Dying with Dignity Western Australia, which have helped inform the community and make people aware of what is proposed in this legislation. I also acknowledge the work of Andrew Denton, who used his profile to show his strong support for the legislation.

There are many more reasons that I could give for why I would like to see the legislation passed, but I think I have given the basic idea of why I support the bill and why I support it in this form. I do think it will be a historic day when the vote is held. I sincerely hope members can see fit to pass the legislation, because if we do not pass it at this opportunity, with the bill having gone through the Legislative Assembly and come to us, there may not be another opportunity for many, many years. I think the community is ready. I think the debate has been mature, respectful and dignified. There is no doubt in my mind that it is time we gave members of our community the choice to end their lives at the time of their choosing. As members of the community, we face all kinds of choices every day. We make all kinds of choices about all kinds of things every day. It strikes me as odd that perhaps the biggest one of all is denied us, for reasons that I do not really understand. I do not understand why we cannot make that choice ourselves.

This is a once-in-a-lifetime opportunity. As I said in my introductory remarks, I think we will all remember the time that we were in the Parliament of Western Australia when the Voluntary Assisted Dying Bill was debated. I hope we will all remember the time that it was passed. In my view, this is an excellent, well-crafted piece of legislation that covers many of the concerns about the notion of voluntary assisted dying that have been raised through the committee and ministerial expert panel stages and by members of the public and members of Parliament. I think it strikes the very necessary balance between what is acceptable to the public and the Parliament, and covers off on the views of members of the Legislative Council. I commend the bill to the house. I certainly look forward to its passage. Thank you.

HON MARTIN Pritchard (North Metropolitan) [8.54 pm]: As we get older, we come to face death more often. Our parents die. I just want to talk very briefly about the passing of my parents. I was listening to Hon Robin Chapple and there were some similarities. In 2016, my stepmother passed away. Kit, or Catherine as I called her, because she was a real lady, was 92. When she was 23, she actually went into hospital with tuberculosis. Through the rest of her life, she worked very hard. She smoked a lot and she drank a bit, but she always faced life straight in the eye. Kit, or Catherine, went into St John of God Midland Public Hospital at the age of 92. Basically, her body was giving out. But because of her early experiences in hospital, the biggest fear for Catherine was actually being in hospital. She had some delirium, so when we used to visit her we would often try to convince her that it was a hotel so that she would not become so aggressive in her more lucid moments, which had shocked the family because of the fact that, as I said, she was a lady. This lady passed away in hospital with fear and anxiety. She would never have thought of taking advantage of voluntary assisted dying and would just try and eke out every bit of life that she could. Even in her darkest hours, she was still hoping to go home and resume her life.

Six weeks after she passed away, my father went into hospital. He had actually been in hospital eight years earlier—around 2008. He went into Royal Perth Hospital. He had treated his body quite harshly during his life. He was a bricklayer, very blond and very pale. He used to spend his days in the sun laying bricks, with a pair of shorts and a pair of thongs on—I think I have mentioned that before—and ended up with multiple melanomas. In 2008, he went into Royal Perth Hospital. It was the first time that a doctor had approached me to talk about palliative care. The reaction of the family was one of horror, because we thought they had given up on my father and that he would pass away. Indeed, he came very, very close. Again, his main aim was to try to continue living, which he did. He came out of hospital with about 20 per cent of his eyesight left, about 20 per cent of his hearing left and using a walker. He spent the next eight years—again, I have spoken about this before—with a quality of life that I would not have thought was tremendous. He used to look forward to one morning a week when I would take him to the casino. He and Kit used to enjoy a half day at the casino. I do not know whether I would have thought it would be a good quality of life, but in 2016, six weeks after my stepmother passed away, he went into St John of God in Midland with aspiration pneumonia. He was 87—he was younger than my stepmother. Again, all he wanted to do was to get out of there, come home and live life as much as he could, irrespective of my view on the quality of his life. Of course, he did not. I think they basically just continued to up his morphine and he passed away. He would not have taken advantage of voluntary assisted dying either.

Extracted from finalised Hansard
My father-in-law passed away in 2012. He had an inoperable brain tumour. I was lucky enough to be able to take about six months off work at the time and I spent time taking him to Subiaco to have his chemotherapy and radiation treatment to try to shrink the tumour. They were reasonably good times, funnily enough. There was a lot of pressure, but they were reasonably good times. My father-in-law was sitting at home with us one afternoon when he got up and fell back down again with a heart attack, probably because of the strain of the chemotherapy and the radiation. I look back on that and say, “Well, we had a reasonably good time leading into his death, and his death was quick.” I remember thinking at the time, although I did not say it to my mother-in-law, that that was a good death. I suppose most of us hope that we are not going to die a painful or a dragged-out death, but a quick, painless death, or to fade away while we are asleep. The fact is that sometimes death is good; most of the time death is bad; and sometimes death is horrendous. That is for multiple reasons, pain being one, but there are others. During this debate, many people have talked about being in the arms of loved ones, whether it be through the opportunity to do that with VAD, or whether that be through high levels of palliative care. The fact of the matter is that not everybody has a happy family. Some people dislike their families. Some people do not have families. Whether someone dies alone with a doctor under VAD or alone suffering, it is still going to be a bad death.

If a person is in great pain, the only thing that VAD will do is alleviate their suffering. I understand that, and I accept it. I think that this legislation has the potential to help some people—not that many, I do not think, but some people—who have the will to face death on their own terms as an alternative to a horrendous death, and I accept that. However, as I said, there is still going to be a lot of unfairness in the world. People are going to die when they should not die; people are going to die in pain. This bill is not the answer to everything, but I accept that it has the potential to help some people.

When this campaign started—that is really what has been happening over the last number of months; there have been campaigns—I was quite taken aback by the fact that the campaigns commenced prior to any bill being before the house. Prior to anybody actually seeing the bill, people were saying, “This is fantastic. I want voluntary assisted dying. It doesn’t matter what the bill says; I want voluntary assisted dying.” Others were saying, “It doesn’t matter what the bill says; we can’t have voluntary assisted dying. It’ll be the end of society as we know it.” I was quite taken aback by the fact that the campaigns started so early. I think that most people in the community are debating the theme rather than the bill. I ask members to understand that we have the responsibility to try to make sure that the bill will achieve the aims that it has been drafted to achieve. My concern is that people have entrenched themselves into a position without actually reading the bill. That has happened with the public as well. Even before this bill was before the house, people were saying that 88 per cent of the public want voluntary assisted dying. I do not know whether that is correct or not. It probably is, but it still does not alleviate us from the responsibility of improving the bill if we can, or if it needs it. I have drafted some amendments. I would not say that I am an expert in this area at all, and I will not be unhappy if the amendments get defeated, if that is the will of the house. But the fact is that we are actually debating this bill and should try to improve it, even if at the end of the day we do not accept those amendments because they do not make the bill better.

Before this bill was before the house, we started receiving emails. Hon Robin Chapple, who is out of the house on urgent parliamentary business, talked about receiving 80-odd emails. I think I have probably received 7 000 or 8 000 emails. When I first took on this role, I made the mistake of answering my own emails. I have seen the emails on both sides. I am not suggesting that the pro forma emails that I have received are not valid—they are. However, I must say that I have answered only the emails that I know have been written and that actually tell a story and ask me to respond. Those are the emails that I have responded to. I have met quite a number of people who have sent those emails. I apologise to my constituency: I have not responded to the pro forma emails on either side, mainly because they did not ask me for a response, which was a very happy coincidence.

With the polling, again, this has been a campaign. Normally, if one engages a pollster, they will say, “Tell me what answer you want, and then we’ll draft the question.” Now, again, I would imagine that these polls have some value. I concede that the majority of our constituents fear death and, if faced with a horrendous death, would like to have the choice under this legislation. But it does not alleviate our responsibility to try to improve the bill as best as we can.

Following on from that campaign concept—because it has been tackled as a campaign on both sides—there has been tremendous overreach in people’s claims. Someone will say, “Nevada, everybody dies and they shouldn’t”, and somebody else will say, “No, everybody should have that right.” There is tremendous overreach. It would have been nice if within the campaigns there had been a little bit more discussion to try to get to the position that I think we all want, and that is the best outcome for our community.

I do not see myself as a warrior on either side of this debate. I see my role as someone who is in the middle, with probably the vast majority of people who do not want to see people die horrendous deaths, but also do not want to devalue life. If we do our job here, I believe we can achieve both through this bill.

For me, the biggest problem with this bill is the drafting. In a past life, I did a lot of drafting of industrial instruments. We always wanted to take the opportunity to do the drafting ourselves. The drafter has tremendous power in any negotiations, because they set the theme. The theme of this bill has been set by the people who have drafted it, and
it should not be beyond us to improve it. As I said, I have proposed a number of amendments, and, again, if they
do not get accepted, as long as it is the will of the house, I do not have a problem with that. I have endeavoured to
address the areas of concern I have in the amendments I have proposed.

One thing that the Premier said that struck a chord with me was that he believed that this was really a bill to facilitate
death or death rather than life or death. If that is the case and we are talking about an elderly person who is going
to die anyway but might have the choice of dying a couple of months earlier rather than having two extra months
of life that would be fairly horrendous, I do not have a particular concern with that. I know there are moral issues,
but I do not have a particular concern with that, if that is the person’s choice.

Hon Nick Goiran: Honourable member, will you take an interjection?

Hon MARTIN PRITCHARD: Certainly.

Hon Nick Goiran: I hear what you’re saying but the concern I have is what happens if the diagnosis is wrong.

Hon MARTIN PRITCHARD: That is exactly where I was going. One of the concerns I have is that to make it
an argument of—for want of better wording—death and death as best we can, we have to try to get the prognosis
right. That is not going to be 100 per cent. There will be mistakes; I understand that. But we want to try to get the
best prognosis we can. I understand the difficulties in the regions, but I cannot believe that it could be appropriate
for a person to say, “I’m going to die in six months; I should take advantage of voluntary assisted dying”, based
on the advice of a general practitioner. With all the respect in the world for general practitioners, there are some
who specialise, but the vast majority are the doctors down the corner that people go to for some cough medicine.
The vast majority are generalists. It worries me that, because of the issues and problems we have in the regions, we
are going to say, “Okay, it’s a long way away so let’s just allow general practitioners to determine that a metastasised
cancer is going to cause death within six months.” I do not think I would be prepared to accept that as a prognosis.

One of my proposed amendments addresses one of Hon Robin Chapple’s fears and proposes that one of the doctors
should hold some specialisation in the area that is the subject of the application. I actually have no concerns
whateversoever about the coordinating doctor being a general practitioner. Indeed, one would hope that it would be
a general practitioner who has some relationship with their patient, would be able to observe any family coercion
and would be best placed to determine capacity. However, I am not sure that a general practitioner in the back lots
of the regions would have the ability to provide the most accurate prognosis possible when it comes to things
outside their area of speciality. If members in this place determine that that amendment is not appropriate, that is
fine; that will be the will of the house, and I am happy to accept the will of the house.

On a personal note, I went to a general practitioner—I will not name him—because, as members may notice, I am
getting a little thin on top and I noticed a tingling feeling up there. I thought, “My dad had a lot of melanomas;
maybe I should get it checked out.” I went to my general practitioner, who I have been seeing for years. He said
that there was nothing there, that there was no problem and that he could not see anything—fine. I went to a skin
specialist the next day, because I did not accept that, and there was crystallisation; it was a pre-cancerous sunspot.
It was probably nothing to worry about, but a general practitioner does not deal with dermatology often, and he
completely overlooked it, even when I was pointing in exactly the right spot. That concerns me. Unfortunately,
we had another bad experience with the same doctor nearly 20 years ago when he did not pick up on my wife’s
heart attack. He kept diagnosing her with indigestion and sending her home with Mylanta and so on. Eventually
she was throwing up in the middle of the night; we took her to the emergency department and it was too late to
repair her heart. Maybe we do not have great general practitioners in the northern suburbs! I do not mean any
offence by that, but as I said, I do not think I would accept a general practitioner’s prognosis that I have four or
five months to live due to cancer. That is one area I have looked at.

The bill deals with coercion, but it is something on which we need to focus because, in my view, there can be
many different types of coercion, including external, from the family, and internal—“I don’t want to be a burden.”
There are many concerns in that area. I am also concerned about capacity. When I first read the bill, I thought,
“Oh, ‘capacity’ means a patient has the capacity to make a decision.” It is not really that. All that is required in the
bill is that the person understands what is being said to them. If the doctor says to the patient, “You know that if
you take this poison, you’ll die”, and the person says yes, that is capacity. That concerns me. I do not know a lot
about mental illness; I have tried to get a little bit of information on it over the past couple of months, but I would
have thought that if someone has just been given a prognosis of six months to live, there would be a good chance
that they might be demoralised or depressed. It would seem to me that the doctor—I do not mind if it is the
coordinating doctor—should have some responsibility, not just to ask, “Do you understand?”, but to make sure
that there is nothing treatable affecting the patient’s decision. That is something else I looked at.

I have in the past been involved in a lot of negotiations, and most negotiations are basically just discussions between
people. Hon Robin Chapple will be disappointed with me again, because I have proposed an amendment to
provide that the doctor cannot raise the issue of voluntary assisted dying. A lot of people still rely on a doctor’s
lead when it comes to their treatment. Again, if the chamber determines that that amendment is not appropriate,
I will bend to the will of the chamber.

Extracted from finalised Hansard
The Department of Health has people on staff who can go out to the regions to discuss all the options, but not be part of the decision-making process. For example, a senior nurse practitioner with broad knowledge in this area could go out to the regions and talk to the patient so that they know what options are out there. Something along those lines would certainly give me confidence that the patient is informed. I truly do not want to deny people who are suffering the right to ask for an early death. I do not believe this bill is an assisted suicide bill; it is still talking about death and death. I would not lose any sleep if someone determined that they did not want to live those last few months if it meant living in agony. Personally, I have fears about my own death. I do not think about it too often, but one of the fears is being unable to breathe, and there are a number of diseases that lead to that end. I might, rather than live with the fear, anxiety and pain, if there is pain, choose to access voluntary assisted dying. I am not opposed to the concept, but I am concerned that we made our decision before we got the bill and that the Legislative Assembly had no opportunity to debate in any earnest way any amendments. The only opportunity that members will have to look at amendments that may improve the bill will be in this place. If I am wrong and the bill does not need any improvement and I am very much in the minority, as I said, I will accept that that is the will of the chamber. However, I do not want people to just blind themselves. I do not think that my amendments are fantastic—other people probably have more expertise in dealing with amendments than I do—but I want people to look at any amendment that comes forward and make a determination about those amendments on their merit. I think at least one or two amendments will go through, so the other place will have to consider them anyway. Whether it considers two, five or whatever number of amendments, I do not want to destroy the bill, but I think there is an opportunity to improve it.

In my past life, I often did the numbers. I always thought that in this place it was easier to get 18 for a yes vote than it was for a no vote. A number of people are still undecided, but I think that the opportunity is diminishing. Although some members support the bill, I suggest that should not blind them to considering a good amendment, than it was for a no vote. A number of people are still undecided, but I think that the opportunity is diminishing. Whether it considers two, five or whatever number of amendments, I do not want to destroy the bill, but I think there is an opportunity to improve it.

In my understanding, our Lord is almighty, all powerful, benevolent and infallible, because God is perfect; yet humans are not any of these and we are very fallible. In my view, God’s teachings for us are the truth and perfect. His teachings were learnt and understood and translated by humans for humans so that the good news could be spread around the world in a form that humans could understand. At the same time, because we are fallible and our father’s teachings have been translated by prophets who did their very best but who were constrained by the time in which they lived their lives, and by their social values and societal practices when they did their holy work, their translated teachings about our Lord must be viewed through the prism of the central teaching of our Lord—that is, to love one another and to take care of one another. Otherwise, we would be dogmatically following all the teachings in the Bible. We would still be condoning slavery because there are instructions for slave masters in the New Testament on how to treat their slaves. We would still be treating wives as property in accordance with the Ten Commandments or having no divorce as part of normal Australian family law because anyone who divorces his wife and marries another woman or the man who marries a divorced woman commits adultery. There is severe punishment for adultery in the traditional teaching of Christianity.

I know that our Lord loves us and our Lord has mercy on us. All his teachings, however, must be viewed through the prism of the central teaching. I believe that our Lord loves us, that everyone of us is his son and daughter and he wants the best for us. Imagine this scenario? You are lying in your sick bed, suffering from a terminal illness and unbearable pain that cannot be managed by modern medical intervention. The question that springs to my

Extracted from finalised Hansard
mind is: would our Lord want us to suffer or would our Lord have mercy on us and want to help take away the pain and suffering? I believe that our Lord would prefer the latter. Our Lord is a force of good. Our Lord is a force of mercy. I am certain that our Lord wants us to have dignity, liberty and self-determination at any stage of our life.

Based on these strong beliefs, as a Catholic, it has been on the public record that I support in principle voluntary euthanasia for terminally ill patients whose pain and suffering cannot be medically managed. My position is understood through media reports, newsletters and things like that. However, this position does not equate with my accepting any view that is presented in front of me. As a legislator, I feel I have a duty to look at any bill that is presented to me, especially a bill like the one we are looking at now—a very significant piece of legislation.

I would like to take this opportunity to thank the hundreds of people who wrote to me, rang me and met with me to express their views both for and against voluntary assisted dying. In particular, I would like to mention Reverend Peter Abetz, Mr Carl Brown and Ms Belinda Teh for their time and for sharing their views. I think the debate has been conducted in a fashion that all of us as Western Australians can be proud of. We may not agree with each other on policy issues, but we are a mature democracy and we can have a robust but respectful contest of ideas. I am proud to be a Western Australian.

When I started to look at the Voluntary Assisted Dying Bill, which had been passed by the other place, I told myself to keep an open eye and an open mind, and to be very mindful of the issues raised by Parliament, the Legislative Assembly and people in the community. I watched all the members’ speeches in the second reading debate in the other place. I watched the recording of probably half the consideration in detail stage in the other place. Of the many concerns raised with me, I have identified a few that drew my attention in particular. I wish to take this opportunity to go through them, and they are about coercion, psychiatric assessment and doctors raising the subject.

In terms of the concerns about coercion, from the outside, I was concerned that vulnerable people might be subject to coercion and choose voluntary assisted dying, as has been raised with me by people who met with me and wrote to me. However, after further research and study, I am satisfied that the safeguards contained in the bill are, on balance, strong and sufficient. The focus of the Voluntary Assisted Dying Bill is on it being voluntary. If there is any doubt of the voluntary nature of the request to access voluntary assisted dying, the bill requires the coordinating practitioner and the consulting practitioner to refer the patient to a health practitioner with relevant expertise for further assessment. If, after further assessment, there is still uncertainty about whether the request is voluntary and valid, the request will stop there; however, an application can be made to the State Administrative Tribunal for further assessment.

I have heard time and again about the hypothetical example of family members giving subtle messages to the elderly or the terminally ill that they are a burden and that it would be good for everyone if that person were to choose voluntary assisted dying. I understand the concept; I recognise that. At the same time, I also recognise that we do not live in a theoretical world. We live in the real world, which is full of uncertainties and full of risks. I do not say that in a flippant way. The reality is that we cannot ensure that there are zero fatalities on the roads, but we still use the roads for vehicle traffic. This is a fact of life, and I say that in the most sincere and genuine fashion. On balance, I am satisfied that my concerns about coercion are resolved by the safeguards contained in the Voluntary Assisted Dying Bill.

I wish to move on to the next subject, which is the psychiatric assessment. This is another concern, as the bill contains no requirement for a patient to obtain a psychiatric assessment to ensure that they are not suffering from depression, which would cloud their judgement to make an informed decision. From the surface, it looked to me to be a reasonable concern and a reasonable point. Nonetheless, I did further research and I am now satisfied that my concerns on this point are also resolved. According to the Voluntary Assisted Dying Bill, to be eligible for, or have access to, voluntary assisted dying, one must be assessed by a coordinating practitioner and a consulting practitioner as having decision-making capacity. I have strong faith in our medical profession. I have faith that it will do the right thing by Western Australians. As it stands now, in Western Australia, it is not illegal for people who suffer from a terminal illness and unmanageable pain to refuse treatment, food or water. In fact, as we have heard from the stories and testimonies, many patients choose that way to end their suffering. In many cases, it takes days, if not weeks, for their suffering to end. As I was listening to his speech in the second reading debate, Mr Simon Millman, of the other place, noted that there is no requirement for any psychiatric assessment for people who choose to end their suffering by refusing treatment, food or water. If we can afford people dignity and respect by providing voluntary assisted dying as an option for them to exercise so they do not have to go down the path of refusing food or water, which would cause them to suffer for days, if not weeks, as a society we should seriously look at that option and enact that. Based on this, I am having difficulty supporting the requirement for a psychiatric assessment.

I wish to move on to the last concern that caught my eye, which is doctors raising the subject of voluntary assisted dying. The Victorian model prohibits a doctor from discussing and bringing up the subject of voluntary assisted dying with their patient. Initially I was inclined to support or at least look at that as an option. If Victoria chose a certain path, we should probably look at it and seriously consider whether we should adopt it. Again, with further research, I found that Victoria is the only jurisdiction in the world that prohibits the doctor from raising the subject of voluntary assisted dying. Furthermore, as submissions to the Ministerial Expert Panel on Voluntary Assisted
Dying pointed out, if the legislation is passed through Parliament, voluntary assisted dying will be a legal medical option and it should form part of a medical practitioner’s general discussion with their patients about end-of-life care. I agree with this rationale, and I am satisfied that I can support the position that doctors should be able to raise the subject of voluntary assisted dying with their patients. This is not to say that doctors who have a conscientious objection to voluntary assisted dying have to raise this issue; they do not have to according to the current bill. A doctor who has a conscientious objection to voluntary assisted dying can refuse a request from a patient to access voluntary assisted dying. On this subject, I do not think that only doctors who object to the notion of voluntary assisted dying can be regarded as conscientious—that is, conscientious objectors. I agree with Canadian doctor Dr Sandy Buchman, who is of the view that those medical doctors, including him, who assist their patients to access voluntary assisted dying should be regarded as conscientious providers. I think he has a point.

I support palliative care and I support voluntary assisted dying, and I do not think they are mutually exclusive. As a matter of fact, I think they can work hand in hand to provide the best service that can be provided to other Western Australians. If someone chooses to exercise their right to access voluntary assisted dying, palliative care should continue. It is entirely possible for someone who has requested access to voluntary assisted dying to have their pain and suffering from their condition managed through palliative care in the meantime. That person may withdraw their request for access to voluntary assisted dying. It is entirely possible. We understand that the bill provides that a person who requests access to voluntary assisted dying can stop at any stage. It is entirely voluntary. At the same time, I am very glad that the McGowan Labor government is investing a record amount in palliative care.

After consideration and deliberation over the past several months, and very intensively over the past two weeks, I hereby declare my support for the Voluntary Assisted Dying Bill 2019 in its entirety. Let us not forget that there are severe penalties in the bill for people who do the wrong thing, with the maximum proposed penalty of life imprisonment. Opponents of the Voluntary Assisted Dying Bill argue that it is a dangerous step for us to take as a society. Some proponents contend that the bill does not go far enough to enable more people to access voluntary assisted dying. My view is that this is a conservative bill, and rightly so, because we are dealing with a very significant piece of legislation. We are dealing with a very important issue—people’s end-of-life choices and their dignity and respect. I believe the bill has struck the right balance.

I would like to thank Premier Mark McGowan; the McGowan Labor government; the member for Morley, Amber-Jade Sanderson; and the members of the Joint Select Committee on End of Life Choices for their leadership and effort on this issue. I also acknowledge my learned friend Hon Nick Goiran for his work. I may not agree with the honourable member on this issue, but I absolutely respect him for his work, his work ethic and his dedication to something that I know he genuinely believes in.

The Australian community wants to give people who wish to access voluntary assisted dying the dignity and respect that they deserve. Support for voluntary assisted dying for terminally ill people was above 70 per cent in the 1980s and 1990s. A May 1996 Morgan poll revealed support for voluntary assisted dying was 74 per cent. The more recent polls, as we know, show us that support for voluntary assisted dying is well over 80 per cent and at times close to 90 per cent. I absolutely respect people’s choice at the end of their life. It is an option not everyone will choose, and if they do not agree with it, they do not have to exercise it.

Debate adjourned, pursuant to standing orders.

Legislative Council

Wednesday, 16 October 2019

Resumed from 15 October.

HON PIERRE YANG (South Metropolitan) [1.13 pm]: I thank Madam President for the opportunity to continue my contribution to this very important debate. Picking up from where I finished last night, I absolutely respect people’s choice at the end of their life. Voluntary assisted dying is an option that not everyone will exercise. If people do not agree with it, they do not have to exercise it. As a society, we must ensure there is an option for those of us who wish to exercise it or at least wish to think about exercising an option.

By the Constitution of Western Australia, the Parliament of Western Australia is to make laws for the peace, order and good government for Western Australia and its people. Ultimately, the government consists of three branches—the judiciary, legislature and executive. The legitimacy of the government in those three branches is from the people of Western Australia. That is how democracy works. I support a democracy that is guided and protected by the rule of law. That ensures that everyone is treated equally and that a minority of the community is not discriminated against. That is how a liberal democracy works in modern times.
As part of this democratic process and of this democratic way of government, the Voluntary Assisted Dying Bill came about. The Voluntary Assisted Dying Bill will ensure that people are treated equally and those who do not support it will not be forced to adopt it. The bill protects people’s rights. Protecting all people’s rights and dignity is a sign of the humanity of society. Protecting all people’s rights and their dignity at the end of their life is a sign of the ultimate humanity of society. In his second reading contribution in the other place, the Premier said —

This is the ultimate act of personal choice, of freedom, of individual rights.

It is very true. The Western Australian community has debated this issue for decades. The bill has been thoroughly consulted. The process culminated in the Voluntary Assisted Dying Bill 2019. It is now the Parliament of Western Australia’s duty to debate and pass the Voluntary Assisted Dying Bill 2019 for the benefit of the people of Western Australia. I support the bill.

HON CHARLES SMITH (East Metropolitan) [1.17 pm]: The Voluntary Assisted Dying Bill is perhaps the most controversial and far-reaching bill this fortieth Parliament will likely face. I have heard a lot of emotive stories from contributors, but I have not really heard any well-informed or well-researched arguments from those who purport to support this bill.

Let us examine the bill and let us see how this legislation came to be and what it means for us all. On 13 September 2017, a select committee was established to look into elder abuse in Western Australia. One year later, the committee completed its report titled “I Never Thought It Would Happen to Me: When Trust Is Broken”. The report made 51 findings and 35 recommendations. This report is extensive. I encourage members to review it again before casting their votes on the legislation before us.

I will turn members’ attention to this short quote contained within that report, which states —

*Mum will not even tell the GP what is going on as she is so embarrassed that her kids would behave in this way. She will also not mention it to her friends. This leaves people in her situation very isolated.*

The report goes on to state —

*The scourge of elder abuse is three-fold: ‘the abuse is often hidden, associated with shame and under-reported’. The Committee has heard that the feelings of shame that accompany elder abuse are often entangled with deep-seated feelings of parental obligation and responsibility:*

*Elder abuse is a deeply personal complex issue ... when adult children abuse their parents, feelings of parental love and responsibility and concern over their potential failure as parents that this should happen and come to pass is a real limitation on older people reporting on elder abuse.*

The report also notes the concept of inheritance impatience, stating —

*‘Inheritance impatience’ is a relatively new descriptor for behaviour that is not a new phenomenon in society. Inheritance impatience may be triggered by factors such as mortgage stress or increased financial stress on families due to the current global economic climate.*

The report found that elder abuse is all too common in this state and urged that an action plan be developed to combat it. As far as I know, nothing further has happened. If we take those recommendations seriously and agree with what the report found, I personally have real issues with how to reconcile that with the legislation that is before us. Shortly before this committee was established, another committee was set up to look into a different issue, which, as I have just said, is intrinsically linked to the inquiry into elder abuse. That committee inquiry was into the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end-of-life choices. The report for that inquiry was completed on 23 August 2018. The report makes 64 references to elder abuse, with 63 of those references being in the minority report. Chapter 1 of the majority report notes some arguments against assisted dying, such as —

- Sick and elderly will be coerced into dying.
- Vulnerable groups such as the disabled, mentally ill, aged and frail will be at risk if the laws are changed.
- If euthanasia is allowed the elderly will see themselves as a burden.

The one reference to elder abuse in the majority report was in a quote from the Australian Family Association, which stated —

*Australia’s ageing population has seen an increase in elder abuse. Allowing voluntary euthanasia and assisted suicide opens the door for disabled, sick and elderly people to see themselves as a financial and emotional burden. The ‘right to die’ could become a ‘duty to die’. No safeguards can protect against this.*

Following the tabling of the report of the Joint Select Committee on End of Life Choices in 2018, the McGowan government announced that it would introduce assisted dying legislation. Following that announcement, the Minister for Health, Roger Cook, established the Ministerial Expert Panel on Voluntary Assisted Dying to undertake a consultation process to inform its recommendations for the development of voluntary assisted dying legislation.

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The panel was established in December 2018. In an update on 1 February 2019, the panel reported that it would publish a discussion paper by the end of March this year. That paper was released, and in April, the panel reported that it had been consulting for nearly one month. A later update from May stated that the consultation process concluded on 24 May. The panel’s update reported that it was a two-month consultation process. On 4 June, the panel submitted its final report to the minister. One must ask how the panel was able to draft such a document within less than two weeks from the date on which it concluded its consultation.

On 7 August, the Voluntary Assisted Dying Bill was introduced into the lower house. To me, that appears to be a suspiciously short time in which to draft such a lengthy and important piece of legislation; it is almost as if it was already drafted. Even the strongest of advocates must question this clearly rushed process. I commend the panel for its incredible efforts undertaken under such stress, but I cannot help but be extremely cautious about what is now before the house. It seems to me that the government has clearly rushed this bill and is clearly trying to rush it through Parliament. This conduct itself needs to be considered as we go to vote on this legislation. The parliamentary report and the expert panel report are noticeably different. The legislation is clearly not based on the parliamentary report. However, with the time frame in mind, one cannot help but think that the legislation was drafted prior to the completion of the expert panel report.

The government has shown that it is more than happy to push through any bill that it thinks will win it votes, regardless of the consequences. The government obviously thinks it is onto a winner with this bill, with its highly emotive language and content. The second reading speeches show that the government is entirely reliant on appealing to emotion over reason. For example, my friend the member for Armadale, Dr Tony Buti, proposed an amendment to prevent doctors from bringing up the topic of assisted dying with their patients. He noted his concerns about people who are more vulnerable, such as the intellectually disabled and elderly, and for whom doctors have a remarkable amount of influence, whether or not they recognise it. These people may want to please or feel the need to take instruction. Although this issue already exists, I see nothing in this legislation that will properly fight undue influence—there are merely words that say that it is a crime to exert such influence. I think Dr Buti has a good point. The report of the Victorian Ministerial Advisory Panel on Voluntary Assisted Dying noted that an important safeguard is needed to protect against this, yet the Western Australian government seemed to disregard that in its bizarre model, which has a more relaxed requirement that somehow provides more safeguards.

I completely understand why some people may want this legislation, but as legislators we have to strongly consider what is before us and not bow to some knee-jerk fear that we will upset voters. We have to vote on the quality of the legislation before us. Let us look at a few of the safeguards. A simple and easy way to prove that a system of assisted dying is safe is to count how many safeguards there are and say that there are so many that it would be impossible for there to be a breach. In truth, it is just a political tool of the government to list everything it can—even every requirement—as a safeguard. Victoria proudly announced that its legislation has 68 safeguards and its system is the safest in the world. WA is upping the ante to 102. However, the government is curiously quiet on its confidence in the safety of its system. I have little doubt that the next jurisdiction that pushes for euthanasia will have a greater number of safeguards so that it can insist that its system is even safer.

As Dr Buti noted, vulnerable people are undoubtedly the most prone to abuse or undue influence, whether that influence is innocent or not. One of these 102 safeguards, which is imported directly from the Victorian legislation, is clause 25(3), which states —

*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 to another person who has appropriate skills and training to make a determination in relation to the matter.*

This cannot be stressed enough. It is perhaps the most important safeguard but it appears to be severely lacking in this legislation. I refer members to the New South Wales case Justins v Regina. The case involved a man, his wife and a family friend. The man repeatedly attempted suicide after a diagnosis of Alzheimer’s disease. He applied to the Dignitas clinic in Switzerland to end his life; however, his application was rejected on account of the disease. His wife and friend developed a plan whereby the friend would go to Mexico and obtain Nembutal to assist the man to suicide. The man would also take Maxolon to deal with the anticipated sickness caused by Nembutal. While the friend was in Mexico, the man’s wife took him to a doctor, not their family doctor, to obtain a medical certificate stating that the man was “quite capable of making his own decisions and understanding the nature of those decisions”. She then took him to a solicitor and had his will changed. His previous will left 50 per cent of his $2 million estate to his wife and 25 per cent each to his two daughters. His amended will gave the daughters $100 000 each, or one per cent of the estate, with the remaining 98 per cent going to the wife. Later, the wife admitted in the trial that she knew that the man did not have testamentary capacity at the time he signed the will. The new will was made one week before he died from ingestion of the drugs. This case is obviously an extreme example. I challenge the Premier to point out to me any provision in this bill that could stop actions of this nature. In short, it cannot. I doubt any system has safeguards that would stop that happening. At best, all we could do is punish people after the fact.

It is a strange state of affairs when we have abolished the death penalty due to wrongful deaths and created a system whereby a person can seek to end their life. Wrongful deaths will no doubt occur if this system passes and remains

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around long enough. The question is: do we have the mechanisms available to minimise these deaths and a way to prosecute the offenders? Thus far, I am simply not convinced. A lot of people have said to me, “But Oregon hasn’t had any problems.” These kinds of claims are impossible to substantiate. If someone has successfully caused the death of another person and dodged the system, of course, there is not going to be a prosecution. Similarly, it is impossible to get 100 per cent accurate data on anything—crimes are not reported, bodies are not found, a murder may be mistakenly deemed an accident. These things happen; not everything is reported and not every misdeed is caught. We ceased capital punishment years ago because we knew the system could get it wrong.

Consider for a moment the elements that make a person eligible for assisted dying. For ease of reference, I will refer to the criteria outlined by the expert panel. The person must be aged 18 years or over; be a citizen or permanent resident; be ordinarily resident in WA for 12 months or more; and have decision-making capacity. Is the person making an informed decision? Is the person making an enduring and voluntary decision? Has the person been diagnosed with an illness, disease or medical condition that is advanced, progressive and will cause death? Is the eligible condition causing suffering to the person that cannot be relieved in a manner the person considers tolerable; and is death reasonably foreseeable within 12 months? I refer to a person’s decision-making capacity. Informed decision-making and outside influence are undoubtedly debatable. “Decision-making capacity” is certainly a vague term. Even medically trained practitioners may vary in their interpretation of the definition, much like with what constitutes an informed decision. The real meat of the eligibility criteria comes in the last three points—the illness, suffering and life expectancy. When I received a briefing, a question on these conditions was posed to the expert panel. The panel was asked whether a person with diabetes, for example, who found that distressing and refused to take their insulin would qualify under this legislation. There was a moment of silence before the panel said yes.

Hon CHARLES SMITH: That’s because they would die.

Hon Colin Holt: Exactly. That is the point.

Put simply, these qualifications are vague. They are vague for the purpose of keeping preclusions to a minimum; however, the problem is that it means many other very treatable diseases or ailments may fall within its scope. Similarly, with respect to the alleviation of suffering, what about cases of people who may be ill but also suffer from chronic pain syndrome? This issue also continues for the purposes of the 12-month requirement. Again, this is impossible to diagnose with complete accuracy. It can be significantly shorter or indeed much longer. We have no doubt all heard stories of people who were told they would live for only so long, but who went on to live a long and moderately healthy life. For example, the great Professor Stephen Hawking was told that he would live only a handful of years after his diagnosis at age 21. He died more than 50 years later, aged 78. His contribution and achievement in physics is undoubtedly one of the most remarkable in the last 100 years or so. Similarly, as the parliamentary minority report observes, there have been many examples in Oregon of the ingestion of the drug well after a person’s diagnosed years to live. In 14 of the 17 years recorded, there was at least one case of a person taking the drug after one year had passed. In four recorded cases, people ingested the drug some two years after diagnosis.

I would like to raise one final issue before I conclude—that is, so-called doctor shopping, which is when a patient sees numerous doctors until they find one who agrees that they fit within the window for assisted dying. To my understanding, no jurisdiction has really answered this problem. In a 2010 paper in the *Disability and Health Journal*, Marilyn Golden and Tyler Zoanni state —

> ... in many instances, patients have engaged in “doctor shopping,” which can circumvent these supposed protections. When the first physician a patient approached refused to comply with the request for lethal drugs, possibly because the patient did not meet the conditions of the law, the patient sought out a second physician, and in some cases, a third and fourth, until someone finally agreed. In fact, in the first three years assisted suicide was legal in Oregon, patients had to ask at least two physicians before receiving lethal drugs in 59% of cases …

I see nothing in this legislation that would prevent this happening. I acknowledge the strong and understandable desire to alleviate the suffering of a patient with a terminal illness. However, I am on principle opposed to any legislative change that would allow medical professionals the right to terminate the life of a patient or assist patients in ending their own life. Irrespective of intent or planned safeguards, I believe that introducing legislation to allow euthanasia and assisted dying would constitute a radical and unacceptable shift in our views towards the value and preservation of human life. It would introduce and condone a culture of dying that would gradually spread through our institutions and civil society. Once this culture of death in the form of state-sanctioned killing and assisted suicide has been introduced, the pressure to expand the euthanasia criteria to include more people aside from the terminally ill will become relentless.

I agree with former Australian Medical Association president Michael Gannon in his assessment, and I quote —

> Once you legislate this you cross the Rubicon. Our position is we need to do better with end-of-life care and we say that doctors should have no role in intentionally ending a patient’s life. The medical profession is concerned because we will be expected to be involved.

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Rather than legalising euthanasia and assisted suicide, I believe, as others have said, that the state government should focus on improving access to, and the standard of, palliative care in Western Australia. In my view, radically changing the entire ethical framework in relation to human life is fraught with danger.

HON ALANNA CLOHESY (East Metropolitan — Parliamentary Secretary) [1.41 pm]: I rise in support of the Voluntary Assisted Dying Bill 2019. I do not do this easily and I do not do it lightly. Like many others in this place, I do so following deep contemplation over a long period on the issue of assisted dying, and particularly following excruciatingly painful and undignified deaths of loved ones—and in the face of deep loss and deep grief. But I have also considered the detail, in significant consideration, of the bill before us. I have not automatically accepted or taken for granted any of the compelling arguments on any side of this debate, nor have I dismissed out of hand any of the debate proffered so far; I have considered it all. Although I might have a set of very particular personal experiences and a set of values that might lead one to suspect that I am a likely supporter of the bill, do not take that for granted. I also have a strong belief that good public policy, good public law, must be based in evidence and grounded in reasoned analysis, and this bill has been developed following consideration of extensive evidence and analysis.

The Joint Select Committee on End of Life Choices received more than 700 submissions. It held 81 hearings and heard from 130 witnesses. The Ministerial Expert Panel on Voluntary Assisted Dying took the detail of the select committee and held an extensive consultative process and developed the framework for this bill. The ministerial expert panel heard from 867 participants and received 541 submissions. That is not to mention the extensive surveys conducted by community organisations, special interest groups, media, some members of Parliament and other interested parties. It is clear to me that this bill has had extensive meaningful engagement and consultation and detailed analysis based on relevant evidence. I cannot think of a bill that has had such an extensive process in its development and deliberation in the history of this place. The recommendations of the joint select committee and the ministerial expert panel have also been carefully considered by government throughout that extensive process. On my part, I therefore consider the evidence and analysis to be reasoned and clear.

I turn to the detail of the bill, which, as I said, is based on sound evidence. I was thinking: Why do we need this bill? Why is this legislation needed? Simply put, we purportedly live in a caring society. We provide hospitals, health systems, world-class education systems and myriad support and other social services. We do this as a caring society. If we care about the way our citizens live, we ought also care about the way in which our citizens die. That caring means that we should not countenance or cause undue suffering to others. However, right now, there are many people nearing the end of their life who are experiencing immeasurable suffering. I have witnessed loved ones experience such suffering and I felt completely inadequate, but, more than that, parts of our system cannot adequately respond to that pain and suffering that people are currently experiencing. Granted that the group of people for whom palliative care cannot ease their suffering is comparatively small, and this bill has very strict criteria on who may be eligible for voluntary assisted dying—so that narrows the gap even further. We are bound to provide for those whose life is limited but who are beyond the scope of palliative care because we are a caring society.

I have witnessed firsthand the absolutely amazing work that palliative care professionals do. I have witnessed their caring approach. I have watched the way they work so incredibly hard to find medical solutions to improve the comfort level and medical responses for people nearing the end of their life. I have watched them work tirelessly doing that. But I have also seen firsthand how palliative care is no longer the relief from extreme pain or suffering that some people experience. My observations can also be found in the evidence provided by the select committee, which found —… it is clear from the evidence that even with access to the best quality palliative care, not all suffering can be alleviated. Palliative care physicians themselves acknowledge this.

The select committee received significant evidence also from families of loved ones for whom palliative care was limited; I quote —

*She was still in a lot of pain and a lot of discomfort in this period here because, because if she is not using her muscles and stuff, then she is basically wasting, and that comes with discomfort. You are talking about continence as well. She could not eat a lot of food anymore. Her stomach was rejecting food. I would not say she had any quality of life from here on in.*

That witness’s experience mirrors my own family’s experience. My mother-in-law was a dignified woman throughout her life. She valued privacy and the way in which she presented to the world was important to her. Following a head injury, she deteriorated rapidly. She was medicated, so her breathing was difficult and her muscles contorted. I might come back to that. The short story is that she had access to fantastic palliative care, great palliative care, but it was limited—very limited—for alleviating the suffering she was experiencing.

Therefore, I am really pleased that the government has recently significantly increased funding for palliative care. There has been a total increase of $65.2 million with the recent announcement of $17.8 million. This will increase access to palliative care services throughout Western Australia, and I am really pleased about that. I am particularly pleased about the increase in palliative care services across regional Western Australia. The regions

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have for a long time experienced a lack of palliative care, and I am very pleased that those services will be increased for families throughout Western Australia. But even with this significant increase to palliative care, it is, as I mentioned, for some people no longer an option.

Further to that, the lack of access to voluntary assisted dying has in the past caused many people to make difficult choices. I have heard the experiences of many family members and friends whose loved ones, because of the lack of a legal framework that this bill will provide, have felt forced to choose their end of life alone. For example, one person ended his life because he wanted his end of life to be of his own choosing. For him, there was no choice; he had bone cancer and had suffered from it for a number of years, and the cancer was advanced and terminal. He had received good palliative care, but his medical professionals made it clear that his end was near. He was in constant, unbearable pain, but the medication he was prescribed was unable to alleviate the intense pain he was experiencing. The medication also affected other aspects of his quality of life. He had always been a good talker and laughed uproariously—sometimes at the most absurd things—but he could no longer talk and could no longer laugh. He had always been a person who made informed choices about his life; he was active in his own life, if you like. He had lived his life surrounded by family and friends and was a very jovial fellow, but because he did not want his family to have any suspicion at all about the way in which he would die, he died alone. He was terminally ill and he chose to end his life.

I understand that this bill does not support suicide because it makes a very clear distinction. I believe suicide is tragically sad. I understand suicide to be the loss of life of a person who does not have a terminal illness and is not dying. I personally have worked very hard to try to prevent suicide, but this bill is based on the premise that voluntary assisted dying involves a personal choice about the way in which a person may die, when and only when their death is inevitable and imminent.

During the course of community debate on this bill, some people have pointed to other potential flow-on effects, including that voluntary assisted dying will lead to forced euthanasia. It is an argument that suggests we start at one end of a supposed continuum and progress through to a supposed logical conclusion. What I have noticed about these types of arguments is that they are what is termed a logical fallacy: committing X will allow something else to be caused to happen, therefore X should not be allowed. One of the things I have noticed in my many years in public policy is that these types of arguments, also known as “slippery slope” arguments, occur whenever significant public policy change is being considered. I have seen these kinds of arguments used in debates on sex discrimination, equal opportunity, abortion law reform and, more recently, marriage equality. But changes have been effected in all those public policy areas, and the sky has not fallen in. Significant change is difficult, but we must do it with reasoned analysis.

The argument continues that if we accept some measure of voluntary assisted dying, no matter how highly regulated or tightly managed it might be, it will invariably lead to the acceptance of a set of values that are not currently held in society, or to practices being taken to an extreme. The Joint Select Committee on End of Life Choices found that there is no evidence for these concerns. The select committee pointed to the example of Oregon, USA, where a similar law has been in place for more than 20 years. I quote part of finding 38 of the committee’s report —

The experience in Oregon, where the law has undergone no change or expansion since its introduction in 1997, demonstrates the invalidity of any attempt to apply a universal slippery slope argument.

I acknowledge and understand the concerns of some people, particularly people in the disability sector, that if we start here, people with disability may become particularly vulnerable should the law expand. I understand the personal and very close feelings of being threatened that that argument may provide, but I also know that in addition to the evidence provided to the select committee, there are other factors to consider. This bill is clearly defined in its intent and purpose. Its intent is for those whose medical condition is terminal. Its intent is for those whose life is ending. The lives of many people with disability are continuing and there is nothing in this bill that indicates any characteristics other than a terminal, immediately impending illness. Furthermore, the approval process is detailed and closely managed. The request for voluntary assisted dying must come from the person; in fact, there has to be three separate requests. Importantly, the request and approval process must be transparent. For me, this component of transparency brings the whole process into the open for regulation and scrutiny. That clarity, that openness, is an important safeguard. It also reduces, not enhances, the likelihood that practices become anything more than assisting those with terminal illness under strict and refined criteria to bring forward their inevitable death.

Furthermore, it has taken many, many years to bring this bill to fruition. My colleague Hon Alannah MacTiernan outlined the various attempts to bring similar bills to fruition over something like 25 years. This bill has a long way still to travel—I know that—and the process of change is not easy. Even if this bill is successful, the process of bringing any other change through this Parliament is very, very unlikely.

I also want to talk about another way the bill will be implemented that has concerned me for some time. It relates to coercion and people choosing voluntary assisted dying because they feel they are a burden. Again, prepare for the tears with this one; it is close to my heart as well. My mum died at a relatively young age for a woman. She had respiratory illnesses all her life. They had been misdiagnosed. Throughout her engagement with the medical profession she never challenged a diagnosis; she never requested a second opinion. When she was dying, I sat with Extracted from finalised Hansard
her and noticed a large lump. I asked her about it. Had she brought it to the attention of the nursing staff? No, she had not brought it to the attention of the nursing staff? She did not want to because they were so busy. Had she brought it to the attention of her doctors? No, she had not. She did not want to disturb them. Had she talked about it with any other members of our family? No, she had not. She did not want to be a burden. She said that she had already been a burden for a few years and she did not want to be more of a burden. I do not know whether she would have chosen voluntary assisted dying at the end—I would hope for her that she would have because it would have made her death easier. But with this bill I wanted to make sure that other people like her, women who are socialised into a kind of passivity and a sense of worthlessness and those people who feel that they are nothing more than a burden, do not choose voluntary assisted dying as an option as the least burdensome choice for the medical profession or their families. I took a detailed look at the safeguards contained in the bill. In addition to the safeguards I referred to earlier, I understand that the process to apply for voluntary assisted dying is rigorous and sound. I understand that the practice of assessment by two doctors who are required to be trained by law in this area will act as a very reasonable safeguard to detect coercion, as I described this part of a request for burden.

Other areas of the operational provisions, particularly parts 2, 3 and 4, and the review provisions in part 5, are, I think, important safeguards to ensure that people who feel that they are not worthy or are a burden will not choose voluntary assisted dying unnecessarily. But the most important part about all the safeguards is that not one part of this bill and not one safeguard works in isolation. The important part of this bill is the interrelatedness of the way each part works in sequence, but together as a whole, as a check against each other. That is what makes this a whole safeguarded system. That is the important double-check for people who may not feel that their life is worthwhile. For me, this bill, on balance, provides patients with a choice that they currently do not have and it provides them with dignity. It is enclosed with safeguards to protect patients and the integrity of the process. Its development has been based on clear evidence and reasoned analysis. It is a caring bill for a caring society.

I want to thank sincerely all those people who have shared their views with me—more than that, who have shared deeply personal and often painful experiences. I want to thank the over 1 000 people who contacted me about this bill and to also apologise to those people who tried to phone my office the day our office phone numbers were published because my phone lines were down. It was a telecommunications issue. If I had been there and if the lines had been working, we would have listened.

Thanks also to the members of the Joint Select Committee on End of Life Choices and the ministerial expert panel, and the countless health professionals, community organisations, professional organisations and others who have contributed to this debate so far.

This is a caring bill for a caring society.

HON DR STEVE THOMAS (South West) [2.07 pm]: Madam President, thank you for the opportunity to make some comments on the Voluntary Assisted Dying Bill. I do not intend to talk too much about my personal history and the history of my family and friends and their various deaths. I hope that members will simply accept that my experiences are not dissimilar to everybody else’s. I am not generally of the view that I need to share those in any great detail, but I will, as is my usual bent, take the conversation to some different places than the conversation that has generally occurred. I do so because I think it is important. I have been around long enough to know that it is unusual for any member of this house to be swayed by the contribution of another member of the house in the debate on particularly important issues, so I am not silly enough to expect that my words will shift the vote of any other person; and, to some degree I suspect, neither should it. But I do take this opportunity to congratulate members on the standard of debate so far and the way it has been conducted. I think the respect that has been shown in this house is a credit to this house, and I hope that the rest of debate continues along at that same standard. That is not to say that that standard has been maintained universally throughout the debate. I think the standard in this house has been an example that could be reflected upon, in particular by those on both sides of the argument who seem happy to make contact with members of Parliament and me and my office expounding a view on one direction or another. Other members have probably found a very similar thing, but I find that the public approach to this has been one of the two extremes. The people who write to or contact us are either absolutely adamant that this is a good bill or absolutely adamant that it is the worst bill in the history of bills. I have found it very difficult, as I have done with other complicated debates, such as climate change, for example, to have a conversation about the technicalities when people are expert in all the things that they know and say without, in my view, in the most part, having read or understood the bill or knowing much about the issue apart from having a firm opinion in one direction or the other. I find that immensely frustrating. For those who want to debate, it is very difficult to do so with people who are absolutely certain of their ground. That is the problem when we talk about social issues. Every person is a member of society and therefore, to some degree, an expert in what they are saying. I will come back in a little while to who is really expert in this particular field.

Instead of talking about friends and family who have gone before me, I thought I would talk a little more about the actual process. When I first thought about this address, I thought that I would talk in some detail about the process of euthanasia, because I am probably the only person in this room who has dispensed it. I imagine I am probably the only person in this Parliament who has done so, but that is not to make light of it. I start by saying that when members hear somebody say, “You would kill an animal if they were suffering like this, so why won’t we do it for a human?”;

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I find that a most enraging, petulant and stupid comment. We do not chain human beings up outside—or we should not. We do not starve them. We do not kill them and eat them. As one who has euthanised thousands, as far as I am aware, no-one in the human euthanasia field has ever been faced with the statement “If nanna is sicker than $300, just put her down.” To suggest that we equate humans with animals and that makes it okay is a spurious argument and is insulting. It is not the case that it is done easily or lightly, even in the animal sphere. Some veterinarians refuse to euthanase animals on the basis that it is traumatic for both the owner and the vet. For those people who work in the field of killing animals, particularly those who work in abattoirs, it is an immensely traumatic job and not many people survive it for any length of time. Can we put the statement “We treat animals better; therefore, it’s okay” to one side in the debate? Whether people are for or against this bill, let us put that to one side.

Hon Nick Goiran: Can I make the observation that animals also cannot consent, unlike a human being, so it is manifestly different.

Hon Dr STEVE THOMAS: Yes, true. I guess I am making the point that there is a difference between the sanctity of life of an animal and the sanctity of life of a human, so let us not treat them in the same way. Having said that, I also do not believe that this is a religious debate. For me it is not. The reality is that I have never felt the urge to make others conform to my faith. I say to those at the other end of the argument for whom this is a religious debate that if they are correct and suicide is a mortal sin, do not do it. If they believe that those people who do it will be punished, that is their belief, but that is not a reason for me to engage in a debate to prevent this from going forward. I have never felt the urge to force my religious view on anybody else, and I maintain that view. This is not a religious debate—it has never been and it should not be. I will get to this a little later, but I will use what I call, sadly, the pseudoscience of psychology. For me, this is a scientific debate; it is not a debate about religion. I hope that we can put that on the backburner as an issue that is not relevant to the things that we do in this house. If people think that the supporters of this bill have a religious problem, that is their problem. It is not their role or my role to impose that view upon them, so let us put that aside for the moment and take it back to the real sensitivity of the debate.

I have not gone into the details that other members have covered, but if people are of the view that assisted suicide is not an option—I would love to think that everybody is of that view, but they are not—there are other ways for them to approach their end-of-life care. I have not heard anybody talk about it yet, so I will make some comments about how it can be managed in the best possible way. If a person wants to go through the best possible end-of-life process, obviously they will need the best possible end-of-life care. I agree with all those members who have said that palliative care needs to be improved and that there is a long way to go. I spent 10 years as the chairman of the South West Health Forum and we could not get a gerontologist in the south west for a long time—that is, one aged-care specialist. It was very difficult to get a palliative care specialist in the south west. When the appointment was finally made, it was not a state appointment; St John of God Bunbury Hospital put in a very good palliative care unit. I have mentioned that before and I have praised it and I do so again.

People need good end-of-life care. For those who do not want to take that final step, I offer a piece of advice, and this has been available to patients and their doctors for some period. If a person’s pain is extreme and their incapacity is high, they have the capacity to discuss with their medical professionals today the need to increase their dose rates of various painkillers up to the point at which it may be a risk to their life. I say to those people who want to go down that path that if they go to their doctor at the moment and say, “Will you please kill me?”, they have to say no, but if they go to their doctor and say, “I understand that I have a high pain disease and I have a low pain threshold, and I understand that you will need to increase the doses of an opiate of some form to the point at which it will start to have negative impacts and at some point you will most likely have to increase that dose to the point at which it will most likely end my life”, the doctor has the capacity to do that now. Parts of the medical profession talk about increasing the dose—lots of doctors have increased the dose—to the point at which end of life is perhaps not a certainty, but the person will get there eventually. The problem is that opiates are one of those drugs to which resistance builds almost universally amongst people. That is why drug addicts start on a fairly low dose of opiates and then build up to significantly high doses. The doses that a person will have to be on will be very high. There will come a point in that process when there will be respiratory suppression, particularly if opiates are used in conjunction with dissociative anaesthetics. I do not propose to go through all the details and the names, because I do not want to talk about a manual for the process, but there is a point, particularly with that combined structure and plan, at which there is effectively a likelihood of the end of life. A person’s medical support crew can put that in place today. It is a conversation that a person has with their medical professionals about understanding the risks. It is a bit like the way people can say to their medical professionals that they do not want to revived. People can also say to their medical professionals that they do not want certain treatments, and they can ultimately refuse food. All of these things are possible now. That is not to say that there is not a group of people who will say that is not adequate, but I wanted to put that as part of the debate—to say that there are alternatives that people need to be aware of as part of this conversation, and I am pleased to have the opportunity to do so.

My concern with the bill is not religious, and I am glad we have removed the animal component, to be honest. My concern with the bill is this: I am always concerned with precedents in community activity. I think we are effectively and essentially a binary species. We do not deal with intricacies very well; we never have. There is this great line

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in *Yes Minister* that people do not want to know all of the substance of an argument, they just want to know who the goodies and baddies are. We are very much a binary species, and that remains my view. We effectively say that something is in or it is out. I think the correspondence I have received during the course of this debate reflects precisely that. There is no intracity or discussion about the debate. People are either firmly in favour, which in my view is the majority, or they are firmly against. I am not of the view that just because the majority of people are in favour of something it means that all politicians therefore have to follow in line, because I do not think that necessarily leads to the best outcome. Hitler was popularly elected, but that does not mean it was good for the world. At the last state election the Labor Party was 55 per cent to 45 per cent in favour. I do not even think that is necessarily good for Western Australia! It is not my view that simply because something is popular, it is the right outcome. The degree of venom that has come out from some people in the process at both ends of the argument should be an embarrassment to them. Some of it has been disgusting—from both ends. I am either going to hell at one end or I am not going to get preselected on the other. If that is how I should judge how I stand, how I speak and how I vote, we should all just go home, because we are all wasting our time. Doing something just because it is popular is not good enough. If it was just the popular vote that ruled, there would not be a Green member in the house and there potentially would not be a crossbench member in the house—there would not be much of anything but the two or three major parties. We might as well go to the Queensland system with only a lower house and no proportional representation, and we sort of throw democracy out the window a bit in the process.

**Hon Colin Tincknell:** Everyone would be a crossbencher.

**Hon Dr STEVE THOMAS:** No, everybody would be from one of the three major parties. If it was just that, it would be an interesting place, and we would get those big swings that Queensland gets. Can we put that to one side as well. There are those who have said this is the end of our political careers or we will never get preselected, and polling that says people will change their vote based on this issue. Some will, I get that, but if we are threatened by that, if that is the threat that makes us want to do one thing or the other, I have no right to be here and neither do any members. In the debate so far I have not heard anybody say that is what has driven them. I have heard people refer to it and I have heard people mention it, but in every speech I have also heard members say it is just one small component to what I am mentioning. I think that is a very good thing; I really think it is.

I am always cautious about polling. I have been around long enough. I saw the polling that said that the Morrison government was going to lose the election, so I take polling with a grain of salt. I am also always a little sceptical of the polling questions. Again, there is a great *Yes Minister* episode in which the question of whether people want conscription or not is asked. The answer that came back was that it just depends what question is asked in the polling. If the question is whether people want young people taught military discipline, everybody says yes. If the question is whether young people trained to shoot guns around the place, the answer is predominantly no. *Yes Minister* should be the bible for everybody here. Polling depends on what people are asked. What if polling asks whether someone supports the current safeguards in the bill without having asked them what they know about the bill, whether they have read it and what they have read about the safeguards? My view is that we are a binary species. If we support the bill, we are going to say yes, we support the safeguards. If we support the concept of the bill, we support the safeguards currently in it, because we want it. If we do not support the bill, we do not support the safeguards. We are binary; we are a binary species. We are this end or that end. A complex debate will hopefully happen in this house because it will raise the standard of the house that shall not be named; we will see a highly competent and complex debate. That debate needs to be allowed to happen without this pressure.

I try not to name-drop, but my old friend Joey Armenti has been a part of the campaign positive to the bill. We have been friends for nearly 20 years now. He will still be my friend at the end of the process, although we agree to disagree. I want to thank him for the respect that he has shown me in the debate, because not many people allow us to agree to disagree respectfully, and he has done precisely that. I think next time we meet it is his buy! He has done this very, very well.

In my view we are a binary species, and this becomes my problem with the bill. If we are a binary species, we then endorse suicide as a solution to a medical problem. We can agree to disagree on this, and I will give some examples of why I think we are a binary species. To me this becomes the major stumbling block of the bill so far—it is not religious, it is not anything else. This is my problem. My good friend who has now passed away, Dr Val Lishman, was a legend of medicine in the south west and used to call psychologists a curse upon society, and I sort of join him in that opinion. They always make me very nervous. But we are going to drag a bit of psychology into the argument. This is my problem: as a binary species, we are very poor at nuancing components. We do that. Some of our greatest failures in policy have been because we do not recognise that we are effectively a binary species. I will use an example. I know we are digressing into alternative social policy here, but domestic violence is a curse upon the community in which it exists, and there have been government programs and campaigns on domestic violence for longer than I have been involved in politics. Members might remember that I worked for six or seven years in the federal sphere, and I watched this process in action. There is a problem with domestic violence programs. We have had award-winning ones. Members probably remember the campaign “Violence Against Women, Australia Says No”. It was around for years. It won international awards. It was this great advertising campaign that brought in champions of both genders; it was this massive award-winning campaign. What happened to domestic violence rates...
at the end of that campaign? Does anybody think that the campaign actually improved outcomes? All the figures say that there has been effectively no change; in fact, some of the figures say that domestic violence is as bad as it has ever been. Here is why I think that occurs. Things like those domestic violence campaigns are actually campaigns in a political space to get a political response that does not reflect the reality of human behaviour on the ground. The political response is to make people feel better about the process, to make people think something is being done. There is a great line in Yes Minister: “I want to fix education.” “Do you want to fix education or appear to be trying to fix education?” “Obviously, it is the second; I can’t do the first.” Domestic violence campaigns are very much about advertising campaigns to make people think that something is happening. We are a binary species in my view because, behaviourally, it is very difficult to say that violence is bad in one set of circumstances. There are communities and people for whom violence is endemic, and in a lot of society we encourage it.

I am old enough to remember when we went to the football and clapped on the other team. If we did not like them very much, we let them go on in silence. Now we abuse them as they run onto the field. I will never forget going to my first State of Origin match to see the opposing team booted onto the field. I could not believe it. I am getting on a bit now, so I am going back 30 years. This endemic violence and abuse has been around for 30 years, but we encourage it. We encourage the abuse of football players. We see movies and video games that encourage violence and abuse. We put on movies in which lots of people are attacked and killed and all the rest of it. At the end of that process, we say to people who are probably affected by drugs and alcohol in difficult social circumstances, “Violence is not appropriate in this set of circumstances when the victim is identified this way.” I think that is why they fail. If we approach all violence as a negative, we have the capacity to influence it and try to remove it from society. If we pick and choose where we approach it, I think we have a problem. Because we are a binary species, I do not think we absorb the nuances of that debate. That is why I think those programs and campaigns fail.

My issue with the Voluntary Assisted Dying Bill before the house today is that I think it provides that in a set of circumstances that the government and the Parliament of Western Australia agree with, we think that suicide is a legitimate medical option. I absolutely get that for a number of people, that is exactly the case. That is the message I get from those people who say, “We want you to support this bill.” They say that in these circumstances, we think suicide is acceptable. My problem with supporting this bill is that I think we are a binary species. We do not necessarily have the opportunity to remove all those alternative situations in which the death of the patient is the desired outcome. That becomes my issue, and why I struggle to support the bill.

We are all against the death penalty because we think it is abhorrent. I think we need to be very careful about how we make voluntary assisted dying okay and in what circumstances. I fully accept that people do not want to be in pain into the future. They do not want their final years to be ones of suffering. I get that, I really do. As other members have said, I think good palliative care for most people is sufficient but not all people. There will be circumstances in which the best of intent probably comes up short. I have enormous sympathy for those people and for members who, in a gentle and great way, have shown support for the bill today. I have enormous respect for Hon Tjorn Sibma, who has come out in a public manner. I think he is someone of great integrity and intelligence, who would have significantly considered his view before doing so. I welcome and support his decision as being due to his conscience. I think other members have so far expressed themselves in a great way.

However, I understand that we are afraid of death and the manner of our dying. It is a pretty common human condition to be in; it really is. Nobody wants to go through that level of pain. However, I have struggled to support the bill simply because of the reflection in the greater community where we say that in one set of circumstances medically provided death—medically provided suicide—is the right outcome when it is not for others. It is easy potentially. People will say, “When you’re not suffering, that is an easy position to take.”

I will try to finish on this note. We talked about the sanctity of life. Members have mentioned the sanctity of life. That is not a religious statement. Plenty of people who are atheists believe in the sanctity of life above everything else. If we believe in that concept, whether we believe it is a religious concept, it is important for those who go through a difficult end-of-life experience to do so showing the sort of strength of character that shows to the people around them, particularly future generations, that life is precious and worth holding onto no matter the circumstances we are in. I hope that if I am faced with those circumstances, I will have the strength of character and the power of force to do precisely that—to say that every day is precious and every life is precious and, despite the pain, I remain of that view.

Most people will do that irrespective of whether this bill passes. However, that is why I have struggled to support this bill. I hope that when the final test comes, I am able to live up to the words I say today. I have known family members who have done precisely that. I expect this bill to pass the house. I think the second reading speech will be agreed to in a pretty timely manner, to be honest. I have no intention of holding up the bill in debate during the Committee of the Whole stage. I will say my piece and let the bill go forward. However, I think it can go forward without my support at the end of the second reading stage. I think that will happen. I hope, that going forward, the standard of debate we have seen to date remains.

I truly hope that the generations who follow me see an example at the end of my life that reflects the sanctity of human life and the notion that every day matters. That is why I am unable to support the bill today.

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HON JIM CHOWN (Agricultural) [2.38 pm]: First, let me state that I will not make any personal statements about end-of-life experiences that I have experienced, nor will I read out and burden the house with any of the thousands of emails I have received about this matter before the house for debate today. May I also acknowledge speeches such as Hon Alanna Clohesy put forward. Thank you for your courage. We certainly appreciated your words and the words of others who have had the courage to do so. That sentiment is mine sincerely; however, I do not have that sort of courage because I get quite emotional about these things.

I have been quite indecisive with my position on this bill. I have actually lost sleep over this for many, many weeks, and that is out of character for me, quite frankly. I am the sort of person who has gone through life weighing up the pros and cons when coming to a decision. However, I have come to a decision, and I will make that known as I go further through my speech today. Part of my indecision has been caused by my firm belief that palliative care goes hand in hand with end-of-life choices. The parlous state of palliative care in this state has come to the fore on more than one occasion in this house. I certainly thank people like Hon Nick Goiran and the President of the house, Hon Kate Doust, for their initiation of the Parliamentary Friends of Palliative Care group, which has regular meetings in this place.

I believe I was the first person, since I have been a member, to put forward a motion targeting the lack of palliative care services in regional Western Australia, which I did on 12 October 2017. That lack of palliative care has become more evident as time has gone by. I put a question to the Minister for Health on 27 November 2018 on that issue. My question asked how many palliative care specialists there are in Western Australia, and the answer that came back was 11.35 full-time equivalents. If we combined that number with those in private health institutions, it actually got to about 15 FTE. I have been fully informed by palliative care operatives in the Western Australian health system that nobody actually knew the answer to that question—they had to have a phone hook-up and meeting. They added up the numbers and found, much to their surprise, that there was a very, very low number of palliative care specialists in this state, and virtually none in regional Western Australia. I moved a further motion on palliative care on 3 April this year—I add that both those motions were supported unanimously by the house—and went through a whole set of figures for palliative care in this state, or the lack of it. I actually challenged the government to step up and fund palliative care so that people could have true end-of-life choices. The figures that I listed during the debate on that motion have been used extensively by the Australian Medical Association, members of Parliament and the press. I am quite proud to have brought forward in a public forum such as this place and put on Hansard the issue of the lack of palliative care services, and to have seen those figures expressed again and again in regard to the bill we are discussing today.

Just for the information of the house, since those motions were supported, and I assume because I asked government backbenchers to go to the Minister for Health and impress upon him that the government needed to appropriately fund or put more funding towards palliative care in this state, there was an announcement in May of an additional $41 million for palliative care and a more recent announcement of $17.8 million. Both those tranches of funding will be spread over four years. The amount of $17.8 million was announced just prior to this bill coming to the Legislative Council. I take some heart from the fact that the minister’s press statement states that this will include across all the regions—

… the establishment of new specialist district palliative care teams comprising of medical, nursing, allied health and Aboriginal health workers.

The breakdown of this funding includes $3.6 million for the goldfields, which will increase the current palliative care FTE of 4.1 to 12.45 FTE. The great southern will have an increase in its FTE from three to 11.45. The Kimberley region used to have a visiting palliative care specialist three times a year. I have been informed that every time they went up there to address the staff on how to provide palliative care correctly, they virtually had to start from stage 1 each time because of staff turnover. In fact, every time they went there, they could not put in a proper program for palliative care because the people to whom they had originally spoken had moved to other places. It is encouraging that the Kimberley will have expenditure of $4.4 million and an additional 9.95 staff, as stated in the minister’s press statement. The midwest and Gascoyne, which includes part of my electorate, will go from 2.7 FTE to 13.55 FTE; the Pilbara will go from 1.65 FTE to 13.45 FTE; the south west will go from 11 FTE to 16.9 FTE; and the wheatbelt, which is all of my electorate, will receive $2.7 million and the number of staff will go from 5.3 FTE to 11.45 FTE. It is a start. It is not a large amount of money in the context of the health budget, but it is a start, and it is a good start for palliative care. I certainly hope that the Minister for Health abides by this press release and at the very least accelerates this expenditure and puts these programs in place as soon as possible. Next year would not be early enough. A question was asked yesterday by Hon Colin Holt about how this will occur and we were told that there will be a 17 per cent increase in funding each year going forward. I would like to see a 50 per cent increase each year for the next couple of years in this allocation of funding for palliative care. Be that as it may, I have absolutely no doubt that had it not been for the pressure from this place, that extra money would not have been allocated to palliative care by this government. I congratulate everybody—I congratulate myself as well—for at least this happening at this stage of this bill.

My indecision about the bill was because of the parlous state of palliative care in Western Australia at large. I am still concerned about the metropolitan area, quite frankly. As stated in the report of the Joint Select Committee on

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End of Life Choices, Silver Chain does a lot of unfunded, pro bono work for people who are dying at home from a terminal illness. I asked a question in this house to the Parliamentary Secretary to the Minister for Health on extra funding for Silver Chain and the response was that its contract is up for renewal in 2021 and that, up until that point, there may be some contractual arrangements that need to be discussed. I found that response to be disingenuous and disappointing, because the government cannot tell me that Silver Chain would not accept a variation to that contract arrangement for more money to allow palliative care to take place appropriately in a residence in the metropolitan area, where the greater proportion of the population of this state resides.

Be that as it may, my decision is to support the bill. The reasons for that decision are more than one. I have listened to the case against the bill, but I believe that the population at large is ready for a change of our culture and certainly of our medical practices to allow people to have quality of life and quality in death if they choose to do so when they have a terminal illness. Our population is fully informed about and fully cognisant of their responsibilities, even though people at times get up in court and say, “I didn’t know that, Your Honour”, when in fact they did, but that is no excuse under the law. It is my firm belief that Western Australia is certainly ready for voluntary assisted dying for a number of reasons. One of the reasons that swayed me was a coroner’s report that stated that from 2012 to 2017, there were 199 cases of intentional self-harm by people with terminal or debilitating illnesses. Almost one person a day commits suicide in this state, which is more than the number of people who die on our roads. Some people commit suicide after they have been diagnosed with a terminal illness because they feel they do not have an option. If we can save even half of those people from doing that by adopting this bill, we will have done a great thing on behalf of the population of Western Australia. I cannot think of anything more traumatic for a person than to come home, knowing they have a loved one who is diagnosed as terminally ill and is under stress, and to find them dead somewhere on the property, or in the bedroom, or in the car that they have taken and driven somewhere else, to alleviate that person of the pressure. I think the survivors would probably never overcome the guilt. If we can go some way to alleviate at least that mental pressure and give them an alternative to know that if it gets too much for them, they have this option and they can exercise this option with the people who have supported them all their life, that is one reason I am prepared to support this bill.

Quite frankly, when we break down the figures in the coroner’s report, we see it is approximately 33 people a year. It is not a big number.

Hon Colin Holt: It’s 10 per cent.

Hon JIM CHOWN: Correct, it is 10 per cent. These are people who should be cared for and I think this legislation will go some way to caring for them.

As I stated on a previous occasion in a motion to the house, the Australian Bureau of Statistics states that in 2016 we had 14,839 deaths attributed to terminal illness in Western Australia. Approximately 70 per cent, or around 10,000, of those deaths were expected. As I have stated, I have spoken to palliative care specialists and attended as many meetings with the Parliamentary Friends of Palliative Care as I possibly could. At the last meeting I attended there was a panel of palliative care specialists. I asked the panel about my understanding that two to four per cent of people under palliative care cannot be helped by palliative care. Hon Alanna Clohesy addressed that issue in her speech today. The response was, “That’s not quite right. Medicine is progressing and possibly drugs will be available at some stage in the future and we can alleviate a fair bit of that stress to some degree for that two to four per cent of people.” I do not understand the use of the words “to some degree” because that sends me the message that palliative care cannot alleviate unbearable suffering. Once again, if we break down the statistics, it means that 200 people in this state, in the last six months of their lives, who are dying from a diagnosed terminal illness cannot be helped by the best palliative care available today. It is 200 people. That is a lot of people who suffer against their will and die in an intolerable manner because they do not have a legal option to exercise the rights in this bill. I find that incredibly disturbing and I do not want to be one of them, quite frankly. I would like to have the option. I challenge everybody in this place. We do not know what is in front of us, but if you were suffering intolerably and the option was available to you and you had a chance to go quietly and peacefully with your family, I challenge that most of you would at least think about it.

Hon Colin Holt: You’d have the chance.

Hon JIM CHOWN: I certainly would. I had a pivotal conversation with a lifelong friend whose opinion I respect. He is a very strong practising Catholic and will be until the day he dies, and so is his family. I told him I was undecided about voluntary assisted dying and asked him what he thought about it. His response was immediate. He did not even think about it. He said, “Jim, I would like to have the choice if I required a choice.” Certainly, 82 per cent of people in my electorate support the intention of this bill. It is the Liberal Party’s annual general meeting time in my electorate and I have attended a number of branches. I have had one member contact me saying they were against the intention of this bill but I have had a large number of Liberals tell me they support the intention of this bill.

This bill has my support. However, I would like to also state that I support Hon Martin Pritchard’s proposed amendment. I thank him for the amendment. I think it is an important amendment. The amendment states that a practitioner is not compelled or in fact authorised to initiate discussions about VAD as part of a patient’s
treatment program with those who are suffering from a terminally diagnosed illness. I support this bill contingent on the passage of this amendment because, as stated in the title, this must be, without exception, a voluntary process by the patient. A patient who wishes to exercise their right to utilise voluntary assisted dying must do so without being prompted or coerced. Again, the emphasis is on the word “voluntary”. To have a medical practitioner propose VAD as a treatment option undermines the voluntary aspect of this bill. Any perception of coercion, whether it be real or perceived, is a step too far, especially for those unfortunate people who, I have no doubt, would be in a fragile and confused frame of mind as they move forward in a condition that will eventually cause their death. I believe that if medical practitioners are compelled to bring up VAD as a treatment option, such an action severely compromises the medical professions’ sacred philosophy and practice in the western world of doing its utmost to prolong life. To impose such a condition upon our highly trained medical practitioners is in reality a step too far. However, if a patient with a terminal illness wishes to initiate such a discussion on VAD, the responsibility then resides solely with the patient.

I have discussed this proposed amendment with other members in this place and they are of a like mind on this particular matter. I have also discussed this amendment with the government as recently as last evening, and it indicated that it has no objection to Hon Martin Pritchard’s proposed amendment, and will more than likely put forward a similar, if not identical, amendment. I look forward to that. I take discussions behind the Chair seriously. As we move forward into Committee of the Whole House, I certainly hope that that proposed amendment is moved and accepted by this house.

Hon Alannah MacTiernan: Which amendment, member, is it that you’re talking about?

Hon JIM CHOWN: I have not got the number here, minister, but I am happy to bring it up later.

HON LAURIE GRAHAM (Agricultural) [2.58 pm]: I wish to commence my contribution on the Voluntary Assisted Dying Bill 2019 by reaffirming that I support the bill in its present form and will vote in support of its passage at all stages. We have an extraordinary opportunity to participate in debate on this bill and to have the freedom to vote according to one’s conscience. That rarely happens. Should the bill not be supported, I believe that it will be a very long time before the matter is considered again. I fully support and respect the right of the majority of members of this house to reject the bill if that is the will of the house.

A number of my friends and acquaintances are surprised that, as a practising Roman Catholic, I would support any legislation that provides the right of eligible persons to end their life at a time of their choosing. A few weeks ago I attended a church service in Geraldton. The topic of the homily on the night was the Voluntary Assisted Dying Bill, which really surprised me. I felt sorry for those who attended the service and who would not have understood that the key message of that homily was meant solely for me. I see little difference in the use of medications administered to patients for pain control that may well hasten their death in some instances and an eligible patient’s decision to opt for voluntary assisted dying medication. I find it interesting that when I have spoken to people of faith on this issue, I have found them to be mainly very supportive of both options that people should have at the end of their life. The bill provides appropriate protection for vulnerable people. It allows those who have been diagnosed with six months or less to live with severe pain or suffering to opt to end their life in a dignified manner. I have always made it known that I support legislation that gives people the right to end their life at a time of their choosing if they meet the eligibility criteria set out in the bill. Nothing I have heard in the debate in this house or the other house has changed that view.

I initially intended to make my comments on the bill with reference to the large number of letters and emails I have received from residents mainly within the Agricultural Region. I received a large number of group emails from all over the state to which, like many members, I chose not to respond. Instead of talking about those, I intend to talk about personal circumstances. Although I can be emotional at times, I trust that I will be able to get through this. I have had reasonably pleasant experiences with death to date, so hopefully I will get through this without too much delay. I have opted not to refer in detail to the bill, the committee report or the specialist panel. I believe those have been well covered by members who have spoken to date and will be covered by others who will speak during the debate.

On my personal circumstances, my mother passed away some 40 years ago within a few months of being diagnosed with an advanced brain cancer. She pleaded with doctors to operate on the tumour as she desired to live the full and happy life she had before, and she accepted that the operation may well be unsuccessful and hasten her death. After the unsuccessful operation, the machine that was supporting her life was turned off after we had the opportunity to say goodbye. As a family, we totally supported her wishes. I believe my mother would have seriously considered using VAD in the right circumstances if that had been available at the time.

My father was in the opposite situation. He chose to live the last few years of his life at Nazareth House Geraldton. He initially moved from his house to respite care as he could not cope with a large house after several falls in the garden and he needed an extended period of respite. He quickly grew to love the institution and received great care in the low-care accommodation section that was available at that time. He had no wish to live his last years with his children, but regularly had holidays with us all. Dad had the most peaceful death in his own room on the verandah. I was able to be present at the time of his last breath. He rang my sister and brother early in the afternoon.
to say goodbye and he phoned me to ask me to call in on the way home from work that day. He had a very active, independent life. When I visited that day, I had no idea that he had decided that this was farewell. Within three hours of my arriving he had passed away. The point I am trying to make is that his body was broken. His soul was willing but his body was no longer active. He had a high threshold for pain; pain did not worry him. I know he would not have accepted VAD as an option to terminate his life, so we are all very different people; that is the way we are. Perhaps I am a little more like my mother.

My mother-in-law was diagnosed with breast cancer and passed away in 1999. She chose to live with us for about the last 10 years of her life. She fought breast cancer for the first five years and then got an eight-year reprieve. That was followed by two years of what I could only describe as hell for her, and she opted initially for treatment to try to get another window of time. When that failed, she received medical care to see out her days. She spent a considerable amount of time discussing with family and friends where she saw life going. I know that if voluntary assisted dying had been available, she would certainly have been a candidate. She hoarded medication should the need arise, but on the day of her death she asked my daughter to take her to hospital because she needed some pain relief, and within three hours she had passed away. It was very similar to dad. She obviously got to hospital, realised that the end was near and decided to move along.

I am reluctant to harp on about people’s personal experiences. My father-in-law worked in the Murchison area, collecting samples for Western Mining in those days. Uranium was the favourite of the day in that era and I have no doubt that that resulted in him picking up a rare type of leukaemia. He passed away also after a short illness. The point of raising his death is that he did not consider leukaemia to be cancer. He had a number of friends who worked in the same industry in the same location and who were diagnosed with cancer. He expressed the view, “If it ever happens to me, make sure the gun is handy.” He had his way out and he saw that suicide was an acceptable way for those people to terminate their lives.

I am trying to stress that we are all different. The calls we make on health issues in our lifetime will depend on the circumstances we find ourselves in at the time. As Hon Jim Chown said, I am sure that at a different time you will make a different decision, depending on what options are open to you and where the family is at a particular time. Ongoing pain and suffering will no doubt play a large part in the options that humans pursue in the latter years of their life.

A good friend recently passed away. I will not place his name on the record as I have not discussed it with his family. He was a farmer and worked all his life on the land. He retired to Geraldton, where he wished to pursue the final decade of his life. He was younger than I, so I look around with some concern as to how quickly these things can creep up on us. Within 12 months of being diagnosed, he had passed away. His circumstances were that he just got in and addressed the issue. He did a living will and everything he needed to do, and appointed people to act for him when he was no longer capable of making those decisions. He then turned around and tried to fight the thing. He thought that he would get out there and beat this cancer; however, it was inoperable, and the doctors did their best for him over time.

I would like to comment on the care he received. Much has been said about palliative care in regional centres, and Geraldton has palliative care specialists operating from the hospital. According to the paper that was distributed, staffing is down to 2.7 FTEs, but the level of care he received from the doctors who attended to him and the nursing staff in the hospital was phenomenal. He opted to spend his last days at home, and they fully supported that decision. On a 24/7 basis he could ring up on the phone and if the nurse who was on call could not make it, someone else would come out. There was no suggestion that he had to be taken out of bed and brought to the hospital. They came out and provided fantastic service and pain medication to address his issues. That service was phenomenal, and it concerns me that there is a lack of understanding about the services available in some centres.

I will make some other comments before closing on improvements elsewhere in the regions, which Hon Jim Chown has commented on. I do not see a situation in which I would personally opt for voluntary assisted dying, but I do not believe that a small percentage of eligible people with high levels of pain or suffering should be denied that right. It is only a very small percentage—somewhere in the order of two to five per cent of patients; the number has been quoted as somewhere between 200 and 500 people. In regional Western Australia there are limitations on providing the levels of health care that many in the larger cities expect. However, most people who opt to live in remote locations accept limitations to many services, be it the national broadband network or whatever else. They believe that the lifestyle they are able to enjoy in their preferred community far outweighs the benefits of living in larger towns.

My decision has been largely influenced by my wife, who was a nurse for some 50 years. During her employment she spent 35 years working in emergency departments and palliative care roles in hospitals. For the last 15 years of her working life, she was employed in doctors’ surgeries where she dealt with many elderly patients, many of whom had short life expectancies as a result of skin cancers et cetera. As a nurse, her main concern when she came home at night and could not sleep was the under-medication of patients who were left in severe pain on some occasions. She had the view that some doctors appeared to be more concerned about being held to task if a patient passed away unexpectedly due to medication being administered, rather than addressing the primary concern, which

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is the patient’s welfare. I am not suggesting that she had that problem with a large number of doctors, but she worked in the era when doctors were in the hospital and one or two nurses were left to their own devices at night and used the telephone to talk to doctors. Providing adequate care to patients in great pain was most difficult. This affected not only the patients, but also relatives, family, loved ones and nursing staff; they all became distressed, which made managing those circumstances very difficult. Suicide is also a major issue, and I hope that, with the passing of this bill, people with terminal diseases will at the end of their life seriously consider using voluntary assisted dying rather than putting their loved ones through the trauma that suicide leaves behind.

The issue of the lack of palliative care specialists, particularly in regional Western Australia, has been raised by many members during this debate. However, I was surprised to learn from people I spoke to recently in the regional health industry that the specialists out there are being consulted far too late. Too many doctors are holding on to their patients and trying to diagnose their issues when early referral could result in a much better outcome. There is a major problem with treatment plans under which referrals to specialist palliative care doctors occur far too late. I hope this can be improved in the future. We are not good at talking about issues relating to palliative care when someone is perhaps 15 years away from the end of their life. They do not see it as palliative care, but we need to be realistic. If people do not go into the right care and get the right treatment from the right specialists, their end of life will come much earlier than it otherwise would. However, in the final stages of life, the local general practitioners and nursing staff are best placed to provide primary care for most patients, especially those in regional Western Australia.

I refer again to the government’s recent investment. Extra FTEs have gone into the goldfields, the great southern, the Kimberley, the midwest, the Gascoyne, the Pilbara, the south west and the wheatbelt, and that will go a long way towards addressing the shortfalls that have occurred. I know that in the case of the midwest and Gascoyne, there were no services at all in Carnarvon, so that at least will be addressed. Going from 2.7 to 10.85 FTE positions will go a long way.

In concluding my remarks, I wish to thank all members for the courteous way in which the debate has progressed. I commend the bill to the house.

HON TIM CLIFFORD (East Metropolitan) [3.17 pm]: I rise to speak on the Voluntary Assisted Dying Bill 2019. This is a very important and highly sensitive issue. I do not take this bill lightly and I am fully aware of its historic significance and what it means to so many in our community. I am also aware of the work that has been undertaken by many people over the years to progress this cause, and I am forever grateful for the work in this space that has been undertaken by my colleague Hon Robin Chapple.

Over the last few months many people across Western Australia have expressed their views to me through a multitude of platforms, and I respect all their views, even the ones I do not agree with. They have expressed their views, and I guess it is now time for me to express mine. This issue is a deeply personal one for many of us, and on many levels it brings us back to the frailty of life. Of course, we do not have a choice about the beginning of life and the circumstances into which we are born. But if we are lucky, we are born into a situation in which we have all the love and support that we all need and deserve. Many of us will hopefully live a long and meaningful life—a life of joy and good health, shared with the ones we love. That is, of course, what I hope for, and I am sure everyone else in this chamber hopes for that as well.

Unfortunately, that is not the case for many members of our community. Some people are unfortunate enough to have to endure the worst life can throw at them. Terminal illness is the nightmare that many members of our community experience and needlessly suffer as the end draws near, and that is one of the reasons why I support the bill before the house today. I do not have all the answers, but I want to confront the end of my life in the same way as I have lived it: with dignity, control and in the company of my friends and family, and, I pray, when the end is near, without pain. To be honest, until a few years ago, I was not aware of all the intricacies of the euthanasia debate—dying with dignity, voluntary assisted dying, or whatever other name or title it is given. I was on the periphery. I had experienced death but only at a distance. The sudden deaths of some of my close friends over the years of course have been difficult to deal with, and today I still feel deeply about their passing. But it was not until I saw the trauma my mother experienced as a carer and the pain that was suffered by my mother’s late husband, George, as cancer ravaged his body, that I started to think about some of the assumptions I had made about death. I wrongly assumed that pain as a result of a terminal illness could be dealt with through the advent of more advanced painkillers and pain management. Little did I know about the statistics and the advancements in modern health care, and that people are living longer and that this is something people are more likely to deal with. Sadly, I was wrong.

George was initially diagnosed with throat cancer in February 2008. After years of treatment, countless trips driving from Katanning to Perth for treatment, periods of momentary relief and the hope for a reprieve of remission, sadly, George finally succumbed to aggressive melanomas in September 2016. I was reluctant to share people’s personal stories. Before this debate I did not think it was my position to put forward someone else’s experience, but I had a conversation with my mum and she reflected upon her experiences and George’s views. At the time, George expressed his views to me about his fear of the end of life and his hopes, and he referred to the debate that we are discussing today, at length sometimes.

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In August 2015, George and my mum were informed that George was not going to survive his cancer. Treatments were not working and it was time to just make the most of the time he and my mum had left together. That was a long and excruciating year. It was difficult to hear about how his final months came with little relief. No matter what was done through painkillers or treatment, it did little, if anything, to knock off the pain. For me, reflecting on this, it is even harder to process how George experienced his last days on this earth. I asked my mum what the final months were like and to quote her, “George went through hell.” Following our conversation, my mum asked me to share the following. She wrote a few words and sent them through to me. She said that George last spoke on the Saturday and then lost his ability to speak, and he then went blind. Not long after that he began to have seizures. He would sit up and his eyes would open and he would then fall back on the bed. It was constant and went on for days. That did not stop until the early hours of the following Thursday morning when he eventually passed. As I said, I was initially reluctant to share his story, but he was a strong supporter of voluntary assisted dying and always insisted that he would take his life into his own hands if the pain from the cancer became too much for him to bear. He did not end up doing that, but he did suffer through the pain that he feared the most, and he shared that fear with my mum and the rest of his family.

Before I conclude my remarks, I would like to say that I believe that people should not needlessly suffer. It would be far more compassionate to let a person who is suffering to end their own life in dignity surrounded by loved ones, rather than suffering like George did, with no quality of life, going through unspeakable trauma with the people he loved. It is only years after that I can share this story because my mum never shared it. It is still very difficult for her to describe what she went through with George as his primary carer. But she has been following this debate and she is relieved that we have been discussing this matter at length.

At the end of the day, I urge all members of this house to consider George’s story, people’s experiences and everything when they consider their position on the bill. I understand there has been a lot of noise. I have received all the same emails and correspondence and the views from the different camps, but at the end of the day we are talking about people. I just hope that this bill passes so that many people in our community will not have to continue to suffer.

HON TJORN SIBMA (North Metropolitan) [3.26 pm]: I am a very imperfect person, and within the limit of my own capacity I am trying to deal with a very complicated social, moral and personal issue. Like every single member of this place, I have felt the burden of it—not so much the burden of the content, but the burden of the responsibility. It is pretty clear to everybody in this house what my position is. I will mention it, obviously, for the record, but I want to say that it was a decision not arrived at early and not arrived at easily. In the end, although my decision disappoints some of my colleagues and political supporters, and indeed other people very close to me, I hope that they understand my reasons for making that determination, for at the conclusion of this debate and at the end of my parliamentary career here, whenever that might come, I know with certitude that I would forever regret not voting for this legislation when every fibre of my being is telling me to vote for it. The easiest thing I could do is to accept the status quo. In my evaluation, obviously, the status quo is imperfect, but it holds the potential to be somewhat corrected.

The significance of this bill is obviously greater than the sum of its parts; it is greater than the clauses that constitute it. But it is not, as some would argue, a matter of life and death. In my mind, it is rather about permitting individuals to make some peace with the reality of their inevitable demise and it is an attempt to give them the space to exercise what remains of their autonomy and to exercise that autonomy over the circumstances of their passing. To my mind, this is not a bill that seeks to establish a right to die. Instead, it establishes a right for a very small number of people to make some peace with the reality of their inevitable demise and it is an attempt to give them the space to exercise what remains of their autonomy and to exercise that autonomy over the circumstances of their passing. To my mind, this is not a bill that seeks to establish a right to die. Instead, it establishes a right for a very small number of people to ask for assistance to die when their death—a very difficult death at that—is not just inevitable, but imminent. I want to emphasise this distinction because I think it is conceptually important, and I make it for two reasons. First, a framework of universal or even restricted human rights is probably inapplicable to the reality of human dying. Death is a fact. It is not an object to which one can claim a right, and, as such, I think we can avoid the establishment of a slippery slope to expanded death on demand, as it is so claimed. I also think that this bill’s reach is modest, and that is very important. This bill may well be the most important piece of legislation individual members, using their own individual best judgement, will ever consider in the course of their parliamentary careers. I suspect it will be the case insofar as my parliamentary service is concerned. I also surmise that this is the last opportunity that this Parliament will have to potentially pass legislation such as this—a bill written with the resources of a government, not a private member’s bill. That is also an important distinction, but I say that because I think that if this bill fails now, it will fail for a generation. I truly believe that to be the case.

With some indulgence, I will continue my preamble. I have come to this debate for most as a legislator, not as an advocate for a particular perspective. Until I made statements publicly and very recently, I maintained that perspective because I thought it was the appropriate perspective to maintain. It was not an indicator of my harbouring of any moral equivocation or holding onto any prejudices or resentment. It was not an opportunity either for me to cynically observe the whims of public opinion and pick a winner. I simply required the time, the space and the opportunity to make the best possible decision. With that, I have arrived at the position that I support the principles that underpin this bill and I support the bill itself. I support it in the form that it has been presented to the Legislative Council and I believe that the safeguards embedded within it are well formulated, well balanced.
and practical. With that, I remain a legislative pragmatist. I do not think it is wise to make the best the enemy of the good. Amendments have already appeared on the supplementary notice paper and further amendments may well be moved by members. I believe that those amendments should be treated with respect and given utmost consideration. Although I do not hold to the view that this is a form of legislation that seeks to impose a social change—indeed, I think it is responsive to a change in community sentiment—it carries with it the requirement that the safeguards embedded in it are well balanced, well drafted and appropriate and will continue to maintain the community’s confidence in the long term. Much has been discussed about what I will call, not in any derisive way, the Dr Buti amendment concerning the process by which a physician might raise voluntary assisted dying as an option. I have a deep regard for Dr Buti’s intellect and for his integrity and I was very much moved by his contribution to the debate in the other place, as I have been moved by the contributions of just about every member in this Parliament. Although I have not come to a fixed position on that amendment, I urge this chamber to consider it, particularly if it is a determining amendment in the future of this bill.

As I have said before, my decision has disappointed some, but I believe it has come to the relief of many. It is abundantly and overwhelmingly clear that the majority of Western Australians support voluntary assisted dying conceptually and support this bill specifically, and emphatically wish to see it pass this legislature. They do not, however, want it rushed and they expect us, individually and collectively, to scrutinise it properly. I feel it is my duty to acknowledge that public desire and discharge my parliamentary duty to evaluate this bill, even at this late stage, in the most considered manner. I know that polling, particularly of late, has been received with a great degree of justifiable scepticism. But, frankly, I did not need polling to tell me what the community’s will is on this bill. I think that is because every adult Western Australian intimately understands death and suffering. Each individual knows somebody with a terminal or severely life-limiting condition, have cared for loved ones who have undergone that traumatic journey, or have contemplated in some way their own demise and potentially the circumstances of their own demise. This contemplation of death is an inescapable attribute of our humanity. It is inescapable and is probably the definitive quality or attribute of our mortality. It is what makes us human. In my mind, I do not think we can seriously deride the quality or sincerity of the public’s cognition on such an elemental and personal part of their humanity. I fundamentally dispute the notion that the public has been duped by this. I seriously repudiate that assertion in the strongest possible terms.

I wish to address a part of this if it is not already abundantly clear for people who might feel very disappointed by my decision. They may consider that I have acted wrongly. All I can do is offer them my humble acknowledgement of that sense of hurt and disappointment. I love my detractors and I understand fundamentally their deeply held reasons for opposing this bill. These are people who are not insensitive to human suffering, but, rather, they hold strongly to the tenets of their faith. Their interpretation of their faith precludes their support not only for this bill, but any alternative or amended version of it. I think that is fundamentally true. These people should be respected and they should not be derided for what I consider in these times to be a steadfast religious devotion. Our community has bridged the sectarian Protestant–Catholic schism that divided and defined it in some way for over a century. I do not want to see that replaced with the needlessly reductive cultural war between human secularism and Christianity. Some advocates of this bill—I must stress these individuals are in the absolute minority—have been extremely intemperate and hostile to people of faith in their correspondence with me and in their public remarks. They have been hostile to religion itself and to religious perspectives. I think they have done themselves a personal disservice and have demonstrated a religious prejudice that is unacceptable, and also shown an ignorance of the intellectual, cultural and, indeed, historical origin of secular humanism, which is effectively the prevailing modern ethical framework. Indeed, their worldview, even if they cannot admit it, finds at its genesis the universalism of the Christian doctrine, and I say this as somebody who has no particular religious faith. I have struggled to undertake for the better part of 20 years what I think Soren Kierkegaard called the leap of faith. I have attempted to do it on many occasions and I have never been able to make the leap. I may never do it, but I want to stress my deep and abiding respect for people of religious faith. All I can ask those people to do is to understand my reasoning, and even if they remain unconvinced by my argument, they are reassured that I have applied myself to this task with integrity and diligence as a legislator. It is the bare minimum I owe them and the bare minimum I owe the public.

With that said, I have given some thought as well to the need, the desirability and the acceptability of reflecting on personal circumstances. I have elected not to do that, because I do not think I would be able to maintain this stoic facade for very long and get through the rest of this speech. Suffice it to say that in many ways, in many unexpected and traumatic ways, I am no stranger either to the death of loved ones or unfair suffering, sometimes very cruel suffering—some contemplated within the objects of this bill and some that can never be addressed in any form of legislation.

I believe this bill is designed to provide support to a very select group of our fellow citizens. It promises a compassionate and civilised option at the end of life for Western Australians diagnosed with terminal illnesses and severely life-limiting neurodegenerative conditions whom even the best resourced and most expertly administered palliative care cannot help. This is unfortunately a clinical reality, but it is the reality. We cannot pretend that these fellow Western Australians do not exist or that their travails are inconsequential or not of sufficient statistical...
significance to merit the Parliament’s attention. These people are important, and we are in this place to work in their best interests also. These people, their friends and family, and their physicians require a legislative foundation to act with full autonomy in the face of cruel and unremitting misfortune.

I believe much overdue focus has been given recently to the availability and resourcing of palliative care services throughout Western Australia. It is my sincere view that the depth and breadth of this focus and conversation about the resourcing and availability of palliative care services to Western Australians would probably not have occurred in the level of detail and focus that it has in the absence of debate about this bill. Some might find this to be an ironic outcome, but that would only be one’s view if one first assumed that voluntary assisted dying and palliative care were mutually exclusive options or concepts. I do not subscribe to that notion. I do not find an inherent irreconcilable antagonism between the two. I find that the two exist on a continuum of a clinical care, and there is no inevitable need for the two options to compete for the Parliament’s attention or to compete for funds. With that said, I wish to reassert my profound disappointment at the current level of palliative care funding in this state. Last week, I took it upon myself to write to the Minister for Health concerning this very matter. I will table this correspondence later; I will not read the full letter in. What has frustrated me and, I think, many members here, is that there is no clear transparent line of sight on palliative care resourcing and whether it is adequate, although we all assume it to be inadequate, how that funding is intended to be spent and what outcomes are to be achieved.

I have sought from the minister to have palliative care services listed as a discrete service line item incorporated in WA Health’s resource agreement with the Treasury for the 2020–21 budget year and beyond. This would mean identifying palliative care as a separate expense line item in the portfolio service summary statement in the budget papers, with the anticipated total and yearly expenditure over the forecast estimates period provided in some detail. It would also allow palliative care services to have well-designed key efficiency and key effectiveness indicators developed and then reported against. It would also necessitate future governments to explain reasons for significant movements or variations in actual performance from budget targets year in and year out. This is a transparency mechanism; this is an honesty mechanism. I have done this because I think there is a need to fill, and I have asked the minister to give some contemplation to it in the full knowledge that it is still a difficult thing to do. I have done this because I think the community demands it. What I want out of this bill—all our cogitation here is to this purpose—is to provide all Western Australians with the best possible clinical care, irrespective of their personal circumstances and individual preferences. I have always been reluctant to engage in expedient horse trading along the lines of, “Please make another palliative care funding announcement, and you will win my support for the bill”, and it must be stressed that I have not been invited by the government to do so. I do not transact like that, and I intend never to transact like that. I obviously welcomed the government’s announcement last week, as I will continue to welcome any announcement that improves and increases the funding of palliative care services in Western Australia. I am reassured by the minister’s response. I will also table that letter. With the house’s indulgence, I will quote a certain part of it. The minister thanked me for the correspondence. I quote —

I agree that the discrete reporting of palliative care services within the WA Health budget will ensure transparency and accountability for the resources allocated by the State Government.

Further to your representations on this matter, I am pleased to confirm that I have instructed the Department of Health from the 2020–21 State Budget to include within the significant issues section of the WA Health budget statement, a stand-alone table with supporting commentary illustrating the funding, expenditure and services for palliative care.

I am reassured by that response. I believe the minister to be a man of integrity. We might have significant political disagreements, but I think he is an honest broker. I thank him for undertaking those efforts and I think it will have a transformative effect on the transparency and accountability of palliative care as we move forward. That is almost a very technocratic approach to this matter, but I think it is an important one. This must be stressed: the minister’s positive, open-minded response to that letter was the thing that got me over the line to support this Voluntary Assisted Dying Bill in principle. It was critically important. I am but one member. I just hope that as we are getting closer to this, a degree of flexibility continues to be extended but in a way that obviously does not compromise the intent of the bill.

My philosophic anchors and preoccupations concern the preservation of time-tested values in institutions. I think I need to stress this to explain to people of a conservative disposition why I have made the decision to support this bill. However, I endeavour to practice a version of political conservatism in the Western Australian Liberal Party tradition rather than seek to abide by a strict moral conservatism, let alone impose that unyielding position on others. For brevity’s sake, I am a Queen and country conservative. The unity and safety of the nation state matters to me. Defending our cultural heritage and tradition matters to me. The sanctity of the family and the family home matters to me. A range of things matter to me. What also matters to me is freedom of thought, freedom of speech, freedom of association and freedom of worship. Embedded in that freedom of worship is freedom not to worship. It is entirely consistent with my adherence to this politically conservative philosophy and the empirically grounded pragmatism that manifests itself in its practice that I can support a bill like this, a bill that in the absence of careful scrutiny may be misconstrued by others as a disastrously radical, social experiment. I do not believe that to be the case.

When a sensible case can be made for a reforming change that meets the needs of the day and the anticipated needs of tomorrow and does not undermine social cohesion, I will evaluate that reform through a clear but sceptical lens.
The types of reform that I can support are those that are necessary, moderate and incremental. I believe that this VAD bill is necessary, is moderate in scope and represents an incremental and essential improvement in the clinical and legal framework affecting people facing the end of their life.

I, like many other people in the Liberal Party, subscribe to the belief in the innate worth of the individual and their right to be independent. We afford them the dignity to embrace the sheer unpredictability of life and chart their own course in it. That commitment to individual liberty and the freedom of the individual to make the choices that best suit them must last their entire life span. With the exception of people who suffer a cognitive impairment, this commitment to individual liberty is not issued with the caveat that these freedoms exist only insofar as you are not diagnosed with a terminal illness or an advancing, irreversible, neurodegenerative condition. That is fundamentally why I have chosen to support this bill. I do so without any sense of naivety or without any subscription to the view of unbounded freedoms, unrelenting freedoms—the freedom to be selfish. We live in a community; we live in family life. We are tied together by those bonds of family, bonds to church or bonds to the groups and associations of which we are members. We all owe a sense of obligation and responsibility to one another.

I make this point as well, because it was put to me in a letter to me yesterday by Peter Abetz, a gentleman I respect, that we cannot view this legislation through just the prism of individual rights. I actually agree with him. I think he is right. It is also because of that, because of the effects on family, friends and other loved ones around people who are suffering irreversible, irremediable terminal illnesses and debilitating conditions that I support this bill.

Much has been made of the potential for this bill to lead to wrongful deaths. That is an appropriate, guarded wariness to maintain. I accept that as a position that we must guard against in this bill and bills of this sort. However, I also put it to members—I need not further elaborate on the statistics read out by my friend Hon Jim Chown—people are driven to acts of desperation in all manner of grotesque, unjustifiable and unfair manifestations. I think we owe it to those family members and first responders to limit their exposure to ongoing unjustifiable and needless individual human tragedy. I think this bill provides an opportunity by which that trauma, if not completely avoided, can be significantly minimised.

I wish to speak a little, if I may, to the purported risks this bill poses to vulnerable members of our community. We should always maintain our vigilance against exposing or threatening people who are already in a vulnerable position to even increased threat. Again, this is a reasonable, prudent position to adopt as we scrutinise a bill that deals with issues of great magnitude. However, I think we need to deal firmly with the facts. We need not deal with groups, whether they be people with disabilities or people who are elderly, in a manner that is stereotypical and impugns them with a kind of irremediable propensity toward victimhood. I do not think that is fair. I do not think that is dignified and I do not think it is warranted by the facts. Like my friend, Hon Nick Goiran, I was also a member of the Select Committee into Elder Abuse. That was a very difficult committee to be a part of. The committee, I thought, discharged its responsibility to the full limits of its capacity with great integrity and professionalism and we were supported by excellent staff. I thought the recommendations and findings that that committee made were warranted.

If I have harboured any disappointment, it is that the government has not seen the opportunity to fully discharge a range of those recommendations, particularly as they relate to limiting opportunities for greedy, avaricious people to take financial advantage of the elderly. They do this through the banking and financial sector, shortcomings in Landgate’s management of land title and the abuse of instruments of protection, such as enduring powers of attorney and enduring powers of guardianship—instruments that are designed to protect individuals but are perverted to become powers over individuals and for the misappropriation of their hard-won resources. The committee found that these abuses are not confined to a single modality; there are often comorbidities in this form of abuse.

An important finding of the committee was also a recommendation. It was not the only recommendation, but it is one that rings true in my mind and has informed my position on this bill. I refer to recommendation 1 of that inquiry, which states —

The Government’s response to elder abuse in Western Australia be informed by a human rights–based approach that focuses on the inherent dignity and autonomy of older people.

For me, the inherent dignity and autonomy of older people is essential, and it has been an essential consideration in my evaluation of this bill. I have not met an elderly person who has felt victimised by the prospect of this Voluntary Assisted Dying Bill. They have been victimised in other ways, but they have not felt victimised by this bill. In fact, some of the strongest, most enduring advocates of this bill are not the kinds of people to jump on email campaigns but are octogenarians who have called my office. I like the chutzpah of this example from last week. The call was filtered by staff, obviously. It went along these lines: “There’s a lady on the phone who wants to speak to you. She knows that Parliament’s not sitting so don’t give her any of that crap. She wants to speak to you directly.” I went, “Okay; put her on.” She was a lovely lady. She told me, “I’m 82. I’m healthy. I’ve been following the debate. I’m nobody’s fool; I know exactly what’s in this legislation. You’ve got over 20 years of datasets from international jurisdictions to rely upon. There’s nothing wrong with this. Get on and do it.” She was not the only one who did that. We all have these sorts of pivotal moments through our individual journeys. They are not necessarily the defining moments, but they are important.

I was once the shadow Minister for Seniors and Ageing. I hate the peak agency sort of view of the world when we are dealing with individuals, but when these sorts of issues were raised in fora, not once did I have a member of
It should be the right of members and the right of this house to debate those amendments. I am sure we will all do of this issue has been undertaken by this Parliament we are at a point at which we can have a mature debate on. There are a lot of reasons why I support the bill. At the conclusion of the almost two years in which consideration that in due course.

It really has been a journey. I find that I am in support of the legislation before the house. I have no doubt that in due course.

When Hon Robin Chapple introduced a private member’s bill in 2009 in the Parliament at that time, I was working with the National Party, and it was a bill that we talked about and debated a lot. Mr Acting President, I must indicate that I am not the lead speaker on this bill for the Nationals WA; Hon Colin Holt will be the lead speaker. I apologise; I just saw the timer.

The ACTING PRESIDENT: That is fine.

Hon Jacqui Boydell, (Mining and Pastoral — Deputy Leader of the Nationals WA) [4.07 pm]: As has been said by many members of the house who have spoken already on this exceptionally important piece of legislation before the Legislative Council, this will be one of the most significant and profound debates in which members will be involved. This debate not only is being had in the house now, but also has been going on in our communities and behind the Chair with fellow members of Parliament and the government for nearly two years. I welcome the chance to finally have this debate in the Legislative Council and for members of this house to consider the Voluntary Assisted Dying Bill 2019.

When Hon Robin Chapple introduced a private member’s bill in 2009 in the Parliament at that time, I was working with the National Party, and it was a bill that we talked about and debated a lot. Mr Acting President, I must indicate that I am not the lead speaker on this bill for the Nationals WA; Hon Colin Holt will be the lead speaker. I apologise; I just saw the timer.

The ACTING PRESIDENT: That is fine.

Hon Jacqui Boydell: It was a conversation about voluntary assisted dying, or euthanasia as it was described at that time, that society and members of Parliament were not in the right mindset or ready to have to the degree to which we are having this conversation now. As other members have indicated, I think what has caused the difference is that this is a government bill that has been brought before the house and there has been significant investment by the government in its research of the bill and consultation on it with the wider community, advocacy groups and groups that are against this legislation. I really do believe that many members of the community have had their views heard by members of both houses of the Western Australian Parliament, as it should be. I thank the government for undertaking that process. At the start of this process, Amber-Jade Sanderson, the member for Morley, came to me, put the proposal for a joint select committee to us and asked whether the National Party would consider being involved in that. We absolutely wanted to be involved in the committee because regional people have a voice and they want it to be heard, and the way palliative care and voluntary assisted dying would be delivered to regional people is unique. We firmly wanted to be part of that process and were open about how we were going to engage with people and what we were going to learn along the way because I do not think any of us knew. At that time, I certainly wondered where I would land my position on any legislation put to the house. It really has been a journey. I find that I am in support of the legislation before the house. I have no doubt that when we get to the Committee of the Whole House stage there will be debate and discussion on the amendments already put and any other amendments put by other members. I have absolutely no issue with members doing that. It should be the right of members and the right of this house to debate those amendments. I am sure we will all do that in due course.

There are a lot of reasons why I support the bill. At the conclusion of the almost two years in which consideration of this issue has been undertaken by this Parliament we are at a point at which we can have a mature debate on
this issue, and, so far, to the credit of the Western Australian Parliament, we have done that. I cannot escape the
fact that society in its conversations is not ready to continue to accept that people at the end of their lives might
suffer or that when we have an opportunity to assist, when the right safeguards are in place, there are medical
options and technology to assist and ongoing research, we have an obligation to allow that person to make that
decision. The crux of this issue, for all members, but for me in particular, is that the voluntary nature of the decision
that each person makes in their own individual circumstances must always be protected. People choosing between
voluntary assisted dying and palliative care is not an option. I think they go hand in hand. It is also up to our
medical profession, support services and families to ensure that we, should we get to that point, have before us the
very best alternatives and choices to manage the end phase of our lives. Part of that process is palliative care, part
is support services and part might be the decision to choose voluntary assisted dying. But it is not one or the other;
it is people being able to feel confident and not frightened about what may happen to them or about imposing the
burden of their illness on their family. I know a lot of people, particularly people with children, would not want to
impose that on their children. I would want to be able to find a way, with them by my side, for my children to be
able to support me through end of life without them being scarred by the terrible journey that I might be on. For
me, individually, that is how I would want to approach that.

I have also spent a lot of time considering what “coercion” means because I think it is important to this debate.
Coercion takes away the voluntary nature of assisted dying. Coercion is not just about words spoken to a person
or health professionals. There has been a lot of focus and limelight on the fact that health professionals may coerce
a person by using VAD as a treatment option and an alternative to palliative care. That position has been put to
me on a few occasions. I find it exceptionally offensive for the health profession to suggest that we would give it
the option to utilise voluntary assisted dying as a treatment option. I would say that this is not about doctors, and
this may be where the health profession’s fear about this legislation comes from. This legislation is about the
patient, their family and the choice they make with the knowledge and support that the health profession and the
medical industry give them.

Debate interrupted, pursuant to standing orders.

[page 7734]

Resumed from an earlier stage of the sitting.

HON JACQUI BOYDELL (Mining and Pastoral — Deputy Leader of the Nationals WA) [5.05 pm]: Before
the debate on the bill was interrupted for question time, I was talking about the fact that coercion is an exceptionally
important area of this piece of legislation. We will consider that in due course, particularly in Committee of the
Whole. Coercion is an area in the legislation and certainly the subsequent regulations that is fundamental to this
bill. Voluntary assisted dying should continue to be voluntary. With the removal of the word “voluntary”, we will
end up with a situation in which a person’s choice may be affected by others around them. That is certainly not
the intent of this bill.

I have had many conversations with people in my electorate through forms of correspondence. I have talked to
people who I have seen in different parts of my electorate. I have also talked with my family, and, indeed, my
children, about this issue. All three of my children are supportive of voluntary assisted dying. However, they also
raised the point with me that they are concerned about future generations and the erosion of the rights and
protections of vulnerable people in particular, and that at some point we might become desensitised to death or
assisted dying. I thought it was a really interesting concept that young people would be worried about wanting to
protect the very foundations of our society—that is, to protect the vulnerable and other people living in our society
and ensure that they are not taken advantage of. My answer to them, and certainly to people who have put the
argument to me that we need to protect our future generations, is that this is a passing of the responsibility of
managing our society to the younger generation, as the next generation of leaders in our community and builders
of our society. We should not take away from future generations the decision or the opportunity to manage this
issue. This issue will not go away. I am very, very pleased that young people are considering how to ensure that
vulnerable people and the aged et cetera will not be negatively affected in the future should this bill pass the
Western Australian Parliament. I would like future generations to want to continue to protect those in our society
who are vulnerable. That is a community that I want to be a part of. They are the young people who we seek to
mentor and guide along the way and give them the opportunity to engage in the decision-making process that is
before us. That is a responsibility that I feel keenly. Three young people—my children—want to take that
mantle and are proud to play their part in it. They absolutely want to play their part, and feel they have a right
to do that.

At the outset, when the legislation came to the house, I looked at the government’s comments on the legislation
and how we would consider voluntary assisted dying as opposed to palliative care. It became really obvious to me
during the conversations on this issue that this is not a choice about whether a person has access to palliative care
or voluntary assisted dying; that is not what we are debating. I think members of this house and the wider
community support the opportunity to take advantage of voluntary assisted dying along with the other decisions
that they make about their health care and their end-of-life choices. Those decisions of patients and their families

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are currently being made. Patients make decisions on an ongoing and daily basis about the management of their health, without any regulatory guideline or transparency around how palliative care specialists, general practitioners and families are managing end-of-life processes for people now. That scary situation is being replicated in our hospitals on a daily basis. We should not be afraid to put some regulations in place to support the decision-making process of a patient, and in response to the decision of the patient, a support network for our health professionals so that they can work with the patient and their family in response to the voluntary decisions that the patient makes. That is the key, I think, to whether people choose to access voluntary assisted dying. It is part of a range of options that we should make available to our families and community members of Western Australia.

I want to spend some time focusing on some of the issues that I think will be before the government, if this legislation passes the house, during the implementation phase, or phase 2, of this legislation. I think some of the issues are complex, particularly for regional people. How will the government seek to gain access for regional people into the voluntary assisted dying scheme? Many people I speak to in regional areas are exceptionally supportive of this legislation, but they do not understand how they will be able to access it. One of the eligibility criteria is that 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 the end of life and understand the patient’s palliative care options. I think that fundamentally underpins the issue for how to deliver that to people in regional areas. That can absolutely be done to a gold standard in the metropolitan area, but how do we do that when we are already facing a lack of GPs, palliative care services and specialists visiting our regions? That is a fact now. We already have, to a degree, a two-tiered health system in our state, and I think regional people accept that they will not have the best oncology services at Carnarvon Regional Hospital. They accept that, but what they accept at the moment is a health scheme through the WA Country Health Service and things such as the patient assisted travel scheme. That is a support network that allows people to access specialist services at our top hospitals in Perth. This is an issue that will need to be considered during the implementation phase. If we can have some transparent regulations in place that supports that, no-one would suggest anyone is being denied access to voluntary assisted dying. I will pay close attention to that, and have been concerned about it from the outset. I have mentioned it many times in the media.

I will read off my phone, if that is allowed, the answer the Minister for Health gave today when asked whether he has been able to resolve the issue of using telehealth services, because that is another form of carriage delivery for voluntary assisted dying. His answer so far has been that he has not been able to yet but that he is continuing to have discussions with the Attorney General and the commonwealth Attorney-General. He has made comments in the Legislative Assembly that the department will do whatever is necessary to ensure regional patients have the same opportunity to access the voluntary assisted dying regime as patients in the metropolitan area. That is an undertaking that the minister gave to the Legislative Assembly, and he said it publicly. I want to read that in today because I genuinely think the minister is committed to doing that, and we will all play a role in assisting that to occur. He also said that if we cannot make use of our telehealth facilities, because of some ambiguity around those laws, we will simply have to make use of mobile crews or teams to go out into our regional areas to service country people. That might be worthy of consideration during the implementation phase. Certainly, it is worthy of discussion, along with other things such as whether we will give regional people access to the patient assisted travel scheme to access a specialist palliative care doctor in the city, or maybe a voluntary assisted dying expert in the metropolitan area if there is not one in a patient’s region. Some of our regions have low population bases and they do not have a general practitioner. It is a challenge to get one GP let alone two. That is a very real issue that we all face, and I think the minister is trying to work out a way that country people will be able to access those services, should the legislation pass. There is a long way to go to implement that, but those things are worthy of consideration. Just because we do not have those things in place now is no reason to not support the bill, in my view. This is an ongoing job for the government and it has exhausted an enormous amount of resources to get the bill this far, and that has been great, because it has given the community a level of understanding about what voluntary assisted dying is, and what it will mean and look like should it pass the house. The responsibility then will be on the government to ensure that it continues to work on this issue. The implementation phase is even more important than the development phase of this legislation moving through the house, the joint select committee and the ministerial expert panel before being presented. Should it pass the second reading, the next step is to get a lot of the detail right. One of the fundamentals in getting that implementation phase right is trying to understand continuity of care and facilitating someone’s individual journey through palliative care to maybe a choice to voluntary assisted dying. However the minister sets up the implementation phase, it will be the responsibility of those people and the government to look at the accountability, recording systems and processes that should be in place to address the concerns that are raised during this debate.

Voluntary assisted dying, access to palliative care and managing end-of-life choices will always be individual choices, because we all have different ideas about how that should happen. Those things are always subjective to each person and will always differ. There are differing opinions about whether or not the principle of voluntary assisted dying should be introduced, and many people will choose to not access the scheme. That will be their right, should this legislation pass the house. It will also be another person’s right to choose to access the voluntary assisted dying scheme.

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We will examine all the other safeguards during Committee of the Whole House. Of the people I have spoken to and from the correspondence I have received, the majority are comfortable that this is the right way to go. Nobody believes that there should not be any safeguards in place. Everybody I have spoken to who supports the legislation still want us to ensure the right safeguards are in place as we debate the bill during Committee of the Whole House.

Medical research and technology has allowed us to move ahead in leaps and bounds around how to alleviate physical suffering, particularly in recent times. That will still be the case because there will always be an answer, through research, to alleviate physical pain to a degree. Up until this point we have not been able to alleviate psychological suffering that is brought about by end of life. Voluntary assisted dying seeks to do that because it grants comfort, confidence and a sense of peace, in my view, to the patient and their family. To a degree, that alleviates the psychological suffering of patients and family members. In the past, we have always been able to alleviate physical suffering but we have never been able to give the degree of comfort to know that we can pass without fear. If we as members of this house have the choice and capacity to give that to people, we should do that to alleviate their fear. From my research on this bill, many people might access the voluntary assisted dying scheme but actually many of them may never use it. The alleviation of psychological suffering through the confidence of having a choice will allow people to pass without fear. I think that we would all wish that not only for ourselves but also for members of our community and certainly people in our families.

One of the challenges during the implementation phase will be providing clarity to the community about what will be provided. Will there be clear relationships between doctors and patients? What are the protocols? What will be the relationships between GPs and specialists? Those things need to be very clear. If we take that leap of faith to the implementation phase and make our way through it, those positions will become more clear and people will feel more comfortable with the process. This process is not over at the end of this debate; it is actually only the beginning of creating some clarity around how we do this. As with all things to do with time, time eases angst and allows people to gain confidence in the knowledge of working with different systems. We all do that every day. We learn things and engage every day. Time is great if it is on one’s side. During the implementation phase, we will have time to bring people on that journey, if it is an 18-month period.

I would like to hear the government respond to how it will go about the implementation phase. Will there be a consultation period? Will people be able to provide submissions during the implementation phase et cetera? Being able to understand how that will be conducted will be really beneficial for members of the public. I have brought myself back to this position many times as I have become worried about voluntary assisted dying: Is it the right thing to do? Should we move forward with it? I have had periods of ups and downs through my journey on this legislation. I always bring myself back to the fact that a request for voluntary assisted dying is not a reason to refuse other services available to a person. It is not a reason to refuse palliative care or indeed a choice that the person is made to say, “I don’t want palliative care anymore; I want voluntary assisted dying.” I cannot see that it would work that way. In all things we do with the management of our health, it is about utilising different choices at different phases of the health journey. As it does today when someone is in the final stages of life, palliative care work does not stop because someone has made a decision. If someone makes a decision with their family today that they are going to refuse fluids at the end of their life, that is their choice. It does not mean that palliative care services stop today because they have ultimately made the decision not to receive any more treatment. Palliative care services will still support patients as they make their way through their end-of-life journey. If a patient has refused treatment, including liquids, and has ultimately made a decision they do not want to be here anymore, palliative care services still go on. I imagine that will be the same if they were to choose voluntary assisted dying, should this legislation pass the house. It is a request for assisted dying; it is not a request to stop treatment in all other areas.

Some people have put the argument to me that the medical profession and palliative care services are about supporting life and the right to live and protect life. I completely agree that our medical profession encourages living. It is about: How do we support living? How do we continue to treat people so they can continue to be on this earth? I cannot get away from the fact that palliative care is about supporting life. It is about making the best of the end of life. Voluntary assisted dying will not change palliative care and it will not stop supporting life—it will. The choice to stop palliative care or other options at the end of life rest with each of us. It actually does not mean those services will stop.

It is exceptionally important for the medical profession to understand, as we transition into voluntary assisted dying should it pass the house, that honouring the rights of the patient and their right to continuity of care is paramount. The decision rests with the patient, not the doctor. That is why I have struggled with many of the points of view that have been put to me by the Australian Medical Association of WA or doctors. It has been put to me that I will be giving them the opportunity to kill a patient. I say to those doctors who have said that to me that they misunderstand entirely the intent of voluntary assisted dying. This is not their decision. During the transition of this process, should it pass, the medical profession need to honour the rights and choices of patients and continue to treat them, whether it is palliative care, alternative therapies or oncology. There is a suite of treatments that patients can choose to accept or not. Voluntary assisted dying will purely be one of those. It is not about doctors saying, “You are giving me the right.” It is not—we are giving the right to the patient. The doctor is duty-bound to deliver on what the patient wants.

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I reiterate that a request for voluntary assisted dying is not about either the availability of palliative care or the quality of palliative care; it is about adding to the suite of choices that I, as a patient, want at the end of my life. That is the fundamental key to this legislation. In fact, many people in other countries who have sought voluntary assisted dying have used palliative care services up to that point and have continued to use them past that point. A patient who makes a request for voluntary assisted dying today may not enact that voluntary assisted dying choice for three or four months or further down the track. During that period, all the other services that that patient has been provided to manage their care will not cease. In fact, as other members have said, the palliative care service delivery model has increased in places where voluntary assisted dying has been implemented. There has been a lot of debate in this house about palliative care, or the lack thereof, for the people of Western Australia. I think the debate on voluntary assisted dying and the debates in the house about palliative care have put this issue in the limelight. It has needed to be addressed by consecutive governments over a long time. We have not done it, pure and simple. However, due to the mounting conversation, the government has announced that it will support the extension of palliative care services for the people of Western Australia and that that funding will be ongoing, which is great thing. We should be happy about that. This debate has allowed that to occur.

It is important to consider how we will get the message about voluntary assisted dying to the public during the implementation phase. Those healthcare messages will be really important, and the requirements to report to Parliament also will be exceptionally important. The transparency of the oversight board will be exceptionally important to the ongoing management of voluntary assisted dying in the state of Western Australia. That goes back to my point about the younger generation wanting to ensure that protections are in place and that there is no erosion of the choice—the voluntary part of assisted dying. The reporting requirements, public messaging and transparency in the oversight of the board will be exceptionally important to the ongoing management of voluntary assisted dying. Can it be better? Is it not operating in the way it was intended to? All those decisions will need to be made along the way as we manage voluntary assisted dying as a form of healthcare support service, because that is really what it is.

When I went to many of the community consultations, particularly those in the Mining and Pastoral Region, there was an expectation of the community that voluntary assisted dying would be extended to people with dementia and Alzheimer’s. That concept was raised everywhere I went. People also expected that if they were simply too old to live, they might be able to access the scheme. It was also put to me that people with the wrong prognosis might be on the wrong side of this legislation. Consideration of all those things is justified in the conversation in the lead-up to the legislation, but I cannot see myself reaching the point of wanting to push the boundaries of the legislation and extending access to voluntary assisted dying to the families of people with dementia and Alzheimer’s, because that is to whom we would be extending it. It would not be extended to the patients because such patients would not be able to make that decision. To say that a person is too old to live comes back to the vulnerability factor of people, and that is the concern around people with disabilities. I would not accept a pushing of the boundaries of the legislation in that respect. In due course, I do not believe that future generations will accept the erosion of the protection of elderly people and people with disabilities and mental health issues. It is really difficult for family members to watch their loved ones suffer from dementia and Alzheimer’s, but it comes back to the fact that this must be a fundamental, voluntary choice of the patient. We have to stick to that if we are to ensure that the coercion aspect and the protections and rights of the patient are adhered to. I cannot see myself supporting a pushing of the boundaries to encompass those types of illnesses in this legislation, even in the future.

In finalising my comments today, I say that the implementation team has a lot to consider, such as public messaging about assisted dying and how we maintain international links with other countries as they move forward with their research and development in the area of voluntary assisted dying. Similar to any other healthcare service, it will be incumbent on the medical profession to manage voluntary assisted dying. It will be incumbent on the government to manage the scheme in the interests of the people of Western Australia, and it will be incumbent on the medical profession to manage the voluntary assisted dying alternative for patients and their families. Perhaps the government will consider ways to alleviate the concern about access to the scheme, particularly in regional areas. That might be in the form of nurse practitioner navigator roles or broadening the medical community’s involvement in the assessment process. They are issues for the implementation phase. I raised them because the legislation cannot address some of those issues; that will be done in the implementation phase. It is difficult for members of Parliament when legislation does not address the regulations, how they will be enacted and how they will affect the people on the ground. Most of the time we do not know that when voting for the legislation because we do not have oversight of the regulations at that time. This is one of those pieces of legislation. The government is asking members of this house, as it has asked the community of Western Australia, to take a leap of faith and support this legislation, but we must continue to scrutinise the government’s intent and the implementation phase during Committee of the Whole, which is what the people of Western Australia would expect us to do. I believe we will do that, as we should. Beyond the debate and the third reading in this house, it is incumbent on all members of the Legislative Council and the Legislative Assembly to be engaged in some way in the implementation phase. We should not just drop all the issues that have been raised with us by members of the community once the bill passes. This is a job for all of us past the third reading stage in this house. I know that I intend to be involved in that.

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and feed into the government issues that have been raised with me. It will be incumbent on the government to have an answer to that. That is how I have reached the position of suggesting that I will support the bill, and I will definitely have some involvement in the implementation phase, if I can. I think that the people of Western Australia expect us to do that. I have taken a leap of faith, with the good intent of the government and a very genuine engagement by the Minister for Health on this issue. I have met with him many times, as well as members of his office and, indeed, the Department of Health, and, I have to say, they have taken on board any issues that I have raised with them. They know they have to get to the point of addressing it. That is why I read in the minister’s responses to the questions on whether we can use telehealth and a mobile team that the minister and his department are working on those issues; I have no doubt about that.

I commend the bill, I support the bill, and I thank other members of this house for their contributions as we debate this issue.

HON MICHAEL MISCHIN (North Metropolitan — Deputy Leader of the Opposition) [5.40 pm]: I rise to make a few observations on this very important legislation that has divided people, and has exercised the minds and consciences of not only members of the community, but also, I suspect, any member of this place who takes their responsibilities seriously. I have certainly given anxious consideration to this matter over a great period—ever since the idea was floated prior to the last election, and, indeed, going back to 2010, when Hon Robin Chapple’s Voluntary Euthanasia Bill was introduced into this place and argued over a rather greater period than this bill has been, with longer and very astute and deep contributions from members. I have listened with care to what has been said on behalf of the proponents and supporters of this bill, and I have listened with care to those who have said something critical about it. Perhaps I can indicate that I was particularly interested yesterday in listening to Hon Nick Goiran, because this is a matter that exercises his conscience and his moral touchstone very deeply. It is a matter that concerns him very deeply, as do quite a number of issues with a moral perspective to them. Although some might dismiss it as being a particular view that is irrelevant to current society, I think it is wrong to do that, because there are certain moral touchstones that we all ascribe to, whether or not we have a faith-based background and commitment. We were all brought up in a society that has particular views about what is right and what is wrong.

I looked back on my second reading contribution in 2010 and was surprised to find that many of the things that have been raised in the course of argument in the last couple of years and in this place were also canvassed back then. I found that what I thought about the subject and said then, which I probably articulated better than I am now, has not really changed a great deal, and some of those things were reflected by Hon Nick Goiran’s comments. I have to say that I do not disagree with anything he said about his understanding of the bill. I will come to my position on the bill in just a moment. Rather than go through the issues that he raised, I will say that every one of them was sound and not one of them has been contradicted so far by any supporter of the bill.

There has been bracket creep in every jurisdiction that has implemented this sort of legislation. It is almost inevitable. People always push the boundaries of rules and some will blatantly ignore them for their own personal advantage or inclination. Whenever one draws a line that is not based on a sound principle, there will always be a case on the other side of that line that someone will try to bring within the bounds of the operation of the law—always.

Getting back to the bill and where I stand on it, I will start off with some basic principles. Do I respect the principle of personal autonomy? Yes, I do, within reason. Do I believe that personal autonomy is an absolute right? No, I do not. Our community is not, has not and can never be based on a moral standard governed only by personal autonomy. Any human community involves a compromise. Society is based on compromise, and the values that are established by that compromise enhance rather than detract from the common good. We cannot base a society simply on what might suit an individual, no matter how much it is for that individual’s benefit. Those community standards and touchstones vary from culture to culture, but there are certain commonalities that bind autonomous humans into a society. In our society, it includes things like our belief in democracy; our respect for institutions; our adherence to respecting the sensitivities of others and their views; even common courtesies, like standing in queues and saying “thank you” and “please”; respecting our elders; and not being rude to others. It includes our spirit of volunteering and of wanting to, as part of our human condition, give of ourselves for the benefit of our fellow citizens—our fellow man and woman. Pertinently to this debate, it also includes respect for elders and respect for the value of human life. It also includes the old-fashioned notions that I think one speaker touched on, suggesting they were perhaps out of step with the twenty-first century, but things like the Hippocratic oath have essential guiding principles. Our doctors and medical practitioners are vested with the power and influence of the knowledge and skills that they possess. The influence that that knowledge and skill allows them to wield ought to apply to caring and curing and treating with a view to relieving suffering, but short of killing their patients. There is a subtle but important distinction between palliating the suffering of someone and actively ending their life. It may be that, as a consequence of assisting someone to cope with a condition, a doctor knows that they are also accelerating the time of their death, but that is a very different thing from killing them as an end and as an objective. I will expand on that in a little while, but that is important, and we sometimes lose track of that. I think it is wrong, for example, to say that the Australian Medical Association and medical practitioners are exaggerating the importance of that. We need to be very careful that we are not making them the instruments of our suicide or the killing of patients. I will address that further in the context of this bill.

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Suicide itself is not illegal. Once upon a time, it was. It is not something that a person takes lightly. They do it because they are suffering. They are suffering so badly that they see suicide, with all its attendant risks of failure and other permanent and crippling harm and harm to their loved ones, as the only means of relieving that suffering. Do we respect that decision on the basis of personal autonomy? No, we do not, because that is one of the values that our society thinks is important—but we try instead to expend an awful lot of resources, time and effort to alleviate the suffering as best we can, knowing that often we cannot, in order to prevent them from taking their own lives, and notwithstanding that, by doing that, we are making the rest of their lives a misery. We publish helpline numbers under stories of suicides or attempted suicides or suspected suicides or for people with mental health issues. Just as an aside, until fairly recently The West Australian was doing that for stories of euthanasia. It has changed that now into something a little more bland because it does not want to use the word “suicide” in that context. Indeed, the government does not want to use “suicide” in that context.

In any event, our respect for the ill and elderly is another value of our society. Tribal, primitive societies did not have the resources to feed and maintain the old and sick to the extent that we can. Not only do we spend an extraordinary amount of money and resources on premature babies to keep them alive, but also our respect for human life, being a fundamental of our society and its values, results in us spending an enormous amount of money on aged care, nursing care and the like. I will not get into the silly pet argument. I think the falsity of that argument and its flaws are self-evident. I refer to the one in which so-and-so has suffered, and we would not let our dog, our budgie or our cat suffer in that way, and we put them down to relieve their suffering; therefore, we should have that available as a matter of course to human beings. There are an awful lot of distinctions. I will not go into them because I think they are self-evident. I will explain them to people if they need to know. It is a very different thing from euthanasing humans. We cannot help those animals. They cannot reason. They cannot think their way through it. We cannot ask them if they would like us to do that.

We are told that this issue of voluntary assisted dying comes down to a matter of personal choice. I get back to the principles. Am I sympathetic to the relief of unnecessary suffering? Undoubtedly, yes—absolutely. Am I anxious to promote and make available reasonable avenues to people by which their suffering can be relieved? Yes, absolutely. Do I support easing the death of those with terminal illnesses or injuries if necessary by hastening their passing at their informed request? Yes, I do. Do I believe that there may come a time when people are so advanced in years that they become tired of life, that every moment of their waking existence reminds them of the faculties they have lost or are losing, and they yearn for death to relieve their suffering? Yes, I do. Do I think they ought to be given the opportunity to decide their time and manner of death? As a matter of principle, yes, I do. Would I like to take advantage of such an opportunity in due course? Frankly, probably. Will I support this bill because of self-interest that it may deliver to me what I might one day want? No. Will I support this bill out of political expediency because I am told by its advocates that the public wants it? No. Will I support this bill on the strength of newspaper opinion polls, emails, phone calls and government propaganda and fora? No. Will I support this bill? No, I cannot. I cannot for a number of reasons. Although I support the idea, at least in the abstract, of alleviating suffering as much as possible, I cannot do so for several reasons.

One reason is that I have no confidence in the government that has promoted it. This was supposed to be an election commitment—so be it. We have heard appeals to put politics aside and to have an honest and respectful debate on this very important social, bioethical and sensitive issue, but we have not had that. I am not criticising anyone in this chamber, but it is the debate that has gone on outside this chamber and the public relations campaign waged in respect of it that has been wrong.

The Joint Select Committee on End of Life Choices was established to consider this issue. I will not go over Hon Nick Goiran’s comments other than to say that the terms of reference were possibly deliberately limited to avoid looking into the cons rather than the pros. We do not know what went on; the minutes of those proceedings were not tabled or made available on this very important social issue. We do not know to what extent that committee considered those matters. Hon Nick Goiran presented a dissenting report of considerable length. That is the only evidence we have of the arguments against. The Ministerial Expert Panel on Voluntary Assisted Dying was set up to craft a bill. Understandably, it was not interested in revisiting the question of whether the scheme introduced a voluntary euthanasia bill. This not a voluntary euthanasia bill—quite the contrary. Why? It is because the expert panel thought that that title has negative connotations, so it changed the terminology. The government tells us that terminating one’s life in advance of a natural course of death is not suicide. I am instinctively suspicious of anyone who needs to change commonly understood language in order to achieve an end and make it palatable. We could call it “Assisting You to Join the Angels in the Holy Choir Invisible Bill” perhaps. Would that make it better? Would people cope with that better than calling it what it is? Oddly enough, the second reading speech and many other contributions draw on the many generations of debate about euthanasia in support of it, yet that would seem to be totally irrelevant because that was about euthanasia. Societies have been set up to promote euthanasia,
but this is not euthanasia; it is something else. This is not a government that wants, as was said, an honest, up-front, facing-these-difficult-issues-in-a-mature-way type of debate—not outside this chamber. I am suspicious of its commitment to ensure that this is a working piece of legislation rather than a step along fulfilling a popular electoral commitment.

In consideration in detail in the other place, numerous amendments were put up—something like 20 amendments. I think only a handful were put up by the Liberal opposition, yet there was condemnation about how the Liberals were going to block the bill and how we are the ones standing in the way of this great reform. That was wholly dishonest and wholly political. A number of amendments will be put forward by Hon Martin Pritchard. I am yet to consider the merits of those, but they seem to be soundly based. He is a gentleman who takes his responsibilities seriously. I am sure that those in the other place who put up amendments to the bill took their responsibility seriously, but is this government, which wants a respectful improvement to debate, and will hopefully introduce a scheme as important as this into the Western Australian community, interested in that? No; it has dismissed out of hand any consideration of amendments. If there was an appetite in this government, I felt, to accommodate genuine concerns, that if we had had a green bill that we could have considered in advance, and if we had had some cross-party input, we might disagree on the scheme. But knowing that the government is intending to put it through and debate issues behind the Chair in order to come to a formula that people are comfortable with is the best available, I might have had a different attitude towards this bill. But I suspect it. I see certain flaws in it and things that can be improved, and those will be developed over time. But I cannot in all conscience support a bill that is being presented on a “take it or leave it” basis by a government that is targeting one party in particular for political reasons, and is not prepared to listen or even entertain amendments put up by its own people who have concerns. I mention the member for Armadale because he had a particular personal interest in some of the risks posed by this bill. How far did that get? Nowhere. That is the sort of respectful debate that we are having. There is a problem, and we have a Premier who has indicated on numerous occasions that this house’s consideration of the issues is blocking this bill.

Sitting suspended from 6.00 to 7.00 pm

Hon MICHAEL MISCHIN: I left off by making the point that despite appeals to not politicise this important matter, regrettably, that is precisely what this government has done. Fora have been held by members on the government side to promote the Voluntary Assisted Dying Bill. It is fine that they have been explaining the bill to people, but at the same time they have been saying that the hold-up will be on the Liberal side and that people should contact the Liberal powerbroker in their area and let them know what is happening and that they feel strongly about it. If this were not a take-it-or-leave-it proposition, I might be very inclined to support the bill at its second reading and to deal with it, but it has been made quite plain that that is not going to be the case. I am sorry that that is not the case. I will have to leave it, because I have concerns about this legislation. There are things that I think ought to be done to improve the level of safety for our citizens at one of the times in their lives when they will be most vulnerable to fear, to concern about their families and their finances and with being able to deal with a protracted and potentially fatal illness, and to the stresses of the future and their worry about what is going to happen to them. It is also a time when they will be most available to being influenced by a medical practitioner. I take Hon Jacqui Boydell’s hopes as to the way in which the medical profession will behave and I hope that is right, but what we have seen through bitter experience, as outlined by Hon Nick Goiran in his dissenting report—a minority report perhaps—is that this has not been the case in other jurisdictions that have actually had experience with this sort of legislation.

The safeguards are essential, not only because of human nature, but also because we can never safeguard against everything. Before we start changing the status quo, we have to be satisfied that what we are putting in its place will not make the situation worse, no matter how many safeguards are included as a matter of theory. I stress here that I am not concerned about the relief of suffering for those who have made up their mind and are facing inevitable anguish, pain and suffering. I want their suffering to be relieved. If that means by hastening their demise, that is fine; I understand that. My concern is to ensure that, if we are going to institute a regime like that, to give succour and comfort to the people who really need it and want it, as much as possible there are not going to be unintended and undesirable consequences, and that we will not have some people at their most vulnerable being taken down a path whereby their lives are ended by medical practitioners, perhaps with or without—it does not matter—the complicity of family and those who stand to benefit. That is beside the point, but they would be led down a path whereby their lives would be ended early, when, if they had the proper advice and the ability to think it through, they would take a different choice.

I posit this example, using the scheme in the bill. You, Mr Deputy President, are diagnosed with some terminal illness. You go to your medical practitioner—let us say it is a Dr Nitschke. He reveals to you that you may have limited time to live. You have this particular condition. Of course, you are going to be struck with despair, worry and fear as to the consequences. You look to your doctor for advice and say, “What am I looking forward to? What is going to happen to me?” Your doctor says, “It could be six months, it could be two years, but you’re going to die.” You ask, “How is that going to happen? What can I do?” The doctor will say, “Well, you can get treatment that might delay your death and might cure it; who knows? It is possible that medical advances might make it even better! They may actually find a cure, but chances are that no, it’s not going to happen.” The worst-case scenario
can be spelt out to you. Of course, you are upset about it, you are in despair and you wonder about the cost of the treatment and how your family and loved ones are going to react to all of this and ask, “What do I do, doctor?” The options are laid out, but in amongst them, you could always consider, Mr Depute President, voluntary assisted dying. It will cost a whole lot less and it will be at a time and place of your choosing to have it in the comfort of your own home. You say, “Do I fit into the criteria?” Of course the doctor says, “Well, actually, I have taken the training, I understand how the legislation works and, yes, you do. I might have to stretch it a bit here and there, but, yes, I think you fit within the criteria and I can arrange that.” What about a second opinion? “Yes, we could fix that up too, no worries. I know a doctor who knows a doctor who has done this before.” You ask whether you need to see a palliative care expert — someone who knows what sort of palliative care you would need. “No, you don’t have to do that. They can be expensive and they’ll just tell you that you can be treated. But there are other ways of going about this. Anyway, you think about it, Mr Depute President.” And you do. At your most vulnerable, you go down a path. You can change your mind at any time, it is totally voluntary, of course, but your mindset is such, your feelings are such, that you have this avenue that you can take that will relieve you of a lot of time, pain, anguish, worry and even stress on your family and the saving of resources for them after you are gone. That is the way it can work. That is the way it has worked overseas.

There may be ways of getting around all this and increasing the safeguards. I would have thought that rather than a bias towards some kind of psychiatric or psychological assessment, frankly, the person giving final advice regarding this sort of stuff would be someone skilled in palliative care. However, it does not seem that the government is interested in any changes to this. It has decided the way it will be. On a take-it-or-leave-it basis of what is presented to us, I will have to, I am afraid, leave it. That is because I take my responsibilities seriously. I am not suggesting that others do not. If things go wrong, if after the review in two years or the five years after that or even through some scandal that emerges through the newspapers, even the local newspapers that have been proponents of this scheme, and there is a misuse or an abuse and people have been given terminal drugs for their conditions in circumstances that are stretched or bent or the rules are even broken, I know that the proponents of this legislation will not take responsibility for that. The government of the day will not say, “We got it wrong; we should have thought of something else or fixed up that problem.” Those who have spoken in support of the Voluntary Assisted Dying Bill will not say, “Yes, I should’ve paid more attention and fixed the problem in advance.” Go Gentle Australia and organisations like that will not stand up and say, “Yes, I take responsibility for that.” The media, which have been running their polls, will not take responsibility for it. Success has many fathers regarding this sort of stuff would be someone skilled in palliative care. However, it does not seem that the government is interested in any changes to this. It has decided the way it will be. On a take-it-or-leave-it basis of what is presented to us, I will have to, I am afraid, leave it. That is because I take my responsibilities seriously. I am not suggesting that others do not. If things go wrong, if after the review in two years or the five years after that or even through some scandal that emerges through the newspapers, even the local newspapers that have been proponents of this scheme, and there is a misuse or an abuse and people have been given terminal drugs for their conditions in circumstances that are stretched or bent or the rules are even broken, I know that the proponents of this legislation will not take responsibility for that. The government of the day will not say, “We got it wrong; we should have thought of something else or fixed up that problem.” Those who have spoken in support of the Voluntary Assisted Dying Bill will not say, “Yes, I should’ve paid more attention and fixed the problem in advance.” Go Gentle Australia and organisations like that will not stand up and say, “Yes, I take responsibility for that.” The media, which have been running their polls, will not take responsibility for it. Success has many fathers they say and I am sure that should this legislation pass in its current form, all those who have supported it and the idea behind it will be quite happy to take the credit for it and say what a great victory it was. The moment something goes wrong, I think members will find this bill will be an orphan. Not too many people will say, “Yes, we were warned; we take responsibility for not having listened.”

I may be conservative in my views and approaches but that is because I try to cover off on the worst possible case scenarios rather than say, “Here is a new idea; let’s see how it flies”, particularly when the life and death of my fellow citizens is at stake. All it takes is just one person. I think six in the Northern Territory who were squeezed into the criteria then available but did not fit, but were nevertheless euthanased — sorry; not euthanased, were assisted to die unlawfully—are testimony to the risks.

As for the political pressure that has been put on people, it is not just me saying this. I refer you, Mr Deputy President, to a story on page 20 of The Sunday Times of 13 October headed “Labor MP revolts: Backbenchers cop raw deal”. It starts —

Veteran Labor MP Margaret Quirk has blasted her own side over the VAD Bill, accusing Premier Mark McGowan and Health Minister Roger Cook of treating backbenchers “with contempt”.

I will not read it all out. I seek leave to table it for the purposes of incorporating it into Hansard. It is on the public record anyway, but I think it needs to be said that it outlines how there has been a dangerous level of influence and disregard, even for the government’s own side. Never mind about the government referring to powerbrokers in the Liberal Party as being the bad guys; their own people are concerned over a matter that should be one of personal conscience with freedom to decide in the interests of their fellow citizens.

Leave granted. [See paper 3275.]

The following material was incorporated —

After speaking against the VAD legislation during nearly 72 hours of debate in the Lower House, when not one of about 20 amendments was approved, Ms Quirk doubled down this week.

Though Labor MPs have been granted a conscience vote on the contentious issue, Ms Quirk said there was clear “implicit” pressure on herself and her colleagues to support the Bill’s smooth passage.

“Certainly I know of a number of occasions where members sought to speak in favour of the Bill and were asked (and agreed) not to speak to expedite the process of the Bill through the Lower House,” Ms Quirk said. “It is a Government Bill (and) there has been an enormous amount of resources put towards it.

“The fact that all other legislation had to take a second place while this was being drafted, the fact that although there was no formal whipping in the House it was clearly evident there was informal whipping—it has never been properly explained to me why this was so important.”

Extracted from finalised Hansard
She also questioned why the draft legislation was only presented to Labor MPs one hour before its release to the media.

“I think it is treating the back bench with some contempt,” she said.

Among the amendments Ms Quirk sought were stronger residency requirements to prevent VAD tourism and the introduction of a de facto “permit system” where the VAD board tasked with ensuring adherence to the legislation would be required to review every case prior to the administration of lethal drugs.

Ms Quirk also attempted to change the Bill so that it required at least one of the assessing doctors to have experience and expertise in the disease expected to cause the patient’s death.

She also supported a proposed amendment from Labor colleague Tony Buti to prevent doctors raising the possibility of VAD with patients unprompted.

Debate moves next week to the Upper House, when Ms Quirk hopes to see many of her proposed amendments revived.

**Hon MICHAEL MISCHIN:** As I have mentioned, there are a number of consequences to this legislation. One of the most significant is that despite every desire to the contrary, it will influence the way in which our society looks at death and the way in which patients are treated. I have a genuine concern that with this alternative method of addressing terminal illness, rather than providing palliative care to try to relieve suffering as much as possible, consistent with the way in which society has approached this issue in the past, and having regard to the advances that might occur into the future, we will have, as one of the raft of treatment options available to some medical practitioners who are inclined to resort to it, the easy way out, in a sense. That may be done compassionately, but my concern is that it will result in people taking this option out of fear, out of despair and out of pain—out of the prospect of those things—when had they taken on the approach of palliative care, submitted to it and had the advice, they might very well have preferred that. However, because of their fear and lack of knowledge, they will make a voluntary—I accept—decision to take this avenue. My concern is that as a consequence of that, governments will have less incentive in due course to invest money in palliative care. I accept that the government has done that on this occasion. However, who knows what will happen in two, four, five or seven years’ time? What is the next stage? Will certain doctors be able to assist people in nursing homes who are suffering and suggest that if they have unacceptable, to them, levels of suffering, they might want to take this way out? I have significant concerns about the way this is going and the morality of a society that permits it. Although I would not stand in the way of it, with adequate safeguards, I am seriously concerned that this will happen over time. That is because we will be inured to the idea. We will not have this debate again. We will not need to. It will be part of the fabric of our society. We will not need to wrestle with those issues.

I am not one to support necessarily members of another political colour, but I do not think I could have put it better than Hon Paul Keating, ex–Prime Minister, as to the potential consequences. I refer to an article that Paul Keating had published in The Sydney Morning Herald of 19 October 2017 with reference to the then pending Victorian legislation. The article is headed “Paul Keating: Voluntary euthanasia is a threshold moment for Australia, and one we should not cross”. I would add to that that it is one that we should not cross casually, based just on an unknown question in a public opinion poll run by a newspaper running a campaign on the subject, without people understanding the implications of what this bill actually does and says, and without there being broad support. I have had some pretty odd ideas put to me by people corresponding with me about what they think is in this bill and the stories and the problems they think will be addressed by it. Paul Keating says —

There is probably no more important issue in contemporary bioethics or a more serious ethical decision for our parliaments than that raised by the Voluntary Assisted Dying Bill 2017 being debated this week in the Victorian Parliament.

Under this bill, conditions and safeguards are outlined that will allow physicians to terminate the life of patients and to assist patients to take their own life.

No matter what justifications are offered for the bill, 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. What matters is that under Victorian law there will be people whose lives we honour and those we believe are better off dead.

In both practical and moral terms, it is misleading to think allowing people to terminate their life is without consequence for the entire society. Too much of the Victorian debate has been about the details and conditions under which people can be terminated and too little about the golden principles that would be abandoned by our legislature.

One of the inevitable aspects of debates about euthanasia is the reluctance on the part of advocates to confront the essence of what they propose. In this case it means permitting physicians to intentionally kill patients or assisting patients in killing themselves. Understandably, the medical profession is gravely concerned by this venture.
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. Few people familiar with our politics would doubt that pressure would mount for further liberalisation based on the demand that people are being discriminated against if denied. The experience of overseas jurisdictions suggests the pressures for further liberalisation are irresistible.

While there are different views strongly expressed within the medical profession, the president of the Australian Medical Association, Dr Michael Gannon, has explained that the formal position of the AMA is opposition to interventions that have as their primary intention the ending of a person’s life.

Dr Gannon recently said: “Once you legislate this you cross the Rubicon. The cause for euthanasia has been made in a very emotional way and this is the latest expression of individual autonomy as an underlying principle. But the sick, the elderly, the disabled, the chronically ill and the dying must never be made to feel they are a burden.”

Palliative Care has issued the most serious warnings. It says at least one in four Victorians who die each year (about 10,000 people) do not have access to needed palliative care, that access in aged residential care is “very low”, that between 2 and 10 per cent of older Australians experience abuse in any given year and that its funding is inadequate to meet growing demand.

The submission highlights the problems with this bill —

He was talking about the Victorian bill on which the Western Australian bill is modelled but has lesser safeguards — it is a disproportionate response to the real problems of patient pain and suffering, a situation that demands greater priority in public care and funding. It is true that if this bill fails then some people will endure more pain and this is difficult for legislators to contemplate. It is also true, however, that more people in our community will be put at risk by this bill than will be granted relief as its beneficiaries. This is the salient point.

Palliative Care said the bill ‘sends the wrong message to people contemplating suicide and undermines suicide prevention efforts.’ How could this not be the case? Suicide is the leading cause of death among people aged 15–44 and the second leading cause of death among people aged 45–54. International studies offer no support for the view that legalising euthanasia is associated with a decrease in non-assisted suicides.

The bill’s failure is pre-set by its design.

The issue is not how many people will choose to die under this proposed law. It is how many people may die when otherwise they wouldn’t. As Dr Gannon says it is “commonplace” for patients to tell doctors in front of their loved ones that they have no wish to be a burden on families.

There are another two paragraphs. If I may, in the time available to me I seek leave to table that and incorporate the last two paragraphs into Hansard.

Leave granted. [See paper 3276.]

The following material was incorporated —

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. 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.

Hon MICHAEL MISCHIN: I thank the house for its indulgence because I think it is important that the article from a former Prime Minister, albeit one with whom I have philosophical and political differences, ought to be heeded. Paul Keating can hardly be considered a conservative and right-wing fanatic. As I said, he is someone with whom I would have disagreements but he outlined very succinctly and pertinently the problems as a matter of principle, some of which I have touched on.

I would very much support the Voluntary Assisted Dying Bill 2019 or legislation of a similar type as long as it does what it is meant to do. I have doubts that we could ever achieve that, but my problem is that there is an

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indication that it will not be negotiable. I am put in a position of having to be conservative about the consequences to our society and how we treat people and with much regret for the situation of those who very much desire access to voluntary assisted dying or fear that they may have to avail themselves of it, I have to vote against the bill in its current form.

**HON COLIN TINCKNELL (South West)** [7.25 pm]: I start my contribution to the second reading debate on the Voluntary Assisted Dying Bill 2019 by thinking about all the people with whom I have talked and consulted and the support that I have had throughout my discussions on this issue since I came to Parliament. Let us not kid ourselves; if this bill passes, it will mean a major change to our society and we do not know what the future holds.

I have had discussions with my family about this issue. Yes, I have had personal health tragedies in my family and in my wife’s family and I have had to deal with doctors misdiagnosing. If euthanasia had been available 15 years ago, my mother-in-law may not have lived the extra 13 years that the doctors said that she did not have. I know how valuable those 13 years were. Yes, similar to many members in this place, I have a personal story, but I will not go into it too deeply. Members of my family have differing views about this issue. I respect all their views, as I have respected the views of my staff when talking to and working with them on this issue. I have made sure that I have heard all sides of the discussion and debate. I have worked with community groups and had community consultation. I have also talked to fellow members in the chamber since the bill first came into play 12 months ago.

One of the things I have realised is that we will go into the unknown if this bill is successful. As I see it, my job in this house is to do what I have always done in my life, at least for the last 20-odd years—that is, to try to solve people’s problems, especially disadvantaged and vulnerable people in our society. That is the way I have approached the issue of euthanasia in its entirety. Before I entered Parliament, as a member of the public in general terms I was in favour of euthanasia. However, after entering Parliament, I realised that my knowledge of euthanasia and how it would be structured in our society was very limited. The benefit of being a member of Parliament is that we get opportunities to listen to experts in their field discuss the different aspects of this very important issue and legislation.

We must be careful about major changes in our society. The bill before us is a major change, and we cannot kid ourselves that it is anything less than that. I see my job in Parliament as being to review, debate and improve legislation to try to make it the best we can before it is passed and enacted as part of the law in this state. That is a very big ask, but I have faith that the 36 members in this place will approach this bill as they do all other important bills—very seriously—to try to achieve a good result. In some people’s eyes, a good result will be no to this bill; in others, it will be yes. I am certainly right in the middle, and I will not be making a final decision on this bill until I see where we go with the amendments during Committee of the Whole. I will give myself time to make a decision that is right on behalf of me, my family, my constituents, other members and everyone around me who I work with and who I trust. I will give myself the time that is needed to make a decision that I believe is right.

As I mentioned earlier, I have some concerns and I would like to talk about them. They are not only my concerns; I will also mention concerns that other people have talked about and what this means to them. It has been fairly well publicised that Aboriginal people have concerns about this bill, and I will talk about that a little later. Many doctors have voiced their concerns about the bill. There have also been concerns expressed about palliative care, or the lack of palliative care, and I will quickly touch on that. The palliative care that is available in Western Australia is second to none; we have some of the best palliative care anywhere in the world. Unfortunately, it is just not available to many people in this big state of ours. Western Australia is an unusual jurisdiction compared with so many states and countries in the world, and we are charged with making laws that will work for the people of Western Australia. Many people in Western Australia do not see this as a choice; their choices are very limited because palliative care is a major concern and it is not available to them.

Mental health professionals have also talked about their concerns and how vulnerable many people feel. People representing disability groups have expressed concerns and some lawyers have even chipped in to voice their concerns about some of the ramifications around the implementation of this bill. I heard so many good speeches yesterday and today about some of those concerns. I have learnt a lot just from listening to all the different sides of the argument, even in this place, over the last two days. It certainly opens up your mind about why this is such a difficult bill to make a decision on. That is the way I feel about it.

Australia’s two most prominent Aboriginal politicians have opposed this bill and talked about their concerns. They and other government members say that the consultation has not been to the standard they would like. It is not easy to talk about Aboriginal health or culture. Number one, Aboriginal people look at health and death and many other things in society quite differently from us. There are 100 000 Indigenous people in this state and it is not a matter of just consulting with them. We need to help them understand, and until they understand, we have some issues.

If we look at euthanasia, or voluntary assisted dying, as it is called, we see that suicide is real to Aboriginal people. They live with this every day. As a matter of fact, the Kimberley is one of the worst jurisdictions in the world for incidences of suicide. Now, when we start talking about euthanasia or VAD, they get confused: “Are you helping...
us to suicide? I thought you were helping us to avoid suicide.” They get very confused in this conversation. The consultation with Aboriginal groups and communities, especially remote communities, has to be done at a very high level. After that great consultation takes place, even if the government has a different view and is still going to put this bill through, it has to be honest with Aboriginal people and let them know what it means, help them to understand, and still say to them, “Sorry, we still back this bill.” It needs to explain to them that this bill is going to go through, and what it will mean in everyday life.

I am not going to come out and blast the government, as Senator Dodson said, because I do not think the government has gone out of its way to not consult with Aboriginal people. This is a very difficult bill that will change our society and could have positive or negative ramifications to their cultural life and society. They are already under stress and under pressure in many areas of health, life expectancy and trust, working with governments and government agencies, and the only way that trust can improve is through helping them to understand. At this stage, it seems to me that their understanding of this issue is not great.

There are cultural changes here. If an Aboriginal or Torres Strait Islander patient is close to death, it is important that they do not die alone. Family presence is culturally crucial at this time. They believe that if the spirit does not have the chance to leave the body, there will be a major disruption in the family. They have a completely different cultural belief from us. Their dreamtime or lore is very similar to our faith and other people’s faith in our society, and we must respect that and work with them as best as we can to help them make the changes if this bill goes through and becomes part of our law.

As I said before, I came into this place as a “yes”, and now I am a “maybe”. I will be a definite “no” unless certain amendments are made to the law as it sits right now.

When dealing with Aboriginal people, we have to go about it with a different protocol. We cannot consult with them in a way that we would with most whitefellas. It has to be done in a completely different and time-consuming way. I want to represent them in this house. In the 1980s, suicide in Aboriginal communities was virtually non-existent. We have seen how that has changed. Now, 95 per cent of Aboriginal people have been affected by suicide, and Aboriginal people are six times more likely to commit suicide than non-Aboriginal people. We know all that. They are now very confused and do not understand why we are talking about assisting them to die when they are very ill and at the end of their life. It is a cultural concern.

I look now to the concerns of doctors, and I share some of their concerns. Many surveys have been done. We have found in election results around the world and in this country that surveys do not mean much. Everyone knows that to get the answer we want depends on the question that we ask. Sometimes that can be very difficult and surveys change. People’s attitudes change as they gain more information and knowledge about a subject.

Hon Kyle McGinn: Is that surveys or polls?

Hon COLIN TINCKNELL: Surveys, polls, research—whatever you want to call it.

I would like to see an amendment to allow for a specialist of a patient’s disease to be involved in the euthanasia process. I cannot imagine two GPs making a decision to end someone’s life, even when one of them is the local doctor of that patient, without that. I want someone who has specialist experience in the disease that a person is dying from to be involved in the process so the patient has all the information before them before making the decision to end their life.

I also believe that registered health practitioners should be prohibited from suggesting euthanasia to a patient. The main reason for that is to protect vulnerable people in our society. I mentioned before people who have mental health issues. It takes a lot longer than two weeks to assess that. People with disabilities already feel that they do not get a fair go and that they are not listened to and are not fully understood in society. They feel very vulnerable. As I mentioned at the start, other groups are concerned about the bill. These are some of my non-negotiables. I would like the house to support those amendments.

We also believe that doctors must be independent; there should be no relationships between doctors because, once again, there will not be enough diversity of views. If a specialist is not involved, something will be missing and mistakes will happen and unintended consequences will ultimately arise.

What real choices will people who cannot access palliative care have? The government says that VAD will be available for everyone, but at the moment palliative care is not available for everyone. There is a lack of choice. If this bill is all about choice, I see a lack of choice right there, especially in regional areas. Many words have been spoken both to the media and in this house about that issue. Yes, it is true that the government has put extra money into palliative care, and I commend it for that, but we are way short. It is not the government’s fault that it is way short, but this government is asking us to support a voluntary assisted dying bill while palliative care standards are not what they should be in this state. Many people in Australia cannot access palliative care, and Western Australia has the worst record. That must change. We need to improve that before we give people choice about finishing their lives. Palliative care experts have said that we are $140 million short. The government put an extra $17.5 million into palliative care recently—everyone can do the maths—but we are still a bit short. That needs to be improved.
When I talk about specialist and other doctors being involved, people say that country people will not be able to access VAD. That may be the case, but how do we improve that? We give them specialists, doctors and palliative care, and we improve the conditions of access to medicines and health in regional areas. If we can do it for VAD, we should be able to do it in those other areas. This government wants this bill to be passed, and that is, for me, a major step that would need to be achieved before we start assisting people to end their lives.

One of the issues I want to go back to is the discussion around misdiagnosis. It happens very regularly. If people think that politicians never make mistakes, they are joking, are they not? If they think that doctors have never made a mistake, they are also joking. It happens and it happens regularly every day. It has happened to my family. It has happened to my mother. It has happened to my mother-in-law. Both of them are not here anymore. I have lived that. I do not hate doctors; I love doctors. I have amazing doctors who look after my health. But misdiagnosis happens.

If people do not have the option of VAD, hopefully they will have the option of palliative care. But so many people in regional areas do not have that option. For me, the slippery slope is that they will take up VAD in increasing numbers because they have no other choice; yet, they are basing that on a diagnosis from a doctor who could be mistaken. Even if the diagnosis of the disease that the person has is right, everyone is different and people respond to health issues completely differently. Medicine is not an exact science and it is very, very difficult to know what is going to work for one patient compared with another.

I feel like everyone else in this house, and I would imagine everyone in the other place too—95 MPs who represent the WA Parliament. I want to end suffering. I want to make it easier for people to deal with the final years of their lives. But, at this stage, I have concerns about this bill as it is now. Can I be convinced? I do not know. I will see how we go with these amendments. Some great amendments, which I will be supporting, have already been put up by Hon Martin Pritchard. I imagine that we will receive quite a few other amendments in due course and I can imagine what most of them are going to be—probably fairly similar to the 20 amendments that were put in front of the lower house. I have also heard, behind the Chair, that the government is looking at amendments. I encourage it to improve this bill. I have also done the numbers and I think this bill will go through, but I cannot be one of the members who votes yes unless the bill that we have before us is improved.

The Joint Select Committee on End of Life Choices found that Western Australia has the lowest number of publicly funded inpatient palliative care beds per capita in the country and that access to specialist care is limited across the state. The report stated that this was particularly a problem in regional and remote areas where access to palliative care is almost non-existent. Is it this government’s fault that access to palliative care is almost non-existent in regional areas? No, it is not, but this government wants to put voluntary assisted dying legislation through this Parliament, so it needs to improve palliative care services. The Pilbara, the wheatbelt and the Kimberley are just three areas where palliative care services are not good enough. The service is okay in some of those towns, but it is non-existent in many parts of those areas. The rhetoric about choice is deceptive and irresponsible if people do not have access to palliative care.

We heard what Hon Michael Mischin had to say about the politics of this bill and to some degree I agree with that. I have been very impressed with the contributions of my fellow members in this house. I listened very intently to Hon Martin Pritchard because I know he is in a similar position to me. I have not spoken to him about this bill, but I know that he has been struggling with the decision that he will make, so I really wanted to hear what he had to say, and I agreed with most of it. I listened to the comments that Hon Tjorn Sibma made about the bill. I listened to people in the lower house make very emotional contributions and explain the journey of the people in their lives who have suffered. I do not think too many families have not experienced some sort of suffering.

The main role of doctors in society over the last 10 000 years has been to improve people’s health and to help people recover from sickness. We are putting something in front of them that will be difficult for them to manage properly. It will be difficult for them to have the mindset that is now changing. Some doctors will thrive and do well, but other doctors will really struggle and their patients will struggle with them. The bill is not perfect as it stands today, but it can be improved.

As I said before, when I first came to Parliament, I looked at this house with real confidence, and the reason I looked at this house with real confidence was the diversity of views. I am a big believer in democracy and what it stands for. When a difficult bill like this is put in front of us, there is nothing better than to have seven parties discuss their views. Even though this is not a party issue and everyone has a conscience vote, people have different influences in their life. I have had mine and those influences have helped me to be the person I am today and they have helped me make very difficult decisions in this place. I have been very pleased to hear the diversity of the debate so far. I talked earlier about our role of reviewing debate and improving legislation. I have reviewed and I am now debating. I hope that during the committee stage, we can improve this legislation. If the bill is supported by this house, like everyone else in this house, I will accept the result of Parliament. I believe in democracy. I will continue to work to improve the bill as it rolls out and gets implemented, if that is the situation. I will continue to listen to the debate. It is encouraging to hear that the government may make some amendments. I hope that the information I have learnt has helped. That is my situation. I found myself, like Hon Jim Chown and Hon Martin Pritchard and other members have reported, to be neither in the noes or the yeses and are still making up their minds. I understand
how they feel, because I have been a part of that group as well. I am very happy with the opportunity that has been afforded to me as a member of Parliament to speak to all sides of the argument. I felt very uncomfortable when this issue first came up, and I felt as though no-one in this world was capable of making the right decision. That view has now changed. I believe that the members of Parliament here will debate this issue to its fullest, and if this bill is to go through, they will make sure that it is the best bill that can be put through this house. I have my concerns, and I have voiced those concerns. I agree with lots of other groups that are concerned as well, and I know that nothing can be perfect.

Along with all the other members here, I hope this debate continues in this positive mode and I hope that it moves reasonably swiftly, and we do not have time-wasting going on in this Parliament. I have always been against that. I am not a big fan of filibustering, but every now and then it happens, and sometimes when it happens it has been justified. I have learnt a few things since I came into this Parliament from seeing that happen. I thank members for listening to me, and I look forward to the contributions from fellow members.

HON ROBIN SCOTT (Mining and Pastoral) [7.57 pm]: My contribution this evening to debate on the Voluntary Assisted Dying Bill 2019 will be a short one. It will also be a nuts and bolts contribution, because, given the short time I was given to prepare something, I will do the best I can to articulate. It has been very stressful and sad listening to some members’ contributions, explaining their personal experiences dealing with friends and family who have passed away, and I sympathise with them. I have no intention of making this about me or getting emotional. This is not because I feel no emotion. In fact, I am a very emotional person about life. A couple of drinks and a sad song, and I will give you a bucket of tears. This could be because I am 66 years old, and I am now in the death zone. I am not trying to be funny. I have elderly uncles and aunts back in Scotland, and they are just popping off all the time. We do, in a way, get desensitised to death; we accept that it is inevitable for everyone. The youngest member of my family was only 36 years old when cancer took his life. The oldest was 73 years old. I lost both my parents to cancer, and at this very moment I have one relative and one dear friend being treated with chemotherapy and radiation. We are hoping that the doctors have found this cancer quickly enough, and that there will be a happy ending. Another friend of mine is near the end. Nothing more can be done. Voluntary assisted dying has never been spoken about by any of them.

I have treated this bill like any other bill. I have tried to sift through all the information. I have listened to the people in my electorate for and against. I have responded to every letter, postcard and telephone call. In the end, I decided to break it all down into these four groups of people: the medical industry, the religious industry, the woe-is-me people, and the voters. Starting with the medical industry, in The West Australian of 10 September 2019 it was stated that 2 500 years of medicine has never deliberately ended a life. The Hippocratic oath that we hear so much about says that they will do their best to heal—a very worthy oath indeed.

Delving into medical history, I discovered stories of graverobbers and investigative operations by doctors on the homeless and unclean in Scotland only a few centuries ago. The cadaver trade was thriving. Two of the main characters were Burke and Hare, two Irishmen who moved to Scotland looking for work. They soon discovered that robbing graves and selling the bodies to the medical industry was far more lucrative. Before long, they found that murder was much easier than digging up graves. Professor Robert Knox, a popular anatomy lecturer, paid very well. The fresher the body, the more they were paid. In the end, they were delivering live people to the professor—usually drunk and homeless people. On arrival, a quick blow to the head rendered them unconscious before the gruesome task began of opening them up to see how people function. I am very grateful to Burke, Hare and Professor Knox because without their gruesome trade, we may not have the wonderful knowledge that we have today.

Many people consider Mother Nature to be cruel, but I believe that we humans are far crueler. In the wild, meat-eating animals do what they are designed to do—eat other animals. When they make their kill, it is over very quickly—they shut off their prey’s windpipe or suffocate it. That is the natural way it happens. There is nothing kind or natural about extending someone’s life when they have a terminal illness. There is nothing natural about using chemotherapy or radiation to extend someone’s life. Palliative care does not save lives; it extends life, quickly—they shut off their prey’s windpipe or suffocate it. That is the natural way it happens. There is nothing kind or natural about extending someone’s life when they have a terminal illness. There is nothing natural about using chemotherapy or radiation to extend someone’s life. Palliative care does not save lives; it extends life, sometimes in very painful conditions. If an illness is discovered early enough, chemo and radiation may help, but when a patient is told that they are terminal, nature should take over. By all means, every comfort and medication should assist the patient to slip away.

I have spoken to two palliative care nurses and both are against this bill the way it stands at the moment. They believe that amendments are required. They also told me that doctors have been overmedicating patients for decades. One example was Mrs Smith—not her actual name. The doctor told the nurse that Mrs Smith required some more morphine and the nurse said that she had just given morphine to Mrs Smith. The doctor looked the nurse in the eye and repeated: “Mrs Smith needs more morphine.” Two hours later, Mrs Smith passed on. This practice was recently confirmed by Professor Fiona Stanley in a newspaper article. We cruelly try to extend the lives of terminally ill patients, bleating that the medical industry and palliative care will see them off to the next world with no pain and anguish. They say, “Leave it to us; you have nothing to fear.” Well, there is something to fear. To guarantee no pain, they would, and do, totally anaesthetise the patient. By this time, the patient is riddled with bedsores and unable to tell anybody about their discomfort. However, if this is the way you want to go and leave this world, your wish will be granted and God bless you.
Talking about God, various religions all proclaim that God gave us life and only God can take it away. One religious zealot even suggested that a person should be happy to suffer for their God because he suffered for us. That is not something I want to condone. It would appear that the churches have completely forgotten about the religious wars and battles fought in the name of God. Hundreds of thousands of men and women have been murdered in the name of God. Again, only a few centuries ago we had the dunking chair. This method was invented by the church to whittle out witches who were carrying out witchcraft, which was usually them making up potions to help the sick. The method of deciding whether a person was a witch was 100 per cent effective. Local clergymen would tie them to a chair that would then be swung out over a river, where they would be dunked into the water for a time. If they were deemed to have drowned after being raised, they were proclaimed innocent and passed on to God for eternal life in heaven. However, if they were still alive, they were then brought ashore, tied to a stake and burnt alive as a witch. This was a judicial system operated by many of our religions. They considered that they were taking lives in the name of god. Many of the lives destroyed were innocent victims, so, like the medical industry, the religious industry now has a back seat in my decision-making.

Another problem I have is listening to the “woe is me” people. These members of the general public and some members of Parliament will take all day to tell us how much they have suffered watching their loved ones suffering in pain and discomfort. They never offered to swap places with the patient. They usually want voluntary assisted dying for their loved one, but it is to put an end to their own suffering, not the patient’s suffering. They need to be reminded that it is not them dying, but the loved one lying in bed. They cry while telling us the story of their loved one who had a great life, and it is so sad that they have to die. Well, we are all going to die; no-one is getting out of this life alive. I am sure everyone here has lost a loved one, and as hard as it is, we do get over it. I struggled for a long time thinking about my parents when I lost them. I would cry very easily. My mother was aged only 59 and my father was 73 years old, but now I think of them and I smile. I remember the wonderful times we had in Scotland when I was growing up, and of course the great times and the wonderful life that they gave us here in Australia. We must listen to the wants of the patient and do our best to grant what, in most cases, is their last request.

I, like all members of this chamber, have been swamped by letters, emails and postcards, even occasional phone calls. I have had various people tell me that if I vote for the VAD bill, they will not vote for me at the next election. I always thank them for their communication and tell them not to vote for me because I do not want people of that ilk supporting me. If they do not get what they want, they will pull up stumps and go home, so I say good riddance to them.

The long sitting hours of Parliament debating this bill is a farce, with politicians waving the flag, saying, “Look at me; I’m working overtime for the people”, unless, of course, there is an important footy game on. No-one in Parliament needs to grandstand on this bill. This is a very important bill; in fact, it is probably the most important bill ever brought to this Parliament. We need to be fully functional and have our faculties firing on all cylinders while we debate this bill.

Members are given a conscience vote on the bill, not a personal vote. All members have to vote according to the message from their constituents. I would have no problem stating my personal view if that was the case. However, my constituents comprise both Indigenous people and others, and all mobs have for and against in their midst. I believe it is 50–50 at the moment, and I admit that I had my work carried out trying to sift through the communications. The VAD bill is a highly emotive bill and no matter what we do with it, we will never make it foolproof as we all know there are ingenious fools who will get around any legislation we put forward. Until the government makes a commitment to begin supplying proper palliative care to regional and remote communities to a similar standard that metropolitan patients expect, how can members expect my constituents to support a bill with no choices? Choices have been mentioned by nearly every previous speaker. In my electorate, which is 2.2 million square kilometres, we have no choices. A recent poll showed that 80 per cent of people in my electorate were in favour of the bill. I know I could conduct a poll and get 80 per cent against the bill. One elderly gentleman came into my office in Boulder. He was concerned that because we have no palliative care in Kalgoorlie, the government may force VAD on him because it is cheaper than palliative care. I was able to arrest his worries.

I have attended many meetings for and against this Voluntary Assisted Dying Bill and the chair of the meeting was usually a highly educated medical doctor or a religious leader. Never once have I been invited to a joint meeting with the opposing factions to discuss and debate a possible solution. Both parties are convinced they are correct. Neither side has shown much flexibility or open-mindedness in this debate. Some members here are voting only on their own pre-existing beliefs. I, on the other hand, am determined to hear everyone’s perspective and do the right thing, which is not to exercise my will but the will of my electorate. I say to all constituents in my electorate and every electorate, please remind your member that they must represent your wishes on this very important bill.

To conclude, I am confident that in the next 20 to 30 years, our wonderful Aussie scientists, our great research people, will find a cure for these hideous illnesses. I wonder what the general public will say about the fortieth Parliament and how many people we helped die from 2020 to 2050. Thank you.

Extracted from finalised Hansard
HON MARTIN ALDRIDGE (Agricultural) [8.10 pm]: I rise to speak this evening on the Voluntary Assisted Dying Bill 2019. In doing so, like many speakers before me, I recognise that many views about this proposed reform have been expressed so far, not just in this chamber but also outside this chamber. I must say that thus far, the debate in this place has been very respectful of each other’s view, no matter how divergent that view may be from your own.

I have taken a very genuine and, I think, responsible approach to the matter and now this bill. Prior to the last election, on 15 February 2017, I received an email from an organisation called Dying with Dignity Western Australia and I would like to read it. It states —

Dear Martin Aldridge

Polls consistently indicate that over 80% of Western Australians support the right of the terminally ill to access medical assistance with dignity to die.

Dying With Dignity Western Australia (Inc) asks that the community’s wishes are respected by their representatives supporting a Freedom of Choice at the End of Life Bill.

A cross party group has committed to presenting such a bill to Parliament this year.

This Bill will allow a competent adult who is dying of a terminal illness, and whose suffering remains unbearable despite optimal palliative care, to request medical help to die quickly. There will be strict safeguards in place to ensure this assistance is not abused.

So we ask how you intend to vote on a Freedom of Choice at the End of Life Bill. We will be vigorously promoting candidates who agree to vote yes to this choice.

Remember, for many senior Western Australians this will be the single most important issue in this election.

Please indicate by email in the next 14 days if you will, in principle, support the Freedom of Choice at the End of Life Bill should you be elected on 11th March, 2016.

The public will be informed of your position.

Thank you very much

Murray Hindle

President

Dying with Dignity Western Australian (Inc)

The ACTING PRESIDENT: Order! Members, if you are having conversations, would you mind taking them outside or making them quiet. I am struggling to hear the honourable member on his feet.

Hon MARTIN ALDRIDGE: That was 15 February 2017, some weeks out from the 2017 state election. I draw members’ attention to an article that occurred following that email on Saturday, 4 March 2017 in The Weekend West. It has taken me quite some time to locate this article. I think my office was assisted to locate it by the Parliamentary Library. It was a half-page advertisement in The Weekend West by Dying with Dignity Western Australia. The headline is “80% of Western Australians support freedom of choice at the end of life. Vote for the candidates who support the people.”

I will not go through all the Legislative Assembly members, but I will reflect on the members of the Legislative Council, particularly those who have been identified and have been subsequently elected.

As I understand it, those people obviously agreed in principle with the proposal put to us by email. They were Martin Aldridge, National Party; Darren West, Labor Party; Stephen Dawson, Labor Party; Robin Scott, One Nation; Sally Talbot, Labor Party; Colin Holt, National Party; Charles Smith, One Nation; Samantha Rowe, Labor Party; Alannah MacTiernan, Labor Party; and Sue Ellery, Labor Party. Ten members of this current Legislative Council were identified in this email. Obviously the Greens are missing from that list, but there is a disclaimer at the bottom that says that support for assisted dying is part of the Greens’ platform and is supported by all Greens candidates. Therefore, obviously there was no need to name the Greens. That begs the question of whether a conscience vote is afforded to the Greens. It would appear from this article that all the Greens who were standing at the 2017 election were in support, in principle, of such a policy.

My view has not changed from that time. I have said in the many comments that I have had with constituents and in interactions with the media that I will continue to provide in-principle support to the proposed reform. That does not necessarily mean that I will support a bill in any form, but in-principle support, yes. This matter is too complex and too important, and the final results in some respects are too distant, to enter this debate with a fixed and firm view. I certainly would not be so arrogant as to say that I support this bill in its current form with no amendment whatsoever. I certainly do not take that purist view that other people have taken.

I understand that this bill has had a long history. I was not a member of this place when a private member’s bill by Hon Robin Chapple was considered, but I have heard many members reflect on that time. I understand that prior

Extracted from finalised Hansard
to the election, or at least I can certainly recall, there were media reports about how the Labor Party would support an investigation into such a scheme should it be elected to government. I have not been able to find a policy paper, discussion paper, election commitment or media commentary. It certainly was not mentioned in the then Leader of the Opposition’s campaign launch address. However, I was aware that it was something that the Labor Party intended to pursue if and when it formed government, as it ultimately did.

This investigation came in the form of the Joint Select Committee on End of Life Choices. I acknowledge the significant work of that committee and all its members throughout the 12 months of its inquiry, in particular my parliamentary colleague and the deputy chair of the committee, Hon Colin Holt, who was nominated by the National Party, and, indeed, the Legislative Council, to be a member of the committee. In August 2018, the committee tabled its report, titled “My Life, My Choice”. The government response was tabled some three months later, on 27 November 2018. Of course, members would be aware of the establishment of the Ministerial Expert Panel on Voluntary Assisted Dying. The panel consisted of 13 people. Those members who have already spoken during the second reading debate have outlined many of the areas in which the panel members were subject matter experts in their fields. I came to know two panel members reasonably well during the consultation process. They were Ms Noreen Fynn and Professor Phillip Della, AM. Those two panel members turned up consistently at the forums that I attended. There was another panel member at one of the forums that I attended, but the name of that person escapes me, and I apologise to them. The two forums that I attended were in Northam and Geraldton. I was the only member of Parliament at those two forums, and it was a good opportunity to engage, and learn about the feedback that the ministerial expert panel was seeking.

I also listened to the views of the people who turned up to engage in that process. The bulk of that consultation was obviously undertaken by the panel, supported by the Department of Health. An initial observation that I would draw from that process is that the Department of Health probably does not have a long and established history of consultation. It is particularly good at running hospitals and the public health system generally, but consultation has not been something it has needed to do extensively.

Initially, consultation was planned for Perth, Bunbury, Kalgoorlie, Geraldton and Broome. It was clear from the outset that some shortcomings were associated with that approach; the most obvious being that there was no consultation plan between Geraldton and Broome—the only two places north of the Great Eastern Highway. At that time, the National Party engaged quite strongly with the Minister for Health, both through Parliament and privately, and approximately one month after that announcement, further consultations were extended to Mandurah, Carnarvon, Karratha, Northam and Albany, along with consultations via videoconferencing with community resource centres in regional Western Australia. If we look at the ministerial expert panel’s final report, we see that some of those added regional consultations had greater attendance than some of the metropolitan forums. There was a desire and a demand from Western Australians in regional areas to be engaged in this process. Although it took a bit of effort, I congratulate the government for ultimately extending that consultation.

One of those communities was Quairading. I will talk about Quairading a little more in a moment. I will talk about the forums that I attended. The people who attended the forums in Northam and Geraldton that I was at were generally probably not supporters of the voluntary assisted dying proposal. They were quite concerned about the notion of it. By and large, I think that is what had driven the majority of people who I interacted with at these forums. At both forums, people turned up who were highly sensitised to the issue. But the way in which information was put to them and the way in which the ministerial expert panel members explained how they were considering the process and what was proposed, and what the joint select committee had recommended, I saw some of that fear change to trust. People became more inquisitive about the process. By the end, people were much more confident about the notion.

I also saw disappointment. This is something that other members have also reflected on. There is a misperception in the community that as soon as the Legislative Council hurries up and stops delaying the bill, it will have effect by Christmas. When I explained that the ministerial expert panel, and in fact the explanatory memorandum, refer to a period of 18 months post-passage, I am not sure that the general population quite understands the delay that will occur if and when this bill passes.

Another thing that I think people are not aware of is the restricted approach that has been taken to the regime, particularly with capacity. I think Hon Jacqui Boydell talked about people living with dementia. People have a common misperception that they will simply be able to whack this into their advance healthcare directive. In certain circumstances, people want to be able to access voluntary assisted dying, which clearly will not be the case under this regime.

I conducted some of my own consultation to the extent that I could. I spent extensive time on repeated occasions with palliative care teams in the wheatbelt and the midwest. I spent about half a day in the palliative care unit at Sir Charles Gairdner Hospital. I thank the doctors, nurses, social workers and allied health workers who I spent some time with. It was really quite eye-opening to get a hands-on look at the operation that is the provision of a palliative care service.

I am fairly confident in saying that we probably would not see the same multidisciplinary approach in other specialties of medicine. We see people with a range of training, skills and qualifications coming together and

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managing individual patients and their needs. The thing that was most impressive was the way in which those specialist medical staff, both doctors and others, engage with their patients. It is certainly not what those who typically engage in the health system would usually see. Earlier this week, I heard a speaker say that people who work in the palliative care sector are masters in a difficult conversation. Certainly that was what I saw in operation at Sir Charles Gairdner Hospital and I was very impressed by it. Unfortunately, there is no Sir Charles Gairdner Hospital in my electorate, which is something I will talk about a bit later.

I engaged with many medical professionals. I even reached out to the Aboriginal medical service in the midwest to seek its view. I really did not let an opportunity go by where I could gain an understanding of people’s views and whether they had any specific concerns.

As I said, I had the opportunity to be in Quairading. I cannot recall exactly whether it was before or after the Ministerial Expert Panel on Voluntary Assisted Dying was formed. I think it was after because at the time there was talk about the consultation opportunities. Unfortunately, the closest opportunity for those living in Quairading was to travel to Perth. I was in Quairading with the member for Central Wheatbelt. We had a typical meet and greet with the community at the local bowling club. It was a public invitation for people to attend. There were between 30 and 40 people at the Quairading Bowling Club. The main issue they wanted to engage in that night was voluntary assisted dying. I will tell the house two stories, which go to how polarising and personal this issue can be. One gentleman who stood up was very strong and passionate in his views. He reminded me of the overwhelming community support for voluntary assisted dying. I do not know whether he quoted a figure but he certainly referred to long-term polling that showed community support. He was short and sharp and said, “Anyone who opposes these laws in Parliament should lose their seat at the next election.” That was pretty much his one message to me and he sat back down. Another fellow from the same community got up and said he that he had held a long-term view that something like voluntary assisted dying was the right approach. He was going through a very personal experience at the time because his best friend was dying. In going through that process with his best friend, he changed his mind about his long-held view that voluntary assisted dying was the right path to go down. Therein, just with those two gentlemen at the same forum and from the community, lies the complexity faced by legislators in understanding and navigating a way through this very difficult and sensitive issue.

I will talk a little about polling that has been around for some time. No-one more than a former state director of a political party likes to read polling and similarly dismiss it when it does not suit their own purposes. There have been a lot of references to polling through the course of the second reading debate. The poll conducted by Go Gentle, which was sent to me, is interesting, particularly some of the results from the Agricultural Region. It asked, “The WA Parliament is currently considering a voluntary assisted dying bill. Based on your current level of knowledge, do you support or oppose the voluntary assisted dying bill?” The average for the Agricultural Region was 80.9 per cent. It is interesting to look at the demographics because the highest level of support—89.1 per cent—was among young people aged 18 to 34 years. Those aged 66 years plus, people who members would think are closer to the end of life and thinking about options and care or whose health is ailing, had the lowest level of support at 75.1 per cent.

I thought that was quite interesting, because I did not think that would be the case. Another question was asked—in fact, I think it might be the same question —

The WA Parliament is currently considering a Voluntary Assisted Dying Bill. Based on your current level of knowledge, do you support or oppose the Voluntary Assisted Dying Bill?

The poll results broke down the levels of total support by political party voting intent. Of the political parties, the lowest level of support was actually from Nationals WA voters, at 74.1 per cent. That is still very strong, but not as strong as the support from ALP voters, at 90.2 per cent; 91.3 per cent for Greens voters; and 92.3 per cent for Pauline Hanson’s One Nation voters. Still, that is quite a comparison between people’s political party voting intentions. A range of other questions were asked in the poll. I will not go into them because I am not sure how relevant they are. Certainly, I will not pay much attention to them because when we start asking voters over the phone about appropriate safeguards, I seriously question whether the people who are being asked the questions are fully informed enough to make a decision on such matters.

I briefly talked about palliative care in my introductory remarks and about the opportunity I had to visit the palliative care team at Sir Charles Gairdner Hospital and the palliative care teams that operate in the midwest and wheatbelt. Some members have argued—not during the second reading debate but in the public discourse in the lead-up to the debate—that palliative care is one thing and voluntary assisted dying is another. I had the opportunity to attend a forum this week, organised by Hon Dr Sally Talbot and Hon Colin Holt, with Professor Margaret O’Connor, AM, a palliative care expert from Victoria. If I understood correctly what she was telling us, she argued that there was not a disconnect between the two. That is certainly a view that I would agree with. The problem with the argument that we should not confuse palliative care with the debate we are having on this bill is that in my electorate of Agricultural Region, there is very limited access to palliative care services. I know the government is talking about a significant increase in funding for palliative care over the next four years, and I think the Minister for Health’s media statement quoted a trebling of staff. I acknowledge and welcome that investment. I understand that

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the landscape will shift; it will not shift overnight, but it will shift over time. In some parts of the regions, services are quite reasonable, and in that regard I single out Geraldton and the midwest. St John of God Geraldton Hospital runs a palliative care unit on behalf of the WA Country Health Service, and I have had the opportunity to visit it on several occasions. The feedback I have had from members of the midwest community is that they highly respect and value the contribution that hospital, that unit and its staff make to the wellbeing of their loved ones at the end of life.

In the wheatbelt we are lucky to have Mr Brett Hayes, who resides in York and was Western Australia’s 2018 Nurse of the Year. Brett and his team developed the Wheatbelt TelePalliative Care service, which is a service that, in its most basic form, provides support and continuity in home care through the use of technology. Obviously, telehealth is not able to do everything, but it can certainly support families.

Telehealth can provide answers in the middle of the night. In fact, in some of the examples that were put to me, telehealth even helped loved ones on the east coast, in other parts of Western Australia, or even internationally to say goodbye to their loved ones through the pilot, which was the Wheatbelt TelePalliative Care service. I understand that the work that Brett and his team have done in the wheatbelt will be the basis for expanding a similar model across other regions. I understand that some regions have already embarked into that space; however, more broadly, each region in the WA Country Health Service will be rolling out a telepalliative care service similar to, if not the same as, the pilot that was run in the wheatbelt.

If we are going to have real end-of-life options, palliative care must be reasonably available. I have not heard anyone dispute that notion in the course of this debate. Really, people in our communities should not find themselves faced with the option of a very poor care outcome or voluntary assisted dying. That is unacceptable to me and the reason these issues, in my mind, are not unrelated.

We know that health care is becoming more expensive. We know that gaps are growing, and we know that access to services such as residential aged care can be quite difficult and costly if someone does not have the financial means. A significant pressure and burden is placed on our public hospital system when those people who require residential aged care end up awaiting placement beds in our public hospital system.

I met a constituent and I want to recount this person’s story. I will not identify him. I was at a local agricultural show, which have all occurred over the last few months. It has been a really good opportunity to engage with the community because it is probably the busiest part of the year, when just about every weekend we are at a different town show, a different ag show or a different community event leading up to harvest. I met this fellow at one of my local shows. He came up to me and, as soon as I saw him, I could tell that he had some pretty significant health issues and some fairly obvious physical impairments. He was an older gentleman and he initially expressed concern to me that his local member of the Legislative Assembly had not supported this bill, and he was insisting that I give it my full support. We got chatting, and he went on to articulate his argument a bit further. He said to me, “I want to access VAD when I become a burden on my family.” I did not really say anything to him at the time, because he was very persistent, and also the local member was standing next to me, so I did not want it to be awkward. I did not really think about it at the time, but I have certainly done a lot of reflection on those comments since. I wish I had the opportunity to talk to him a bit more about that, because it is something that has weighed on my mind and certainly does concern me. I do not think we could ever stop or protect people from being faced with making a decision to do what is, in their mind, the honourable thing. I think that is certainly what this gentleman was expressing to me. I never had the opportunity to interrogate him, but, obviously, in his mind, being a burden on his family could have come in many different forms. Obviously, under this regime, he would have to qualify for voluntary assisted dying, but in terms of him making a decision at the point at which he wants to pursue that option, for him, the case that he put to me was that he wanted to be able to exercise that choice so that he did not become a burden on his family.

I want to talk about the regional impacts of this bill. I do not dispute the consistent and long-term polling that has occurred. Certainly, eight out of 10 people support, in principle, voluntary assisted dying. If I were to do a straw poll of all the people I met at all those shows that I stood at and all those people in the street whom I asked about it, that certainly reflects the community sentiment, as far as I can tell. I am concerned about the regional implementation of this regime because I think that those eight out of 10 people also would expect to have reasonable access to the regime if they were in a position of their choosing, and, obviously, qualified.

I have now had two briefings from the government and still do not really understand how the regime will be implemented outside Perth. I think that this is a regional issue, because there is no doubt that under the current regime—this will come out during the Committee of the Whole—reasonable access will be available within metropolitan Perth.

I understand that some 18 months of water is yet to flow under the bridge, so to speak, and some of those things are yet to be worked through and sorted out. Indeed, the Minister for Health commented today that if the only option is to take services to the people, that is what he is prepared to do. I think he also commented on the significant expense of making sure that the service is available throughout what is a very large and, in some areas, population-sparse state.

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It is important to me, and I am sure that it is important to all regional members, that if this bill is supported, it does not create yet another aspect of our healthcare system to which country people either do not get access or have to travel to access. There are obviously reasons why travelling to access a service like this would not be appropriate. That ought to be considered and addressed more than any other deficiency in our healthcare system.

The foundation stone of this bill is access to general practitioners. In Western Australia today, there are over 100 general practitioner vacancies, and—surprise, surprise—not a single one of them is in the metropolitan area. There is actually a surplus of general practitioners in the metropolitan area. This government has responded to that by spending $2 million on a campaign called “GP Urgent Care” connecting patients to GPs who cannot otherwise get full-time work. We have not yet seen strategies to deal with the malapportionment of GPs. I would like to quote something attributed to Hon Mark Coulton, MP, the federal Minister for Regional Services, Decentralisation and Local Government in response to a letter that sought further assistance from the federal government to deal with this primary-care issue. He said —

Over the past decade, the number of GPs has been growing at three times the rate of the population. However, the majority of growth in General Practice is in well-serviced major capital cities and metropolitan areas. Data shows that in some areas, particularly in major cities, the growth in medical services is due to an increase in the number of doctors, rather than genuine increases in patient need for services. Without managing this growth, Australia faces a potential oversupply of around 7,000 medical practitioners by 2030.

They are shocking numbers. If members lived in a community outside metropolitan Perth, they would know all too well the difficulty in accessing a GP. Hon Jacqui Boydell told me the other day that in Karratha, one of our larger cities outside of Perth, there was about a six-week wait to see a general practitioner, which is down to four weeks now.

A lot of our communities have either one doctor or no doctor. This regime requires communities to have two doctors prepared to be trained and qualified in voluntary assisted dying and to not be conscientious objectors. If the bill passes with some of the suggested amendments of requiring a specialist doctor of the disease that the patient is likely to die of, or a psychiatric assessment to determine capacity, this, in my view, will only exacerbate these regional and remote access issues, notwithstanding the merits of any proposal, which will be discussed in due course.

Then there is the issue of voluntary assisted dying drugs. I was told at my first briefing that these will be dispensed from tertiary hospitals. Members, there is no such thing outside of Perth. If pursued, this will delay accessing the drug by some considerable days, and I question whether that delay is appropriate.

The minister’s second reading speech mentions “region” and “regional” twice. The first mention is in reference to Hon Colin Holt, a member for the South West Region, and the second was when he made reference to the increased investment in regional palliative care. During the second reading debate and the committee stage of the bill, I will certainly be pursuing, to the extent that I can, how the government anticipates implementing a scheme such as this to ensure that all Western Australians have reasonable access to it.

One issue that I think requires further attention during this debate is the conscientious objection provisions that are clearly outlined in the bill. Obviously, there may be some people who have views on how they ought to be varied, but what is not clear, from my perspective, is when the conscientious objection is of an institution. We have a number of public–private hospitals in Western Australia such as Joondalup Health Campus, Peel Health Campus and St John of God Midland Public Hospital. I understand that St John of God Midland’s contract allows it to object to delivering certain services, but when that contract was designed, it did not anticipate that at some future stage a service such as voluntary assisted dying might exist. I am interested in understanding how the government will deal with these private operators that run public hospitals now whilst they are under contract and into the future when those contracts will be renewed.

In the short time that I have left, I want to draw on some of the feedback that I have received in my electorate office by way of letter. Some of the stories that I have heard have been very personal, on both sides of the debate, and nearly all of them have been very genuine. Obviously, the odd person has rung up and told me their view in 10 words or fewer and then hung up the phone. By and large, they have been very genuine approaches. I am not sure I would go as far as thanking organisations such as Go Gentle Australia for publishing the phone number of my electorate office; nevertheless, it was good to hear from all those people, even if a couple of those calls went to voicemail.

I have an email that I want to read. I have the permission of this lady to refer to her correspondence. In fact, I think many members will have received the same email, so they may be familiar with it. It came from Ms Yvonne Bowey.

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of Kulin. I happen to know Yvonne’s grandmother-in-law, as she describes her in this email, quite well, Mrs Joscelyn Bowey, who lost a long fight a bit earlier this year. This email was received only on Monday this week. Yvonne said —

Dear Members of the Legislative Council,

I have taken to writing this email as I feel so strongly about the urgent need for the VAD legislation to pass. I am currently living and breathing the palliative care system, with my Dad in a regional hospital in the palliative care room. This is on top of watching my Grandmother in Law, battle and lose the same fight recently.

The care that is being given to my Dad is fantastic, but it can not keep up with his pain levels. We are constantly being told that he should not be in pain and the aim is to make him comfortable, but the medication is not keeping up. There is a constant demand for increased medication, which comes as a reaction to pain, not as a preventative. Dad is of very sound mind and it breaks my heart that he is begging to die, his last wish, and we can not accommodate this. For someone who has worked and volunteered all his adult life, he deserves the right to choose to end his suffering.

And this is really what this is about—choice. When (and I hope sincerely this is a when), the legislation exists, people still have choice, whether to use VAD or not. Currently this choice is not available and so many of our loved ones are suffering needlessly. I am tired of legislation being enacted for the minority and not the majority.

I urge you to consult widely within your electorates/communities. I have not heard of anyone in my community that is opposed to this legislation.

Regards

Yvonne Bowey

One of the other pieces of correspondence was from a lady in Geraldton, who said —

I am writing as a member of your electorate to ask you to please represent me in the following way during debate of the above Bill in the Legislative Assembly and Legislative Council this year:

I am in favour of this Bill and would like to see it introduced as soon as possible.

My preference would be that the Bill had extended to include people with advanced, progressive debilitation who also wish for a VAD option—however, I endorse the current Bill.

My 89-year-old mother wrote the letter below as the debilitation of old age gradually eroded her quality of life:

“I believe that it is my choice when I have really had enough of life, and can no longer be reasonably independent for washing, dressing and feeding. It’s only humane to allow me to bring it to an end.

From their beginning, I have joined WAVES* and EXIT* and cannot believe that those in authority for such matters do not have the intelligence, and empathy, and understanding, and respect and decency to permit adult citizens to make their own minds up when it is time to go.

The old argument that legislation would be open to abuse really doesn’t have much weight—every law in the book is open to, and is abused from time to time when circumstances and pressures and opportunities and temptations are there, and daily life goes on for the rest of the population.

From a purely practical financial point of view, keeping thousands of elderly, unwell people artificially chugging along, with nothing to look forward to and no joie de vivre in their everyday lives seems insane.

For those lovely people who do want to keep on going, and get their letter from the Queen, full marks, and huge respect, but when over and over again in every survey that is done, the citizens of this country overwhelmingly (over 80 percent) say YES to VE*, —

I think “VE” is voluntary euthanasia —

surely the aware members of Parliament should get the message from their voters? ”

I’m sure I’ll feel similarly, wishing to be comfortably conscious to the end, and with those I love.

The legal alternatives currently available do not offer the peace and certainty of VAD:

• suicide—with its risk of pain and/or failure and/or trauma for those finding the body;
• dehydrating or starving oneself;
• agreeing to a medically-induced coma during which one’s loved ones wait and watch, sometimes for days/weeks, until one dies.

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The VAD legislation offers a humane, compassionate, dignified and certain end to life. We have the means to provide this via a carefully regulated process. A humane society would endorse its use.

Yours sincerely

Mr Acting President, can I seek leave for an extension of time?

[Leave granted for the member’s time to be extended.]

Hon MARTIN ALDRIDGE: Thank you, members; I have only a couple of moments left.

There were two other letters that I wanted to refer to. One was from a lady in Narrogin, to put a different point of view. She said this —

As my elected representative in the area of Roe, I strongly urge you to reject the Government’s proposed bill in parliament for voluntary euthanasia on my behalf.

I do not believe this to be a safe practice to be introduced to our state, or country. There are too many opportunities for people to be taken advantage of by family members or others encouraging our sick and elderly to go down this path as a convenience. The power of repetitive speech is enormous. (If it is said often enough it must be true.) There is also too much opportunity for “Doctor shopping” to achieve that final outcome—death. I also believe that if this becomes acceptable in our community, over time, there is every opportunity for the parliament to weaken the original laws. How long before this practice is abused and used as legal murder?

A far better option is to support and strengthen our Palliative Care system. As much as we put such emphasis and care and joy in bringing new life into the world, why do we not have the same approach to a life coming to its end? There are so many kind, compassionate and empathetic people in this system already, can we not promote and support them, grow this system, and encourage more people to take advantage of that care? Surely a gentle and loving time spent with family prior to leaving this world is a far better option than suicide. Rather than spend money on researching drugs to help people die, shouldn’t that money be spent on researching drugs to treat pain? Drugs that can be used to treat pain not only for those in the latter stages of life, but also those who live long lives enduring significant pain.

I feel very strongly against this proposed law, and would appreciate your careful consideration of my comments above, and a resulting NO vote on my behalf. I would also appreciate that this correspondence be regarded as confidential …

Obviously, I will not name that constituent.

The last correspondence that I want to refer to is from a family in Mooliabeenee. They wrote —

I write to you to add my voice to the opposition of the legislation I believe you will take part in voting on, in the not to distant future, for the legalization of euthanasia in our great state W.A.

Irrespective of your thoughts on the issue being wrong or right, you represent my thoughts and ideals, as well as all others in our community that you are paid to represent.

For too long now, have we been told time and time again by politicians and the media that the majority of people want this. Well I’m here to call you all out on that. It is irresponsible of all who make that claim and use it as a base to vote on.

I for one do not know a soul I work with, live with or Socialize with That agree euthanasia (assisted Suicide) is good for our community

As former Prime Minister Paul Keating Stated a few years ago, it is, “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.”

In my research into countries that have adopted the practice (some now for quite some time that there is ample research that has been conducted) The “Righteous reasons, Stringent regulations and all other manner of ethical standards it will abide by” soon fall by the wayside and as is the case with it’s initial inception into legislation, the Moral Compass soon spins out of control.

For example, at the moment there are several trials being held in the Netherlands for Doctors who have Euthanized their clients upon a directive that under no circumstances should they (Doctors) not follow through with the directive, even though the patient, when ‘the time has come’, has objected to being Euthanized to the point where they are sedated so they can be.

But this won’t happen in this country will it? No, we are different human beings here that wouldn’t allow that to occur.

Human Life is precious. Why have suicide prevention programmes? Why have aged care facilities? Why worry for human life that may have contributed untold to our society? Life is a gift. It ought to be cherished, nourished, cared for and looked after.

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I detest where our society is heading at the moment, and get quite sickened that our so called leaders, ALWAYS bow to the minority and disregard the majority. This is how so many great nations have fallen over the last 2000 years. It will never cease to stop occurring, until leaders uphold the majority of voices in the community instead of minorities or their own agenda.

I suggest Very Strongly that you fully research this topic where it has been active in other countries around the world, and then form the view that this has no place in the great state of W.A.

There are a multitude of well researched articles by PhD’s, academics and Doctors on the site ‘Care for Life”

In Respect for all Life …

That is signed by that family. I thank those families and many others who wrote to me and often shared quite personal stories that underpin, to some extent, the strong views that they hold on this matter.

Members have expressed many personal stories during this debate. Some have said that they have not been able to express their personal stories, but have had courage for others who have. I have not had much experience of death. I have lost one grandparent. The rest of my family are still alive, so I really do not have a lot of personal experiences to reflect on or draw from. I know that with the loss of my grandfather a couple of years ago, he was somebody who deteriorated over a number of years. He was diagnosed with a cancerous brain tumour and ended up in an aged-care facility. It is interesting that when he went in, he never wanted to leave the deck of the holiday house on the estuary in Dawesville, but once he was in this aged-care facility, we could not get him to leave. We would take him down the street to the Dome cafe to have a coffee, and we would get there and before even the coffee came out, he wanted to go back. He died a couple of years ago. My grandfather was a very religious man. Although I never talked to him about this before he got sick, I think that he would probably have naturally opposed the notion of voluntary assisted dying, but I know that as he went through his illness, he deteriorated over time. Certainly, he reached a point at which he had definitely contemplated suicide and tried to commit suicide. When he had reached that point, he was physically unable to kill himself. I reflect on those conversations. I have no understanding of the extent that my grandfather suffered, because I think he was heavily sedated at the end of his life, where he was cared for quite well at Kalamunda Hospital. My family members who were much closer to my grandfather have expressed to me their experiences from that process and a desire to make sure that what they saw and experienced with my grandfather was not repeated.

I want to draw my contribution to a conclusion and thank the house for the short extension. Arriving at a decision to support the second reading of this bill is one that has not been easy and has not come naturally. It is something that I have genuinely hesitated upon for many months and it is my intention to engage through the Committee of the Whole House stage and examine each of the amendments in the context that I have described to the house tonight in the way that I have approached the consideration of the bill that is before us. Obviously, that does not commit me to supporting any or all of those amendments. Indeed, I reserve my judgement to see what the VAD bill looks like as we approach the third reading stage.

I thank the house for the extended opportunity to speak and I look forward to hearing the remaining contributions of members.

HON KYLE McGINN (Mining and Pastoral) [9.04 pm]: Thank you, Mr Acting President. I am pleased to rise today to make a contribution to the debate on the Voluntary Assisted Dying Bill 2019 before this house. This is a tough bill to talk on and I have no doubt this will be the hardest speech I have done, followed by the hardest vote I have made in this Parliament. People in both the other chamber and in here have spoken about their personal experiences with circumstances in which having access to voluntary assisted dying could potentially have assisted in a more humane death. It has been very powerful and quite sad at times. I have appreciated the strength members have shown by telling their stories and others’ stories.

I thank other members for a largely respectful debate so far on this bill. It has been a very interesting debate so far. I have been learning as I have been listening to each speech and thank members for their contributions. I have pondered the moral question to this bill for many months and have ensured that I sought information from both sides of the debate so that I would form my own view with a well-informed background and have a good cross-section of information as a foundation to form my view. I have not only done research for my own personal view, but also surveyed my constituency, focusing on the North West Central electorate and the Kalgoorlie electorate, where I am based. I came into this research with the knowledge that this subject is very emotional for people. Frankly, I had not had any experience in this area until engaging in the discussion. Although I did lose my grandfather in recent years, he was in Victoria and I did not find myself confronting the challenges he faced while dying. I have been very fortunate, and I have not had someone in close proximity to me die slowly from a terminal illness.

During the 2017 state election, I was well aware of many election commitments the McGowan Labor team had made. Since coming to government, we have been working hard delivering on those commitments. Along with other members in this chamber, we have been getting through a lot of legislation, making positive change for our communities. This VAD legislation was not part of the election, however. Instead, it has come from public opinion, so I was not fully prepared for it. I am 31 years old and, touch wood, have not had many situations involving the
death of a loved one, which means I have not spent a lot of time thinking about death and the circumstances around
dying from a terminal illness. Sadly, last week I did have to face death when I lost my beautiful Aunty Judy McGinn
in a very unfortunate circumstance that surprised us all. Please just give me a moment to give my condolences to
my cousins, Judy’s son, Daniel, and daughter, Hannah, and my uncle, the love of her life, Uncle Mal. My thoughts
are with you all.

Not having been in a situation in which I have seen the pain people face at the end of their life, I really wanted to
get out and seek the views of my electorate, the medical professionals and other people who understood the issue.
Not only did I do a survey, I also met with people on both sides of the debate, including people who were undecided
on the legislation but had personal experiences of loved ones who had terminal illnesses. One of the main eye-opening
experiences for me was when I visited the Goldfields Regional Palliative Care Service and spoke with the staff
there in two of the rooms. I learnt more about what palliative care is and how critical a role it plays in end-of-life
care in that one day than I had in my entire life. The staff were amazing and showed me a class of professionalism
that left me in awe of what they do to make the end of life for patients the best they can.

Something that struck me from the discussion in the unit and through my survey was the lack of in-home care in
my Kalgoorlie region. It has been causing people to have to leave their homes and family to come to Perth, with
the cost of travel expenses and stress, or to end up in the palliative care unit in Kalgoorlie. They would end up in
the unit well before they were supposed to be there. That puts a lot of unfair pressure on the system and also unfair
stress upon the patient. This must be improved, as regional people deserve the right to be treated at home at the
end of their lives. Many people right across my electorate, and across other areas in regional WA, choose to live
in their town, and they should also be able to choose to die in their town if they want to as well. We have towns of
all sizes where we are upgrading facilities and improving services to try to give people the option to stay where
they want to be. In-home care is a critical health need for regional people. They deserve to be able to access the
same quality health care as people in the metropolitan area.

Last week, the government announced an additional 8.35 full-time equivalent palliative care positions for the
region as part of a new specialist district palliative care team for the goldfields. A total of $3.6 million has been
earmarked for the goldfields and is set to include the establishment of special district palliative care teams
comprising medical, nursing, allied health and Aboriginal health workers. Palliative care patients in the goldfields
who wish to die at home are now set to access 24-hour nursing care by community-based nursing and telehealth.
I was extremely pleased to see this announcement for funding across my entire electorate, with a $4.4 million
investment in the Kimberley for an additional 9.95 full-time equivalent nurses; $4 million for the midwest and
Gascoyne area for an additional 10.85 full-time equivalents; and $4.9 million for the Pilbara, which is an additional
11.8 full-time equivalents. This announcement is in addition to the funding already allocated to this area, bringing
the total investment by the state government for palliative care to $224 million over four years.

Something that has been mentioned in this debate in both chambers is how this bill will affect Aboriginal and Torres Strait Islander people. They already struggle with the health system as it is. I have had, and still have, fears
that this legislation could be used in some way to unfairly disadvantage Indigenous people. I have raised these
cconcerns with the government and have told many people that this cannot be another thing that causes problems
and potentially wrongful deaths. We must ensure that extra protections are in place to make it clear that there will
be no unfair barriers for our First Nations people. When they access health care, they should be accessing health
care with trust that the healthcare system will look after them.

We have many excellent nurses and health professionals working across this state. I have the strong belief that we
need, without question, a navigator through the VAD system to help Indigenous people. This position must be
filled by an Indigenous person. I do not want to hear “culturally competent”. Too many times we see someone
come into the system to look after Indigenous people who has come from Perth and has done a cultural course
here, and ends up out on the lands and in the communities but does not understand the culture that they are dealing
with. What comes with that is stress, problems, and—I hate to say it—probably mistakes. An Indigenous person
will understand the cultural challenges and language barriers, and will be a person whom the patient can trust.
I acknowledge that this role must not be joined with palliative care, because I do not want to see a crossover between
the two. They have to remain separate. I believe this role will help ensure that we do not see anyone slip through
the gaps in this legislation, as I do not want to see a wrongful death result from this bill. I believe that if we do not
help the most vulnerable, as many members have said, then what are we here for? It is a must for me that there is
a commitment to this role in all regions across my electorate. I have had and heard discussions in this chamber
about the implementation stage and how that will roll out into regional areas. I have concerns that it does not state
in the bill that there will be an Indigenous navigator in the regions across my electorate. I hope the government
can explain to me how it will roll this out and assure the house that there will be an Indigenous navigator across
my electorate in each region.

I have also approached my role as a member of the Legislative Council representing the Mining and Pastoral Region
with the goal of having, to the best of my ability, an open door to my community and asking them what they feel
about the issues we face. Politicians constantly get attacked for failing to do this. Regardless of how my record
will be remembered in this house, I want to keep that promise to myself and know that I have done everything

Extracted from finalised Hansard
I can to keep my open-door policy to my community. This is why my survey on VAD was a no-brainer. Some people tried to warn me that, being a very emotional issue, it could be a bad idea to survey the electorate. I knew there would be some angry responses, but I was still confident people would appreciate being given the opportunity to take part in this process.

Thousands of surveys went out to every constituent in the Kalgoorlie and North West Central areas. I decided on those two areas because they are where I spend most of my time, and that is all I had at the time in the way of resources. I got back around 600 responses. My staff had to get rid of a couple of responses that were just blank except for some lovely drawings on my face! I will not explain what they put on there, but it was not very nice. Thank you to the constituents who took the time to share their views and write considered responses.

I have read through these surveys many times. Each time I get to the end, I find myself feeling many emotions—most of all, very sad. I would love to read every response to the chamber tonight but it would take a lot of time to do so. I will read out some that summarise some of the ideas presented. Tonight I will read an equal amount of yes and no responses to try to give a balanced view. Before I start, I must say that I had heard the general response and knew the result would probably come out as a yes in support of the legislation. The percentage split was extremely strong. The result was 80 per cent yes and 20 per cent no. I will say that for both sides—yes and no—palliative care was mentioned, and it was mentioned as a key thing that must be improved, which I believe we have taken important steps to resolve, and I believe the government is committed to continuing to work in that space to make it better into the future.

Something else that was raised both in the survey and in many meetings in my office was how the legislation would affect Aboriginal and Torres Strait Islander people. That was raised in meetings, through emails and across my survey. The survey sent out asked, “Would you support a bill legalising voluntary assisted dying?” I printed the link to the “My Life, My Choice” report from the Joint Select Committee on End of Life Choices. After the question, there was the option to tick beside yes or no, and it also included a blank space to write further comments. I will read out some of the responses from the survey—the stories from the Mining and Pastoral electorate. Some of these responses have been shortened from the full submission written or have been edited for clarity, but they have not been changed from their original meaning. According to my notes, the responses were—

YES—There needs to be safeguards to ensure those making the decision for themselves are of sound mind. This might look like having counselling before the decision. There should also be protections to ensure there is no pressure or encouragement to access assisted dying.

NO—I have been reading about elder abuse and it did not shock or surprise me as our society seems to have screwed values. We weep for murderers who receive a capital punishment sentence yet, are quite unconcerned about putting aging grandma ‘to sleep’. Thank you for seeking the opinion of a voter.

YES—My mum was terminally ill. As her health deteriorated, she couldn’t do anything herself, even eat. She didn’t want us to see her or remember her like this, after all she was the main person who kept the house and family together. Knowing she wasn’t getting better, she didn’t want to live and kept suffering until her body gave up. How cruel is that??

NO—You want my opinion then this is it, life is very precious. We’re all born into the world naturally unless you’re born with IVF assistance, and so we should all die naturally when our time is up, pain and all without having some opinionated doctors and people coming in to speed up the process. If you’re a very sick person and that’s what you want, bad luck, let nature take its course. Otherwise you’re opening the door for family members and health professionals to control your life.

YES—I would fully support it as long as the legislation covered all aspects. There are many in nursing homes with no known family who would think it was beneficial. But only if they are capable of making the decision themselves — if incapable, NO!!

NO—First abortion, now this. Emotion is now being used to opening the gates to killing the most vulnerable.

YES—Dear Kyle, my mum is 96 and does not want to be here anymore, she has asked the doctor to put her to sleep but he said no, I hope one day Kyle you can help, so she can have her say.

NO—Suicide should be prevented, not a treatment option. Please put more funding into palliative care, instead of encouraging suicide. I appreciate that you have sought our opinions on this issue.

YES—When you have family who has cancer, watching them turn into a pain ridden skeletal version of themselves is incredibly hard for them and the family. Make it about choice.

NO—Voluntary assisted dying is suicide. War, famine and disease claim enough lives as it is so why would we allow suicide to claim anymore? The Australian Government support various suicide prevention programs, yet this bill may potentially legalise suicide. Why would the Australian Government and its representatives knowingly support any form of killing? Genocide, murder and voluntary assisted

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dying AKA suicide, all result in the extermination of life. We should be preserving life, not destroying it. There are always alternatives and it’s the Government’s responsibility and duty to explore every possible avenue, as death is not an option.

YES—It’s about time our representatives do what the majority of people of the State want, not what they personally believe.

As members can tell, there are some very emotional responses. I believe it is critical to get these on record because they come straight from the Mining and Pastoral Region electorate. According to my notes, the responses continue —

NO—First they came for the socialists and I did not speak out because I was not a socialist. Then they came for the Jews and I did not speak out because I was not a Jew. Then they came for the trade unionists and I did not speak out because I was not a trade unionist. Then they came for me and there was no one to speak out for me.

YES—After 10 years of chemotherapy—my husband wanted this choice—but after seeing the work of the palliative care team—I also feel this is an option that should be utilised more.

NO—Thank you Kyle for taking time and spending the money to conduct this survey. I trust you received plenty of responses. I cannot support such a bill as I believe life is God-giver and is in His hands according to the words of the Apostle Paul. “Do you not know that you are a temple of God and the Spirit of God dwells in you … that you are not your own.” Corinthians 6:19,20

YES—My life; my choice. I do not believe that people should be condemned to live beyond the life span that they feel comfortable with. In particular, people suffering from medical conditions that reduce the quality of life.

NO—Life belongs to God, he alone has the right to take it. Gen 2:7 and the lord formed man out of the dust of the ground, and breathed into his nostrils the breath of life, and man became  a living being. Euthanasia is murder. Murder is intentional wanton taking of someone’s life. Ex 20:13 You shall not murder. This is a commandment directed at the sanctity of life. Pain, tax & death are all part of life … those died before us were not murdered, why are people going to be routinely killed. Government is not the owner of life.

YES—I watched my mum first die from a long battle with stomach and bowel cancer. Then my dad didn’t want to be here after that, then with dementia he starved himself to death and that was awful.

NO—“For to ask someone else to do the unthinkable in the name of mercy and compassion is to shift the burden of responsibility to other shoulders and to invite another person to bear the guilt. As for asking medical personnel to bear that guilt — anathemia! All its ethics are devoted to the preservati on of life.” Australian author Colleen McCullough address given at Parliament House. My sentiments exactly. Thank you for giving me a chance to voice my opinion.

The following response states, according to my notes —

YES—The decision to end one’s life because of much pain and suffering caused by an incurable disease or disability should be the right of every mature adult in Australia. This right should not be used as a political football!

This next one I thought was quite interesting; it sort of sums up how views can be very different —

YES/NO—My vote is yes, my husband’s vote is no, Sorry for stalemate!!!

I thought that was quite interesting! I am sure they have a very interesting household and plenty of debates. The responses continue, according to my notes —

NO—We are sending a double message to our young people. We are telling them not to commit suicide but then saying it’s OK to take life when it gets old and difficult. This is a dangerous bill. In the countries where it is legal, abuses have occurred and “safeguards” have meant nothing.

YES—My husband recently passed away from cancer. It was cruel to watch.

NO—As a registered trained nurse with 45 years’ experience, I cannot nominate any one time I may have even considered the possibility. There is always something a thoughtful person can do without such drastic (and SINFUL) actions.

YES—Please, please pass this Bill. As a registered nurse I know that many people suffer uncomfortable deaths despite the best palliative care. As a daughter I suffered with my mother as she begged me to help her end it all as she gasped for breath for 6 weeks.

NO—I urge you to vote against the Voluntary Assisted Dying Bill. This bill will place elderly and vulnerable Western Australians at risk. The bill says that patients are at no point obliged to continue with

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the “assisted dying” process but a mere written guarantee can’t contend with the subtle coercive influence of family members and hospital officials with strong financial incentives to relieve themselves of the “burden” of the sick or elderly.

YES—For anyone who has lost loved ones to terminal illness, this is a no-brainer. I suggest you go visit the palliative care unit at Kalgoorlie Hospital. If that doesn’t make up your mind nothing will.

I did go and visit that palliative care unit after reading that response —

NO—Only GodHaters would agree to this and they/you will answer to God for it! “Woe unto them that decree unrighteous decrees...!!

That wording is just too much for me —

“Woe unto them that call evil God, and Good evil...” Is 5:20. “He who justifies the wicked and he who condemns the just, both of them are an abomination to the Lord.” … “He who is not with me, is against me” Matt 12:30. “It is a fearful thing to fall into the hands of the living God!” Heb 10:31.

YES—My children have already been told I do not wish to be revived, should I not be able to tell the nursing staff myself, they must let me go. I do not want my family to see me dying slowly.

NO—I work in health and have done so for 40 years. I have helped hundreds of thousands of people live a meaningful and comfortable life to their natural death. Palliative care works.

YES—We also support: increased mental health services in regional areas, palliative care outside of metro areas, variety of high-quality in-home aged care services, better Centrelink benefits for carers, natural burial and other innovative post-death options.

NO—I wish to register my opposition to the bill to allow voluntary assisted suicide. All West Australians should have full access to quality palliative care before they need to make the choice to try suicide. Suicide is an act of desperation that no one should feel forced into because they don’t have access to other options. Is the bottom line that it’s actually cheaper to allow people to kill themselves rather than to treat them properly?

YES—Having watched both my parents die slowly with no dignity I sincerely wish that my children do not have to witness the same excruciatingly painful end of my life. It’s really important to my family and friends that this option is there if ever needed. Having seen people having to suffer at the end of their lives is heartbreaking—especially if palliative care options are not working for them.

NO—Dear Kyle, “Would I support a bill legalising voluntary assisted dying?” The question presupposes that death is a possibility; and as there is no evidence in existence that beings actually die, this makes asking the question a nonsensical exercise.

That was an interesting one to understand! My notes continue —

YES—Don’t let your religion or views affect the outcomes for people who do not hold those same views. If you do not want to use VAD in the future then you certainly won’t have to. That should not mean that I can’t use it!

NO—I would NOT support a bill legalising voluntary assisted dying. I ask you to focus your attention on improving palliative care availability for all Western Australians. Better palliative care options will really improve end-of-life choices, whilst legalised euthanasia and assisted suicide will only result in more coercion of the elderly and less real choice.

YES—My Aunty died 8 years ago after a very long and distressing death. She had refused medication and food, as she wanted to end her life. It was terrible to watch her suffer, there was nothing peaceful about it. I myself had breast cancer 18 years ago, and if I’m ever faced with the reality it has returned. I want the option to die at home with my family around me, when I feel like the time is right for me. Please vote for voluntary assisted dying and not stop me from having MY CHOICE. Thanking you in anticipation.

Members, those are just a few of the responses I have received, and my staff have said that, especially in the last few weeks, we have seen another flood of letters in the post, emails and phone calls to my electorate office. As members can see, I meant it: when I read through all these responses, at the end of it I felt emotionally broken. For someone who has not experienced much, I am absolutely grateful that I took the time to survey those two electorates to get a sample of their stories and what they want to see me do. It is simple for us to say that we understand our electorates and are in touch; it is another thing when we get the responses and they are sort of what you thought the electorate was thinking. Everyone has spoken about 80 per cent yes, 20 per cent no, and that is the exact result that I got. This is very clearly an issue that people feel passionately about. Members, I hope everyone can understand what a powerful response it was and continues to be for my electorate. I would like to thank all the people who took the opportunity and the time to contact me with their views and have helped to guide me through this very tough decision to ensure I make a decision that I can live with.

Extracted from finalised Hansard
I would also like to mention that I have some aunties who are nurses. One of my aunties, my Aunty Janette, is a specialist palliative care nurse in Victoria. I have spoken with her about what she believes she would do in this situation. She said that she fully supports voluntary assisted dying after working in the industry for that long. I have taken that on board. I have also spoken to my sister, Caddie. Caddie has been working as an assistant nurse for 11 years in aged care, in three different states, in six different workplaces, ranging from nursing facilities to hostels, and has also worked for eight months in a remote community off Darwin. It has always been hard for her to care for residents who no longer want to live due to terminal illness—these are her words: “Having suffered a stroke, they may be unable to feed themselves, wash themselves or do normal day-to-day activities.” Just recently, she cared for a lady who was 90 years old and was diagnosed with emphysema and chronic obstructive pulmonary disease—COPD. She had smoked heavily for 50 years and she needed oxygen 24 hours a day, seven days a week, for the rest of her life. Without it, she could not breathe and would gasp for air. When Caddie used to attend to her cares, she could not do much, due to being exhausted from any movement such as putting on her shoes or pulling up her pants. At the last stages of her COPD she asked Caddie and her family continuously, “Please help me die. This is not living.” Caddie is a firm believer in voluntary assisted dying, if monitored very closely and in consultation with a doctor. She just thinks you should be able to die with dignity.

I will share one last story from a constituent of mine, and then I will return to my seat. This story is from Angie Miller from Kalgoorlie–Boulder. I met Angie at a get-together in Kalgoorlie that welcomed the arrival of Belinda Teh, who walked across Australia from Melbourne to deliver her message to the WA Parliament. I must say that Belinda is a really amazing person and has shown me true passion for her beliefs. I think she has done amazing work in her advocacy in this space. These are the words of Angie, according to my notes—

“My father Dusty Miller was a Vietnam Veteran and founder of the now iconic Birdsville Bakery. In August 2017 just as he had retired, Dad was diagnosed with stage 4 Bladder cancer. Dad fought hard and went through all treatment options, including having his bladder removed. During a brief reprieve from the cancer, Dad bought his dream house along with his dream boat. Dad had a lot to live for. Yet, his cancer returned very quickly, along with multiple other health complications. Due to Dad’s allergy to morphine and other traditional pain relief, doctor’s struggled to find pain medication that was suitable for his needs. During one hospital stay while Doctors were experimenting with different pain relief, Dad would see bugs crawling on the walls, amongst other things. These of course were hallucinations. Countless times throughout the day and with numerous tubes attached to him Dad would try to get out of his bed and leave the hospital. He would yell at me as I would have to stop him and tell him to get back into his bed. Finally the doctors found a rarely used liquid morphine suitable for Dad.

Although his sanity returned it made him drowsy and all he did was sleep. Dad was sent home yet his complications continued to grow. Knowing that medical intervention could not prolong his life and in acute constant pain, my Dad repeatedly asked for assistance from medical staff to end his life. He was always met with the same answer—“we can’t”. Dad announced on at least two occasions that he was going to starve himself. It broke my heart that it was coming to this and this was how I was going to watch him die. However, Dad’s love of food was so strong and perhaps his last pleasure that he just couldn’t do it.

Because Dad slept so much and his body lay motionless he developed a blood clot. I called the ambulance and while we waited half an hour for it to arrive Dad howled in pain and also cried out “this is a blessing as this will finish me off quicker”. When the ambulance finally got there the paramedics had to get permission from senior staff to administer the green whistle. This was because of my Dad’s allergies to pain relief. This was more time in intense pain. While waiting Dad was begging the paramedics to put him on the pump. What he was referring to is the medication pump used for patients right at the end of life and are beyond ingesting medication. Dad wanted out even if it meant being put into an induced coma. I am still haunted by one meeting with a palliative care nurse and locum doctor. Still begging for his life to end, the palliative care nurse asked “why don’t you want to prolong your life”? Dad, while crying replied “because I have no quality of life—if I had a knife on this table in front of me I would take it and push it through my heart.” Dad went on to explain that he would have killed himself by now but he didn’t want his children to find the mess. Their response was still “we can’t”.

Ultimately the treatment for the blood clot just lead to further complications where Dad ended up bleeding profusely into the bag which was the replacement for his bladder. Two days later when the doctors decided to slowly increase his morphine, the nurses tried to move Dad’s body to reduce the chance of bed sores. In pain, Dad yelled out “no, no, no, no”. A few hours later Dad passed away. He did not die at home with dignity like he wanted. I know that if a Voluntary Assisted Dying Law existed my Father’s prolonged suffering could have been avoided.”

Thank you, Angie, for allowing me to share that story. It is very sad. After lots of research and looking into the issue in my electorate and taking this matter very seriously, I give my support to the second reading of this bill. I am looking forward to the Committee of the Whole stage to go through the bill. I will withhold my right to vote on the third reading until after the Committee of the Whole to see what amendments pass.

Extracted from finalised Hansard
I was fairly young at that point—I like to think—I remember having a number of discussions with family, friends. Marshall Perron introduced the Rights of the Terminally Ill Bill into the Northern Territory Parliament. Although voluntary assisted dying since I first remember it being debated in the news, which was, I believe, in 1995 when I was fairly young at that point—I like to think—I remember having a number of discussions with family, friends and other people in the community, and watching the debate unfold over its brief period of enactment, I suppose we would say. That helped to shape my view in support of voluntary assisted dying. In fact, the Northern Territory was the first jurisdiction in the world to explicitly legalise assisted dying when that bill became law on 1 July 1996.

As others have done, I will cite some personal examples and correspondence from constituents and others, as difficult as that may be at times. But I think it is important to get that on the record to understand the various views and experience on this issue that are out there that I and others close to me have had.

I will state from the outset that I wholeheartedly support the voluntary assisted dying. I have been a supporter of voluntary assisted dying since I first remember it being debated in the news, which was, I believe, in 1995 when Marshall Perron introduced the Rights of the Terminally Ill Bill into the Northern Territory Parliament. Although I was fairly young at that point—I like to think—I remember having a number of discussions with family, friends and other people in the community, and watching the debate unfold over its brief period of enactment, I suppose we would say. That helped to shape my view in support of voluntary assisted dying. In fact, the Northern Territory was the first jurisdiction in the world to explicitly legalise assisted dying when that bill became law on 1 July 1996.

As we know, in 1997, the Commonwealth Parliament intervened and overturned the act by introducing section 50A to the Northern Territory (Self-Government) Act 1978, which prohibited the Northern Territory from making laws about assisted dying. At the same time, the Australian Parliament amended similar bills for the Australian Capital Territory and Norfolk Island, also removing their ability to legislate for this issue. The introduction of the legislation in the Northern Territory was not without controversy, of course, but it passed with a vote of 15 to 10. In August 1996, a repeal bill was brought before the NT Parliament, but that too was voted down 14 to 11. The legislation introduced in the Northern Territory 24 years ago was different from the legislation we are debating in Western Australia. However different that legislation was, its ultimate intent was the same—to provide people who are suffering from a terminal illness a choice to go gently, compassionately, and to end their suffering.

Before I get further into my contribution, I want to take the time to acknowledge all the members of the Joint Select Committee on End of Life Choices, the Ministerial Expert Panel on Voluntary Assisted Dying and all the staff associated with those entities for the work they have done, which has greatly helped to inform us all, regardless of our views, and to help shape this bill. I would also like to thank all the people who have emailed me, written to me and spoken to me around the electorate. I respect the views of all of them, regardless of their support or otherwise for voluntary assisted dying or for this bill. I also want to take the time to thank Andrew Denton and Joey Armenti from Go Gentle Australia, who have done an amazing amount of work, and met with many members of this place and the other. I am grateful for their work and also for their boundless compassion towards other people. To all the members who have spoken in this place and in the other, and whose contribution is yet to come, of course, I think the respect that we have all been able to show in this debate, in both places, has been outstanding, as other members have acknowledged. I expect that the debate in this place, particularly during the committee stage, will be lengthy and necessarily comprehensive, as it absolutely must be when we are debating something so important and significant.

I want to talk a little bit about the electorate that I represent. It is an honour to represent the vast and diverse Agricultural Region, which is made up of the Legislative Assembly districts of the Central Wheatbelt, Geraldton, Moore and Roe and covers some 281,246 square kilometres from Kalbarri in the north to Esperance in the south east. It is a very diverse region, and that is to be expected of a region of that size. Some parts of the region are driven by tourism; others rely on mining. Agriculture, of course, is very important throughout the region, as are exports. But all the people and all the communities in that region are united in their passion to make their communities as vibrant as they can be. There are just over 101,000 voters in the electorate, with a median age of 43 years, which is seven years older than the average age of 36 years in Western Australia. Fifteen per cent of people in the electorate were born overseas and 5.9 per cent are Aboriginal or Torres Strait Islander.

I read with interest some data on the emerging age groups in the electorate, as it helps to understand how that may impact on what we might expect the views of people in that region to be. The largest changes in the structure of the age of those in the Agricultural Region occurred between 2011 and 2016. Debate adjourned, pursuant to standing orders.

Extracted from finalised Hansard
When the house adjourned last night, I had been reflecting on some of the statistics in the region that I represent, the Agricultural Region, and talking about the demographics in conjunction with some polling, which I will go on to in a minute. I was saying that the demographics in the age group of 60 to 69 had increased in the period 2011 to 2016 by just over 3,500 people. Indeed, the number of people aged between 70 and 84 years also increased by 2,700-odd in that time; whereas, the population aged between 35 and 49 had decreased by 2,400 people. That shows there is an ageing population in that part of the state. One might imagine that an ageing population would reflect different views on issues such as voluntary assisted dying, but the polling in my electorate and in others is consistent across the state; that is, support for voluntary assisted dying in the community is very strong. In fact, in the Agricultural Region, 80.9 per cent of constituents support voluntary assisted dying, while 13.9 per cent of people are opposed to it.

The survey by Go Gentle Australia, which is the polling I have been referring to, asked a number of questions around the issue. Overall, it found that around the state there is 81.6 per cent support for it. I know that other members have referred to this, but it is important that we reflect on community sentiment on this issue.

When people in the Agricultural Region were asked whether a person with a terminal illness should be allowed to get a doctor to end their life, 83.1 per cent supported that statement and 81 per cent of people across WA supported that statement. Again, despite the changing demographics in my part of the world, there is strong support for voluntary assisted dying, and strong support for two independent doctors as a sufficient safeguard, with 72 per cent—that is, nearly three in four people who are saying yes. Again, the strength of the support for voluntary assisted dying right across the state, no matter where people live, is compelling.

I want to talk about some of the correspondence I have received. I will not read a great deal of that correspondence but I want to thank the individuals, not-for-profit groups and others who wrote or emailed or to whom I spoke around the electorate over the last couple of years while we have been talking about this issue, and especially in this last year. People have shared a lot of very personal experiences, as other members would be fully aware, and have also very strongly reflected their views on both sides of the spectrum. I have to say that, as other members have said, the strength of support for voluntary assisted dying has certainly been reflected in the conversations that I have had with people around the electorate. It has been reflected in conversations I have had with families and friends as well. I think that that obviously aligns with the polling that has been done too.

I just want to read a couple of short stories I have received. The first is from my old flying instructor who taught me to fly in the mid-2000s, Dick Welbon, and his lovely wife Dianna, from Esperance. It is a very brief but poignant email. Dick just says —

Colin,

I just want you to be aware that both Dianna and myself support the VAD bill as do many of our friends and my family. Although my parents pass away in relative peace Dianna’s Father was a very different story. In his 80s his body deteriorated and over a long period of time he could do NOTHING … He pleaded many times to be allowed to die You can imagine the effect on his wide family and the nursing staff as well I don’t doubt.

We ask that you support this bill and persuade your colleges to do likewise.

Dick and his wife are lovely, very intelligent and considered people. They are not necessarily people who I personally would have thought may have had that view on voluntary assisted dying. Nonetheless, they have certainly reflected their overwhelming support for it and I think that certainly needs to be considered.

I also received, among other correspondence, correspondence from doctors in favour of assisted dying, in particular Doctors for Assisted Dying Choice. I refer to a couple of things that it said in its correspondence, which I am sure all members have received. I quote the letter —

There is far more support for VAD legislation amongst doctors than is commonly supposed. Even the 2016 AMA survey revealed that 51.5% of responding members were in support of, not against, assisted dying A survey by Australian Doctor in the same year found 65% of doctors were in favour of VAD.
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 death. 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 the dying.

On careful analysis, we believe the Bill before the House is excellent. It is undoubtedly the safest of its type ever put before a legislature. 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 important to know that doctors genuinely support, and from all accounts the majority of doctors genuinely support, this legislation and think that this bill is good. It is absolutely important that we understand that.

One piece of correspondence that I received referred to the conscience vote. I think it is important for members particularly to reflect on what a conscience vote is. I said earlier in my contribution that I support voluntary assisted dying and I have done for some years, but in exercising a conscience vote, regardless of my view—mind you, it obviously reflects the views of my constituents—if the majority of my constituents did not want this, it would certainly be a much more difficult decision for me to support this legislation. I will not name the correspondent who wrote this letter, but they have said the following things that I think are important—

All three generations of our family support the proposed law on voluntary assisted dying. We are writing to ask you to vote in favour of that law.

They go on to talk a little bit about a conscience vote and what it means. I found their explanation, or definition if we want to call it that, very interesting. I will quote from this letter—

The term ‘conscience vote’ is a misleading one. The moral connotations of ‘conscience’ can lead to the false assumption that parliamentarians have a right to vote according to their own personal moral beliefs in defiance of what their electorates want. A better term is the one used in Canada—‘free vote’. A conscience vote simply means parliamentarians are free, for once, from voting as their party decides. It does not mean they are free from the responsibility of representing their electorate. Conscience is indeed involved in a conscience vote but what that conscience says is, “As an elected representative in a democracy, it would be wrong to vote against what a substantial majority of your electors have made it absolutely clear they want. To vote against the clearly expressed wishes of your electorate would be a betrayal of what democracy stands for.”

I think that that opinion, or definition if you like, from that correspondent about a conscience vote is very pertinent, because decisions like this weigh heavily on your conscience. Giving parliamentarians a conscience or free vote—whatever we want to call it—might sound in theory as though it makes things easy, but it actually makes it very difficult, because we have to think very carefully about what we are supporting and why, and also very much consider the views of our electorates and the people at large in Western Australia. This correspondent makes a very prudent point. As I said before, although I support voluntary assisted dying, I am still duty bound to reflect the wishes of my electorate, and that is certainly my intention with this bill.

I will go on to talk a little about some of my experiences with death and illness. Like many others who have spoken in this debate, I have not had a personal experience of someone close to me reaching their end of life in the awful way that so many people who have shared their stories have. I will talk about my grandfather, who was very healthy and pretty active right until the moment he passed away in 2012. He was one hundred and a half at the time he died. He was still driving out to the farm and “helping” until he was well into his 90s and he was fencing until he was in his late 90s. It was good to have him out there. It kept us busy anyway!

Hon Robin Scott: Supervising!

Hon COLIN de GRUSSA: “Supervising” is probably a good word, Hon Robin Scott! In 2012, sadly, he had a fall and broke his hip. At that stage, he was in a nursing home. He had surgery in Perth and they did a great job, but, unfortunately, as a result of the surgery, he had other complications, including kidney failure. He lay in hospital for a week with failing kidneys and he was not allowed to drink anything. He deteriorated pretty quickly and passed away during that week. I could say that that was a relatively gentle passage beyond this world. I know that our family was grateful that he did not have to suffer extensively during his passing, but I contrast that with a story that Jenny Rickerby has given me permission to read about her parents, Jim and Joy Jarratt. I will read this out because it is pretty important—

Jim and Joy, my parents

My Mum and Dad, Joy and Jim Jarratt, were fit, healthy people and active all their lives. They lived in Albany and were involved community members. They loved to fish. They’d go out and catch fish all the time, off the beach and the rocks. Mum had allergies and had a special diet. Catching her own fish was the only way she knew what she got was okay for her. They kept fishing until virtually they couldn’t, which was in the last year or six months of their lives.

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Mum got ill first, in 2012. She had breast cancer and had chemotherapy and radiation treatment in Perth. She came back to Albany and then they discovered the cancer had gone into her bones. She ended up going into hospice in Albany about January, 2013.

Albany Hospice is a wonderful institution and it does a fantastic job —

She spent about five weeks there before she passed away a couple of days after her 83rd birthday.

To start with Mum refused to take pain killers because she was allergic to morphine. She spent the first two weeks in agony. She’d get a burning sensation in her feet and it would work all the way up through her body and she felt like she was on fire and she’d be saying ‘Oh no, oh no, oh no’. Eventually they convinced her to have painkillers with anti-nausea medication. It did make her a bit sick but at least she wasn’t so much in pain. They were fantastic at the hospice.

…

Mum would have liked the option of assisted dying. She didn’t want to go through the torment of what she was going through.

Dad died in February 2016, seven days before the anniversary of Mum’s death. He had skin cancer and they’d been treating him for it. He’d lost most of his right ear. While looking for the cancer in his body they discovered an aneurism in his stomach. In July 2015 he had an operation in Perth for treating aneurisms that only a few people had even tried to have in Australia. It was successful but it created other medical problems. After the operation he got an infection and he said, ‘I don’t want to be here’.

He was having radiation treatment for the cancer at Sir Charles Gairdner Hospital in Perth and staying at Crawford Lodge. He didn’t really want the treatment and they more or less insisted he keep on. He would walk over for treatment and there was no one at reception to see him. He would just go in, be treated and walk back to the lodge. Because they were treating his face, they burnt all the inside of his mouth and he wasn’t able to eat or drink. They didn’t stop until Dad collapsed in the waiting area and my sister went up and said ‘What the hell’s going on here?’ There was no one at the clinic keeping tabs on him—and Dad wouldn’t say anything.

Dad ended up being admitted to SCGH. My other sister and I came up from Albany to see him and we didn’t recognise him. He was skinny to start with and he’d lost even more weight in just a couple of weeks. They moved him to palliative care at Bethesda Hospital and he was there for two weeks.

He was able to eat a bit by this stage, but he’d decided he was going to die. He basically starved himself to death.

He was 85.

In 2009 my husband was in a motor bike accident in Thailand and had massive bleeding on his brain. They were keeping him alive, but there was no point. As a family we decided to turn off the life support. We knew that’s what he would have wanted.

Jenny goes on to say —

Everyone should have dignity in dying. If a person is not functioning and they are just being kept alive for the sake of it, what’s the point? I believe ‘Do unto others as you would have others do unto you’.

That story from Jenny Rickerby is a contrast with the experience that my family had with my grandfather. It is important that we understand the very human nature of the suffering that people go through.

I want to talk a little bit about the human aspect and what goes through a person’s mind when they are diagnosed with a potentially serious illness. I will talk about that from a very personal point of view. What is it like for those who are given a diagnosis of cancer or some other serious disease and what thoughts go through their mind and those of their family members? I can tell members from my experience that it is unlike anything else. The fear and uncertainty that surrounds you the moment your surgeon calls you in and says, “I’ve got some very bad news” is absolutely terrifying. That happened to me in March 2015 when I was told that I had stage 3 metastatic melanoma after having a mole removed from my left foot and a subsequent biopsy.

The small room that the surgeon had taken me into basically swallowed me up. Because I believed I was fine, I had gone up to Perth on my own and had left the family at home. Making those calls to your wife and your kids, who are pretty young, is incredibly difficult. Of course, while you are having those conversations and going through that experience, coming with all of that are the questions: What happens next? What are my options? What happens if I get to the point at which this is terminal? What happens if I have to go through rounds and rounds of chemotherapy and radiation, as so many other people have done, and we cannot beat this? As someone who had contemplated voluntary assisted dying as a tool for those suffering terminal illnesses, that obviously came into my thoughts. It was an option that I obviously did not want at that point in time, but I wanted to know that at the end of the day, if all else failed, I would have a choice.

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I cannot accept that. No matter how good palliative care is, no matter how much it is funded—I obviously welcome against voluntary assisted dying is that there would be no need for it if only palliative care were properly resourced. In fact, Australia has one of the best palliative care systems in the world. A consistent argument experiences of over 22,000 patients nationally and found that two per cent of patients in the terminal phase suffered best efforts of palliative care. A 2018 report by Palliative Care Australia included an analysis of the palliative care carers, coroners and first responders, testify to the extreme suffering some people experience as they die, despite the any increase in funding or any additional funding for palliative care services—sometimes, for some people, palliative care is not enough. Palliative Care Australia, doctors surveyed by the Australian Medical Association, inquiries held here in Western Australia and in Victoria, and testimonies, including heartbreaking testimonies from experts, families, carers, coroners and first responders, testify to the extreme suffering some people experience as they die, despite the best efforts of palliative care. A 2018 report by Palliative Care Australia included an analysis of the palliative care experiences of over 22,000 patients nationally and found that two per cent of patients in the terminal phase suffered severe distress from pain. In addition, two per cent died in pain despite palliative care in that six-month period, and 569 people across Australia suffered severe distress from breathing difficulties during their terminal phase. Palliative care could not ease their suffering. In 2016, the Australian Medical Association asked its members to what extent they agreed with the statement “Palliative care and medical treatment cannot adequately alleviate the suffering of some patients.” Sixty-eight per cent agreed totally with this statement; 22 per cent disagreed. I would also like to quote the report from the 2017–18 parliamentary inquiry into palliative care in Western Australia, which states — …too many Western Australians are experiencing profound suffering as they die. This is, in part, due to inequitable access to palliative care … However, it is clear from the evidence that even with access to the best quality palliative care, not all suffering can be alleviated. Palliative care physicians themselves acknowledge this.

Our own parliamentary inquiry found that palliative care cannot ease everyone’s suffering. The argument that the solution to the trauma experienced when palliative care does not provide an adequate solution is to give more funding or more resources to palliative care actually does not make sense, because there will always be those people for whom palliative care cannot provide a solution. Palliative care and voluntary assisted dying are not mutually exclusive; they are both very important options for patients in the terminal phase.

I want to go on to talk a little about suicide, acknowledging Mental Health Week last week. We are all wearing our black dog pins today. This is a very serious issue across society. It is also a very serious issue in terms of patients who reach the end of their lives and are going through interminable suffering. I want to talk about the human experience of that. Unfortunately, very recently—in fact, during the most recent parliamentary recess—my cousin in the United Kingdom took his own life. He had a history of mental health issues, and I want to stress that his choice to end his life was as a result of mental health issues and not a terminal illness. What I want to talk about is the aftermath of the choice that he made, as difficult as it is. This was in the first week of the recess just gone. He was in his early 50s and had a couple of kids. His little sister, who I think would be in her early 30s, walked into the house and found him hanging from the ceiling. She had her kids with her—her little family—and it was very distressing for them. The immediate horror of that event for them and then the wider family was incredible, and it is still obviously very palpable across our family. The sad thing, of course, is that the horror of that event spread around the globe to relatives everywhere because of social media, before even his close family knew. I found it quite confronting that we found out about his death through the posts of people on Facebook, which in itself was quite distressing. That choice has had an effect on the family and friends around him. That effect is lingering in my family and will linger for some time. I knew this guy well; we were pretty close over the years. Is...
this what we want the families of those who are suffering from terminal illness to face—that the reality is that the only way out for some of these people is to tie a rope around their neck, asphyxiate themselves or use a firearm or whatever it is? I cannot accept that that is the choice we want to leave to those people and their families—I cannot accept that. The minister said in his second reading speech —

The coroner tells us that around 10 per cent of suicides in Western Australia 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.

I absolutely and completely agree with that. We must offer people at that time of life a choice other than a violent end. It may well be that simply offering that choice is enough for them to not do as my cousin did but actually go on with palliative care. They may never need voluntary assisted dying, but the knowledge that that choice is available may be enough.

I want to read a letter from Margo Beilby. This is another important one. It is about her husband who took his own life, but in a very different way. It is important to contrast the two—what happened to him and what happened to my cousin. The letter states —

Hon Colin De Grussa,

I am not one of your constituents as I now live in Roleystone but I am writing to ask you to please support the voluntary assisted dying Bill when it is presented to parliament later this year.

I see from your web site that your parliamentary office is in Geraldton. My husband, Michael Beilby, was deputy head at Bluff Point PS in the 70s. He was also a member of the Geraldton Yacht Club and editor of its newsletter. And a member of the St Georges Catamaran Club.

Mike was a lifelong asthmatic but he never let that slow him down. But gradually his condition worsened through chronic bronchitis to COPD (Chronic Obstructive Pulmonary Disorder). By 2013 he was down to 20% lung capacity. He also had been diagnosed with Parkinson’s Disease. His doctors told him there was nothing they could do to cure either condition. He faced drowning in his own lung fluids. One of his doctors told him that if he were lucky he would get pneumonia and die relatively quickly.

He decided not to wait for that or a slow choking death. He joined Exit International and found that his best end of life would be Nembutal. He illegally ordered and paid for the drug online. It arrived on the 30th of July 2013. He wanted me to go shopping and come home and find him dead so I couldn’t be charged over his death. I told him that after 51 years of marriage, I was not going to let him die on his own.

On the 31st he mixed the 10g of Nembutal powder in 150ml of water. Sitting in his favourite chair, looking out over our bush block in the house he helped to build, he drank the mixture and then a glass of port. He lay back in the chair and went to sleep and died. I sat beside him and held his hand till I was sure he was dead. Then I called his doctor who called the coroner.

…

I have read the submissions to the End of Life Choices committee and have been saddened by some stories of terrible deaths with people begging to be helped to die. I want everyone to have the option to have as good a death as my husband had.

The contrast between the violence of the only option now available to some people and what the government is proposing in this bill is incredibly relevant and incredibly important. It is certainly a compelling reason to support voluntary assisted dying.

As I said in my opening remarks, I am a supporter of voluntary assisted dying and have been for many years. I certainly support the right of a patient and their family to choose the treatment they receive. That should include a choice about how, and when, they die. The autonomy of a patient, and, indeed, the autonomy of any human being, is incredibly important, as is a person’s need, and right, to dignity at the end of life. Suffering is a very human experience. It is a very individual experience. I do not know what it will feel like. I do not know what it will look like. But I know that if I were experiencing interminable suffering approaching death, I would want to choose how, and when, I pass from this life, and be given the opportunity to say my goodbyes to my family while I could.

I am supportive of this bill. I believe the bill has been very well informed through the lengthy process of the Joint Select Committee on End of Life Choices, the Ministerial Expert Panel on Voluntary Assisted Dying, and the experiences in other jurisdictions, both globally and in Australia through the Victorian legislation. I believe the bill provides a safe approach to legislating for voluntary assisted dying. It contains the necessary checks and balances. From a personal point of view, the bill is probably a bit more conservative than I would desire. I note the comprehensive process that a patient will need to go through in order to access the provisions of this bill. I say at this point that the government must do everything it can and leave no stone unturned to ensure that voluntary assisted dying is

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made available with reasonable equity to all people in Western Australia, no matter where they live. Other members have talked about this, and I am sure we will hear plenty more about it. I know this will be difficult, but it is absolutely critical. I hope that in the minister’s reply he will give some assurance about how this will be done and what plans will be put in place in the second phase should the bill pass this Parliament. I hope this government will work constructively and diligently with the federal government to ensure that those who are eligible for voluntary assisted dying are given access no matter where they live.

There has been a bit of talk about potential amendments to this bill. I note that some amendments have been presented on supplementary notice paper 139, issue 1. I cannot stand before members and say unequivocally that I will not support any amendments to this bill, because that would be negligent on my part as a legislator. Each amendment must be considered on its merits. Most importantly, each amendment must be considered in the context of the whole bill, not as simply an amendment to an individual clause.

In the time I have left, I want to say a bit about one proposed amendment, having thought about this a bit in relation to my own experience. The proposed amendment provides that a health practitioner is not to initiate discussion about voluntary assisted dying. I believe it is incredibly important that a patient knows that their health practitioner will explain all the options that are available to them. When I was diagnosed with melanoma cancer, I went to see my GP to find out about the process and what was going to happen. I knew that I had to see a plastic surgeon and that he would cut a pretty big chunk out of my foot, right down to the bone, but I did not know much beyond that. At that stage, I had not been diagnosed with stage 3 melanoma. Stage 3 means that it has moved from the original site to somewhere else. I asked the doctor what I could do. I knew that the melanoma was pretty serious. She said that the mole that was removed was Clark level IV. I think the Breslow depth was 0.9 millimetres. Normally, that is outside the range at which a biopsy would be done. I asked her about what a biopsy would do, and she said I could have what is called a sentinel node biopsy, where they would find the first lymph node in my leg to which the fluid would move and check it out to see whether the cancer had moved. She said I could actually ask for that to be done. I did that, and they found that the cancer had moved to that lymph node, and that was why it was stage 3. If I had not asked for that biopsy and been aware that that option was available, I would have had stage 4 incurable melanoma, and I certainly would not be here today; I would probably still be in hospital, having significant treatment. The importance of good clinical practice and making the patient aware of every option available to them cannot be overstated. I cannot accept that it is good practice for a doctor not to give a patient all the options. Therefore, I am very concerned about that proposed amendment, having had that personal experience. It is important that we think about the bill in that context.

Having spoken about one of the proposed amendments to the bill, I actually do not believe the bill needs to be amended. I think the bill in its current form is excellent. It strikes a balance between safety and functionality, for want of a better term. Therefore, I do not believe the bill needs to be amended.

In concluding my remarks, it is my sincere belief that we can pass this legislation and introduce voluntary assisted dying in Western Australia. For all those who support this legislation, and for all those who will need this option at the end of their life, I hope we can do this for you. My wish is that this bill be passed expeditiously, notwithstanding the absolute necessity for rigorous scrutiny in Committee of the Whole House. I am sure we will do that. This house has a good reputation for making sure that we apply to legislation as much legislative scrutiny as we possibly can. I support the bill and commend it to the house.

HON ALISON XAMON (North Metropolitan) [12.07 pm]: I rise to make my contribution to the Voluntary Assisted Dying Bill 2019. Like others in this place, I acknowledge that this bill has generated a great deal of community sentiment. Like others, I have received hundreds, if not thousands, of emails, letters and phone calls. I have also, on more occasions than I am happy with, been cornered by individuals who wanted to discuss with me the provisions in this legislation and asked me urgently to vote either for or against this legislation. This is obviously a matter of deep public interest.

I also want to make some comments about how different the tone in dealing with this piece of legislation has been from the last time I debated this type of legislation back in 2010. Although much of the feedback that I have received has been strident, I note that despite everything I have received, I do not believe I have received one threat. That is very different from the tone of the debate that occurred nine years ago when I did receive some pretty nasty threats. We seem to have been able to progress further as a community in dealing with what is actually a very complex matter.

The Greens have a strong policy on voluntary assisted dying. The Voluntary Assisted Dying Bill 2019 largely reflects a lot of what is in our policy. As I said, the last time I spoke on this type of legislation—I am one of 14 members in this chamber who were elected at the time of the thirty-eighth Parliament—was in response to my colleague Hon Robin Chapple’s bill, which sought to bring in a particular regime of voluntary assisted dying. I particularly want to acknowledge my colleague Robin who has been a champion of voluntary assisted dying for decades. He has worked very closely on this issue with community campaigners who understand that this is an issue that is very close to his heart. When I last spoke on that bill, it was not long after my grandfather had died. That had a big effect on how I responded to the bill at that time. My grandpa had been a long-term member of the Western Australian Voluntary Euthanasia Society, which was the previous incarnation of Dying with Dignity Western Australia.
He personally begged me to support this legislation when it came on. At the time that he did that, my grandfather was dying of lung cancer. He was in his 90s. He had developed lung cancer from being a prisoner of war back in World War II. He was one of the Rats of Tobruk. Although he had kicked the nasty habit of smoking not long after he returned to Australia, unfortunately those years of being a POW meant that his lungs had been exposed to the risk of cancer. The final six weeks of his life, I would argue, were six weeks he really did not want to live anymore. If he had had his way, he would have cut his life short just by that period of time. He was, for his final days, in the Murdoch Community Hospice. I acknowledge that the staff there gave him first-class palliative care. We are very lucky to have some wonderful hospices within this state. Nevertheless, even with the very high level of pain relief that he was being proffered, it was not sufficient to manage his pain and, unfortunately, he died in a great deal of pain. One of the comments he made to me when he was in the hospice that has stuck with me—I referred to it back in 2010—was the sentiment that when he was young with his whole life ahead of him, he pointed out that the state did not hesitate to let him go off to war. But he made the point that now that he was old, had lived a full life and was dying, that the state would not let him die, and he felt angry about that.

As in 2010, I will be supporting this legislation, but I also have to acknowledge that since that time, much more has happened in my life and I am not dealing with the rawness of having lost a very precious and wonderful grandfather. That means that I will approach this legislation and indeed the debate around voluntary assisted dying not without my reservations. That is some of what I wish to talk about today. I want to start by saying, however, that I am very clear that I am able to distinguish between voluntary assisted dying when someone’s life is ending and suicide. We know that modern medicine keeps people alive much longer than they otherwise would be alive. That can mean it has the effect of dragging out, particularly at the very end of life, someone’s suffering when ordinarily their time would be up. The alleviation of enormous suffering when a person is about to die anyway, in my opinion, is demonstrably different from the tragedy of a life that is prematurely cut short by suicide. I am genuinely horrified at the coroner’s assertion that about 10 per cent of people who take their lives now are doing so when they have reached end of life. I am particularly horrified because of the circumstances in which families come across the body of their loved one. We have heard from some people within this place already about the very violent and sudden ways in which people die and that they are dying alone. This also has the effect potentially of traumatising first responders who are left with the legacy of having to deal with the circumstances of that death. We also know that if it is a child in particular who discovers a body, that can have very serious implications in the form of post-traumatic stress disorder. I also know that there are far too many instances of people who are nearing the end of life anyway and attempt to take their life in order to cut short their suffering, but who are not able to complete that attempt and are sometimes left with terrible and debilitating disabilities as they reach the end of their life. Nobody can think that that is an okay situation; no right-thinking person would think that this is an acceptable outcome. I also note the genuine fear of those people who take their life, and indeed their family, that if the family is there when their loved one dies, they will be left to deal with the legal repercussions.

I note that a number of people in this place have already referred to the story of a particular advocate for VAD because she has been very vocal in this space for a very long time—that is, the story of Margo and Mike Beilby. I note that the speaker before me read out a letter from Margo. I want to make some comments about Margo’s situation because Margo, or “Mabo” as she is known to me and my family, has actually been a very good friend of mine, a very close friend of mine, for over 20 years. Margo and Mike both used to volunteer in my office on a weekly basis. In fact, Margo still helps me out in the office—thank you, Margo, you are absolutely wonderful. I remember Mike slowly dying as he was working in our office. As has been mentioned, he was slowly drowning in his own bodily fluids and the coughing that we would hear from our office in the back room as he diligently did our filing and assisted with all sorts of things, would sometimes concern us quite deeply.

Mike was a curmudgeonly old man. He was very clear about his own mind and about what he would and would not do. I remember when he made the decision that he was going to seriously look at options and a safe way for him to end his suffering. What has been relayed during the course of this debate is that Margo and Mike actually tried to import particular drugs from China in order to achieve a safe death. The first lot of drugs were intervened; they never got them. It was the second lot of drugs that they managed to get hold of. Mike did everything that he was told he was supposed to do. He made the video to make it quite clear: “This is my choice. This is what I’m going to do. This is why I’m doing this. I’m dying anyway.” They did everything that they were supposed to do to make it clear that this was very much Mike’s choice. As Margo has relayed to everybody, when the time came and Mike made the decision that he was going to do this, she also made the decision that she was going to refuse to leave. She said, “You have been my husband for over 50 years, why would I leave you now when you are dying?” The simple answer to that came out of what followed. After he died, she rang the police and said her husband had died. The police turned up and they asked her where she had been. She said she had been there holding his hand. They told her, “You are not supposed to say that. You are supposed to tell us that you were at the shops or elsewhere.” Being Margo, she said, “Why would I lie? I am not going to do that. I am going to be here. This is my husband.” She was absolutely stoic. It did mean that my husband, who is also a lawyer, and I then spent the next 14 weeks assisting Margo, trying to make sure that she would not get charged, because she had not been responsible for Mike’s death. He was very clear that he was going to make this decision, and good luck talking him out of it. She said to me, “Alison, I am prepared to go to jail if I have to. This is so important to me, I want to be able to make
this statement.” I am pleased that she did not end up getting charged, but I think this really highlights the fear that people have when their time has come and they are dying of the risk for the people they love if they decide they want to stay and be with them. I was very privileged to give the eulogy at Mike’s funeral. As it turned out, Mike was actually a distant relative of mine, but we did not find that out until after we had known each other for about 15 years. That has always stuck very firmly in my mind.

I think there are a lot of reasons that people talk about wanting to have some sort of statutory regime around how they deal with the end of life, because it is about trying to avoid violent deaths, it is about trying to avoid unintended disability and it is also about the protection of the loved ones that they leave behind as well. I note that many people who are advocates for voluntary assisted dying are advocates not necessarily because they intend to avail themselves of this end-of-life choice, but because they want to know that the option is potentially there as no-one knows the circumstances of how they are ultimately going to die. I am really pleased that there has been so much discussion about the choice of palliative care. I am really pleased to see the recent successive announcements that have talked about a boost to palliative care. I think it is important that we acknowledge the Parliamentary Friends of Palliative Care who have been tireless in raising the issue of the need for palliative care options and how inadequate they are in this state. The work of that group is not yet done, because even with all the announcements we have had, we still do not have enough palliative care options available in this state. It is beholden on all of us to ensure that if this legislation is to pass we make sure that it does not become a default option simply because people are not able to receive the care that they want and need at their end of life. To those people who have approached me and told me not to talk about palliative care because it is a distractor and just to talk about voluntary assisted dying I say, “No, you are wrong.” As far as I am concerned, the two are intrinsically linked, and I think it is absolutely essential that we keep talking about palliative care, because we also know that people sometimes call for voluntary assisted dying because they have not been getting the services that they need. I welcome the fact that we are undertaking to significantly boost palliative care in this space. We will have to keep going though, members. We will have to make sure that we do not lose the promises that have been made and that this area continues to expand. I believe that most people are likely to choose the option of palliative care. I do not have anything to base that on; it is just an opinion. I think palliative care can be superb.

I have spoken in this place before about the death of one of my best friends two and a half years ago from cancer. He never expressed a desire to take his life. I was there the weekend that he died and, frankly, he had a superb death. He had a wonderful death. He died at home with his wife, his children and obviously us, his best friends. The palliative care that was offered by Silver Chain was superb; it was so good. I think it is true that when palliative care is offered, a lot of the time it is sufficient. That is why it is all the more important that we make sure we do not drop the ball on this and that palliative care services are always funded. I remain concerned to ensure that this option is available for anyone who wants it, regardless of where they live. I think in a very large state it is very hard sometimes to deliver the appropriate services, and that is a challenge we need to meet. I make it clear that I do not think we are anywhere near close to being able to be comfortable with where we have landed, but I accept also that for a small number of people, my grandpa included, palliative care can reach its limitations. I have heard it estimated that palliative care cannot quite deal with the extreme pain of between two per cent to four per cent of people. I hope they are the only people we are talking about here when we talk about voluntary assisted dying.

I also note that in some ways we are here talking about formalising what we know quite a lot of doctors are actually undertaking in practice. I think we need to acknowledge that. I know of one family matter. I am not going to go into detail, because I am not interested in getting anyone into trouble. I know of people who have means sometimes using those opportunities to give people that alleviation from suffering at end of life that they so very much crave. We should not try to pretend that that is not happening already. We should not try to put this out there as though it is something utterly new that has never happened. Some doctors have been coming out and admitting this. I express some disquiet at the enthusiastic fervour that some doctors seem to demonstrate towards the opportunity to kill their patients, but that aside, I think it is important to acknowledge that many compassionate and professional doctors are quietly doing this in conjunction with patients and family all the time.

I also note that many have chosen to portray this debate as simply being between people of faith and secular interests, and I do not for one second accept that that is the case. It is true that many people of faith have concerns. We have all received correspondence from a number of churches of different faiths urging us to oppose this legislation. I have also heard from many individual people of faith who have urged us to reject this legislation. I have heard the view that VAD must be rejected because to suffer is to be closer to God and those with those views are hoping that I am a god-fearing woman. Members, to be honest, I am not a god-fearing woman. I am more of a New Testament kind of gal, and my God is the ultimate loving God and is not really interested in revenge. In any event, I also recognise that those people with this faith approach are not necessarily in the majority. But many Christians and people of faith who I have heard from have expressed their distress about the possibility that people who do not really want to die will end up having their lives cut short. I think that it is irresponsible for us to simply dismiss those concerns on the basis that they are driven by faith, rather than taking them seriously. I think those concerns are very valid and we must listen. I must also note that I have heard from many Christians and
people of other faiths who support this legislation. Indeed, there is a diversity of faithful Christian understandings of, and responses to, dying and voluntary assisted dying that are consistent with the affirmation that life is a gift of God, regardless of the circumstance. Many of those Christians believe they have been called to be a loving and supportive community around people in need of care as they or their loved ones move closer to the end of mortal life, and as citizens in a pluralistic culture, they also seek to care for and respect their neighbours who may not hold on to their faith in God, yet may experience fear, uncertainty, pain, grief or sometimes extreme and extended suffering as they prepare for their own death or that of their loved ones. They therefore recognise that exploring, accessing and making provision for, or conscientiously objecting to, voluntary assisted dying are all possible Christian responses. It is important to note the diversity of approach from people of faith about this as well, so I do not accept the characterisation of this debate as one of people of faith versus others.

Even though I support this legislation, I want to make a number of comments to those people who have urged me to support it, many of whom, in my opinion, have taken a rather unquestioning approach to their support of voluntary assisted dying. Even though I am voting for it, I do not necessarily agree with all the sentiments that have been put to me. I want to start with my concerns about the title of the report of the Joint Select Committee on End of Life Choices: “My Life, My Choice”. I want to say how sad and disappointed I was when I first saw that title. I recognise that that principle—the idea that it is my life, so it is my choice—is a view that has been widely espoused, and that is undoubtedly why it has been reflected in the title of the majority report of the Joint Select Committee on End of Life Choices. As a suicide prevention advocate, and as a child bereaved by suicide, I want to say what a distressing phrase that is for me. None of us are islands. When someone takes their life, it has a ripple effect, and I do not accept that our lives belong simply to ourselves. I am the mother of three children, and I am a wife, and I believe that when I chose to bring my children into the world, and when I opted to become a life partner to my husband, I was deciding to intertwine my life with theirs. If I were to take a decision to prematurely take my life, that would have a lifelong effect on them. My father chose to take his life when my brother and I were just children. Apparently, advocates of “my life, my choice” would say that it was his life, and it was his choice, to which I say, “Where was my choice? Where was my brother’s choice?”

As I have said already, I accept that this bill is not about suicide—the premature cutting short of the promise of life—but, instead, about the alleviation of terrible suffering at the very end of life, when death is inevitable. I do not accept, and I never will, the idea that just because it is your life, it is your choice, because, as humans, we are complex creatures with interrelated relationships, and I am not persuaded by arguments from people who say that if they want to die, the state has an obligation to facilitate that just because it is their choice. I also think that that sort of approach takes away from the hard work that we put into suicide prevention efforts—the millions of dollars that we invest at both a state and federal level, and the amount of human energy that goes into campaigns to try to make sure that people do not take their own lives. We know that trying to prevent suicide is trying to address issues of despair and hopelessness and, for many, mental illness.

On that note, I have also heard a couple of people advocating for the capacity to access voluntary assisted dying in cases of severe and chronic mental illness. It is not in this bill—thank goodness. Until the day I die, I will never agree to that. I believe that people with mental illness, no matter how severe, are able to engage in recovery such that they can have good and meaningful lives. To anyone who wants to write to me, giving me their stories about how their adult child has a terrible mental illness and how much better off they would be if they were not to live anymore, I am sorry; I am not your person. Go and find someone else to advocate for you because it will not be me. This debate needs to focus on the continuum of final healthcare options when someone is effectively facing entire bodily collapse and is about to die.

I have also heard quite a few people voice the sentiment that they cannot understand why there should be barriers to accessing VAD at all. I am very clear that if someone is asking the state to help them die, there must be barriers so that we can ensure that people are not coerced into taking their own lives. Threat or coercion is actually a thing. I was the Deputy Chair of the Select Committee into Elder Abuse and, as has been already articulated by other members in this place, the issue of psychological abuse is a genuine thing; it is a huge thing. That, coupled with financial abuse and the idea of inheritance impatience, was seen, in evidence taken by the committee, to be a genuine and real risk for elderly people. There is also the idea that people do not want to feel as though they are a burden, and really internalise that idea of being a burden. These are very genuine and real concerns. I do not want to see this bill become a vehicle by which we entrench ageist views towards people. Like other members, I have received multiple emails from children of elderly people saying that they want to have voluntary assisted dying because they say that their parents would not want this. That may be the case, but we do not know. I am always a bit shocked by the number of people who advocate for that. It is interesting, because people whom others may view as having poor quality of life may actually want to keep living. It should never be the case that people are able to be coerced into making these sorts of decisions. This will be really critical. If this legislation is to proceed, we need to make sure that training will be available for doctors to enable them to identify coercion when it occurs. We already know that we need to have training around elder abuse. There is already some training, but we need to have more training about how to identify risks of family and domestic violence, and training on risks around coercion at the end of life will have to be one of those things we are advocating for doctors as well.

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I note that people with disability have also expressed great concern about this legislation, and I hear those concerns. I think it would be a mistake for people to simply dismiss those concerns. I want members to think about how offensive to people with disability some of the language that we use around this debate can be. We talk about, for example, a loss of dignity if people require assistance with toileting, or a range of intimate functions, and how preferable death would be to ever having to have someone assist with toileting. I am going to make it clear that many people with disability require assistance for their whole lives with personal, intimate hygiene, and I want to ask whether we are suggesting that those disabled people are devoid of dignity. Is that what we are suggesting? Or worse, are we suggesting that they would be better off dead? I certainly hope not. Good friends of mine have expressed their frustrations about the way in which some people have used this language in this debate. Their lives have inherent dignity. Whether because of illness, childbirth, injury, disability or terminal illness, we may need help, but that does not make us inherently devoid of dignity. Likewise, we talk about wanting to end life because of pain. Many disabilities bring a lifetime of pain, but that does not mean that people who live with permanent or chronic pain wish to die, so let us be careful about how we use that language. The language of suffering is also highly subjective. One may lose all physical ability but that does not mean that one cannot live a joyous life.

Probably the most dangerous language we use for people with disability is that of burden. Advocates of voluntary assisted dying often say that they want to ensure that they do not become a burden for others, and that is often a critical point in their reasons for wanting the state to assist them to end their life. That is the slippery slope that people with disability fear. Far too often, people with disability are made to feel that they are a burden. We see a systemic denial of critical medical care when individual doctors make a determination, consciously or not, that someone’s life perhaps does not warrant saving. This has emerged in multiple coronial inquiries, as well as in the lived experience of people with disability and the families of people with disability. People with disability are particularly concerned about the language of burden. Language matters, but for those advocating for voluntary assisted dying, I point out that the safeguards matter as well.

To those who say that the legislation is too stringent, I say that if someone is going to ask the state to help them to die, it is absolutely incumbent upon us to ensure that those who do not want to die, do not die, and that those who are pleading for their lives to be recognised as having inherent value are heard. The same concern can be extended to Aboriginal Western Australians, who have also expressed concerns about the message it may send about the value of their lives. We put a lot of effort into trying to save the lives of Aboriginal people, whether because of poor health outcomes or the disproportionate number of First Nation people who take their own life. We need to listen when Aboriginal people say that they are confused about what message this will send. We need to make sure that our health services continue to be trusted; that needs to be at the forefront of our consideration. We also need culturally appropriate training and professional development, co-produced by Aboriginal Australians and delivered by Aboriginal Australians. I hope the government recognises that it needs to do that.

I remain concerned about the issues for regional Western Australians. We will talk more during Committee of the Whole House about ensuring that regional Western Australians are able to access appropriate palliative care—which I have already spoken about—and appropriate advice, services and specialists. There is clearly a gap that will have to be looked at, and that challenge will have to be met. As I have already said, I do not underestimate how much of a challenge that is; it has always been a challenge to try to deliver appropriate and adequate services within a state as large and remote as Western Australia.

I note some of the concerns that have been raised about doctors—that there may be a tendency with some doctors to flag themselves as being the people to go to if people want to ensure quick access to voluntary assisted dying. These sorts of things happen. I recall when my children were little that there were a number of doctors who put themselves out there as being the people to go to if someone wanted to get a conscientious objection form for vaccination; they were the go-to people. We know that these things occur within the medical profession, so we will have to be careful that when decisions are made to end life—because there is no turning back from that—they are made in the most sober and thoughtful way that medical professionals can make possible.

I also flag the concerns that have been raised with me by mental health professionals. They are particularly concerned about the lack of rigour in the assessment of someone requesting an end-of-life option because they have developed a mental illness, are deeply distressed and are experiencing a mental crisis. We should not ignore that; I think that is a genuine concern. As I have already said, I would never support voluntary assisted dying for someone who wants to die because they have a mental illness, although I recognise that if someone is depressed because they are dying, it does not necessarily mean they are not fully able to make a conscious decision about end of life. It is important that we get that balance right and ensure that people are not requesting to die for the wrong reasons.

I have also been approached by people who have said that it would be out of line for me to move amendments to the legislation, that I simply have to support the bill in its current form, and that it would be outrageous for me to even contemplate anything else. My response to that is that they are wrong. As members know, I propose amendments to a lot of bills in this place. Why I would suddenly renge on my responsibility to scrutinise legislation with one of the most important bills that this Parliament has ever debated, defies logic. I will not be taking that approach.

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Although I have listened to people who are both vehemently for and vehemently against the legislation, I have also listened to people who are quietly supportive of the overall principle but have nevertheless expressed significant disquiet about unforeseen implications. Therefore, I think it is very important that I listen attentively to those concerns.

This is not a black-and-white issue, and this bill was never going to be a take-it-or-leave-it matter. It is my role to be party to the crafting of legislation that the chamber should endeavour to make as safe as it possibly can be. There will obviously be debate about what that will look like or, indeed, whether we can ever achieve a point of ultimate safety. I am frankly offended by the suggestion that I should not even consider proposing amendments, let alone vote for amendments, even if I am strongly of the view that they are necessary improvements, because of course I will.

As I made clear at the beginning of my contribution, I will be supporting the second reading of this legislation and, most likely, the third reading, unless someone moves an amendment to include voluntary assisted dying for people who want to die because they have mental illness, in which case I will be out. But I will also carefully contemplate every amendment and vote with my conscience, as is my right. I understand that this legislation will dramatically transform our legal and health landscape. It challenges us as a community and it is a significant shift in the way in which we view and approach life and death. Anything less than the most thoughtful and considered scrutiny of this legislation would constitute a major disservice to the Western Australian community. With those thoughts, I look forward to the committee stage, when we can go into detail a lot more. I commend the bill to the house.

HON AARON STONEHOUSE (South Metropolitan) [12.49 pm]: I rise to speak on the Voluntary Assisted Dying Bill 2019. As a part of classical liberal values, the Liberal Democrats believe that there is no more fundamental expression of individual freedom than the right to decide what you do with your own body. The Liberal Democrats demonstrated this commitment when my colleague, then Senator David Leyonhjelm, introduced a private senator’s bill—the Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015. That bill would have removed the prohibition on the Northern Territory and the Australian Capital Territory to legalise assisted suicide. However, it was narrowly defeated at the second reading in August 2018.

Although I am equally as committed to ensure individual freedom is preserved and upheld, I am a very different man from my former colleague. As a Christian and as someone with rather conservative sensibilities, I approach this legislation from a very different perspective than many of my party. I could share personal stories of my experience of the loss of loved ones, but I would rather not in this case, not only because I feel they are private, but because I would rather not look at this legislation through the lens of my personal experience. When dealing with moral and ethical questions like this, it is important to suspend personal desires and feelings and instead consider this legislation cognisant of the fact that the decisions that will be made here will have a profound impact on the rest of society. Legislators have an immense responsibility, regardless of their support for or opposition to voluntary assisted dying as a concept. We have a duty to critically scrutinise the provisions of this bill and to leave no stone unturned. However, we must also consider that there are fundamental questions that go beyond a clause-by-clause analysis of the bill—questions of autonomy and of the intrinsic value of human life that transcend our examination of the law.

It is for these reasons that I will not be quoting polling data today; I do not think it is terribly relevant to what we are doing here in the Legislative Council. Members of a representative democracy are entrusted by their constituency to research and consider legislation carefully, and not to be blindly led by the whim of popular opinion. Members of Parliament have a responsibility to carefully consider the fine detail and the minutia of legislation. As a result, I have consulted widely in the lead-up to this debate. I met with people from both camps and those from neither. I have had very constructive and informative meetings with Hon Malcolm McCusker, QC, who chaired the Ministerial Expert Panel on Voluntary Assisted Dying and who has long been and remains someone for whom I have the utmost respect. I met with representatives of Go Gentle Australia, including Andrew Denton and his team. I had the opportunity to meet Belinda Teh. I have also corresponded with church representatives, including Archbishop Peter Carnley, whom many would list among our leading theologians. I have had the opportunity to meet with the Australian Christian Lobby and Peter Abetz. I have met with palliative care experts, including Dr Anil Tandon, who chairs the WA Palliative Medicine Specialist Group, and Dr Alison White, the director of hospice and palliative care services at St John of God Murdoch’s Community Hospice. From further afield, I have met with Dr David Grube, who chairs the ethics committee at Lumina Hospice in Oregon, who was able to offer me some insight on how assisted dying has been and is being handled there. I also had the opportunity to meet with Professor Kissane and a representative from Hope, Dr John Daffy. I also hosted David Seymour, MP, the architect of New Zealand’s assisted dying laws, at a Q&A session here at Parliament House, which I was pleased to see several members, along with some from the other place, attend. I am also grateful to the office of the Minister for Health and various staff from WA Health who made themselves available on a number of occasions to brief me and my staff.

Like all members here I suspect, I received considerable feedback within my electorate, the South Metropolitan Region, much of which has proved insightful. The conversations I have had have been detailed and, quite often, brutal. I have come away from them with a far greater understanding of the palliative care industry and voluntary assisted dying than I had to begin with.

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When considering the issue of voluntary assisted dying, it is important for legislators to ask ourselves the following question: do we have the right to control what someone else does with their own body? We may have the political authority to do so, but do we have the right to do so? and, is it right to do so? This is fundamentally a question of autonomy and I believe it is at the heart of this issue. Why do I pose this question and not the opposite, for instance: does someone have a right over their own body? To understand that, we must understand the liberal tradition of a presumption in favour of liberty. Seventeenth century political philosopher John Locke described man as being naturally in a state of perfect freedom to order their actions as they think fit, without asking leave, or depending upon the will of any other man. It is a view that nineteenth century philosopher John Stuart Mill echoed. Mill said the burden of proof is supposed to be with those who are against liberty, who contend for any restriction or prohibition; the a priori presumption is in favour of freedom.

The presumption of liberty is a fundamental liberal principle. It holds that the onus of justification is on those who use coercion to limit freedom. It is a principle that is expressed in social contract theory, in which political and legal authority must be justified. If we accept that there is a presumption in favour of liberty, then we must ask ourselves: when is it justifiable to use coercion to control the actions of another? This again is a question considered by Mill, who developed what we now know as the “harm” principle. Mill said —

That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise or even right … The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. The part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

The phrase “your freedom to swing your fist ends where my nose begins” captures the general sentiment of that principle. Of course, Mill understood that such a principle could apply only to those who are able to exercise their freedom responsibly. Paternalism, under Mill’s harm principle, is still justifiable for those incapable of exercising personal responsibility for their actions, such as children or those with severe cognitive impairment. It is Mill’s harm principle that I apply when considering the issue of voluntary assisted dying. It may sound like a rather atomistic view of society; it is actually not. Indeed, no man is an island and I am an ardent supporter of the institutions of civil society—family, marriage, church, community groups and voluntary organisations. We do have a responsibility to one another, but the questions at the heart of this legislation are: When is it appropriate to use coercion to prevent someone from exercising their own free will? Do we have the right to use coercion to deprive someone of their freedom because we disapprove of their choices? Do we have the right to impose one system of values upon the rest of society? I remind members that the right to do something is apart from the exercise of that right. It might surprise some members to learn that I do not personally approve of voluntary assisted dying. As a Christian, I hold certain views about suicide and about the sanctity of life. In fact, if someone I knew expressed a desire to access voluntary assisted dying, I would try to dissuade them and convince them otherwise. I might argue or debate with them. I might want to show them the error of their ways through outreach, volunteerism and showing them alternative paths. However, despite my disapproval of their actions, I do not feel it is sufficient to use coercive power to prevent them from exercising that right to do so. If we disapprove of someone’s choices, we do not necessarily need to resort to government interference to stifle their freedom.

However, my support for this legislation is not a foregone conclusion. At the heart of liberty is the absence of coercion by others. Consequently, the liberal state’s commitment to protecting liberty is essentially the job of ensuring that its citizens do not coerce each other without compelling justification. If you apply this to voluntary assisted dying, then it is very clear that the state has a role in voluntary assisted dying to prevent the coercion of others. As I say, my support for this bill is not a foregone conclusion. As I indicated in the lead-up to the debate, I support the right to access voluntary assisted dying. Members might say that I support voluntary assisted dying in principle. But I am concerned about how the regime will operate. A policy and a bill are two very different things.

On Tuesday night, Hon Nick Goiran asked members the question: is it possible to design and implement a safe euthanasia regime? Notwithstanding, the confusion of terms in that question and that what we are discussing is voluntary assisted dying and not euthanasia, it is an important question to ask. I have spent my contribution talking about the principles of liberalism.

_Sitting suspended from 1.00 to 2.00 pm_

**Hon AARON STONEHOUSE:** Before we broke for lunch, I was summarising the classical liberal view of autonomy and personal freedom, and my support for the idea that individuals should be free to make choices about their own body, so long as they are not harming anyone else. However, I made it clear that my support for this bill is not a foregone conclusion. My support for this legislation will be contingent upon there being adequate safeguards in place to ensure that there is no coercion and to ensure that those who access voluntary assisted dying are doing so fully informed and with the capacity to make decisions about what they do, and on a number of other areas that I will outline in just a moment. It is my intention at this time to vote for the second reading of this bill, not in support of the

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I take a moment now to outline some of my concerns with the bill as it currently stands. I will start off with one that has already been raised by previous speakers, and that is the lack of a prohibition on medical practitioners raising the question of voluntary assisted dying with their patients. In a perfect liberal society, there should be no problem with a doctor raising such a question with their patients. However, we have to acknowledge that there are people out there with cognitive impairment or with mental health issues, and there are some folks who, in the absence of cognitive impairment or mental health issues, may merely be susceptible to suggestion and gaslighting, and easily led. Cultural differences may have also been overlooked. In our western liberal democracy, there is an emphasis on the autonomy of the individual. There is, I think, a healthy scepticism of authority, and I may be wary of the recommendations of my doctor and not follow their advice blindly. That is not necessarily the case in all cultures. The position of authority that a doctor holds may be held in higher esteem in different cultures. There are also issues of language barriers, whereby patients who may not have the best grasp of the English language are dealing with doctors who might be unfamiliar with their patient’s difficulties in communicating.

I think that the issue of doctors or medical practitioners raising the question of voluntary assisted dying with their patients is compounded further when we consider that, under this regime, doctors will be able to administer the poison to carry out voluntary assisted dying. The doctors—in this case, it would have to be three separate medical practitioners—would become, amongst the three of them, the judge, jury and executioner, if I can use a blunt analogy. There is, in my mind, a fear of more activist doctors taking a very active and progressive, perhaps even pushy, role in facilitating voluntary assisted dying. That they are able to raise the question of voluntary assisted dying, assess someone’s capacity and then refer on to a colleague who can administer voluntary assisted dying raises some concerns that the safeguards in this bill will not be adequate to prevent wrongful deaths in some circumstances. In my consultation, I met with doctors who are intimately familiar with the regime in Oregon, which is the basis for the Victorian regime, which is the basis for the Western Australian regime. It was explained to me that in Oregon, doctors do not administer voluntary assisted dying; voluntary assisted dying is self-administered. There may be concerns about someone with a medical condition who is unable to move their arms because of some motor disorder. In those instances, they are able to use a straw. There may be an issue with someone who is unable to swallow due to throat cancer. In those cases, they are able to use a stomach pump. There are ways around it. It seems to me that if it is to be administered by a physician, by a medical practitioner, that should be the exception, not the rule. I will be very keen to see under what circumstances a medical practitioner can administer voluntary assisted dying. It is important, because we are discussing voluntary assisted dying and it is not intended to be a euthanasia regime or one in which a doctor puts a patient out of their misery. It is meant to be a self-administered voluntary assisted dying regime, in which people exercises their own free will, are able to make fully informed decisions as rational adults, make this decision and do it to themselves.

I also have concerns around the assessment of capacity. This is important for me, because my support for the rights of an individual to make their own choices is based on the idea that they are exercising their own free will and that they are autonomous agents. Therefore, we need to be absolutely certain that those people who access voluntary assisted dying are capable of making those choices, are fully informed and are free from severe mental illness or cognitive impairment when they make those decisions. I have some concerns about whether a general practitioner is best placed to make that assessment. I understand there will be an online training course for GPs; however, it will be a six-hour online course, of which an hour, perhaps, will be dedicated to the assessment of capacity. I have serious doubts that that is adequate in training someone otherwise not familiar with capacity assessment in how to carry out that function. It has been put by advocates of the bill that a GP is best placed to assess capacity. They are someone’s family doctor, they are someone who has a close relationship with a patient, someone who meets with them on a regular basis and probably has a good idea of their family and home situation. That may be the case for some people, but many others, who perhaps can afford to see only GPs who bulk bill, go to a medical clinic at which there are several doctors and see whichever doctor can see them first. That has certainly been my experience. Being young and relatively healthy, I do not have a regular GP; I go to whichever clinic or whichever GP will see me first in the time that I can fit into my busy schedule. I believe that is the case for many people. Those GPs would have no idea what stresses or outside influences there might be on my decision-making capacity at that time.

There is no requirement for a psychiatric assessment. This is a concern to many in the field of psychiatry. However, it is unclear to me at this time how that might be addressed. Mandatory psychiatric assessment would be very onerous and difficult for people in regional WA to access. However, I am very keen to explore that issue. It has been suggested to me that a presumption against capacity rather than a presumption of capacity might be one way to address that.

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It is unclear to me at this time whether that might be a suitable way forward. It is something I will examine in the Committee of the Whole House. There is no mandatory notification of family members by a coordinating medical practitioner. However, it is a little unclear whether such notification would be ethical. It might certainly be the decent thing to do, but given the privacy and confidentiality between a doctor and their patient, mandatory notification would be unethical. That is something I am looking to explore as well.

I have concerns about a few other areas of this legislation but perhaps the one that leaves me most unsettled at this time is the lack of respect for the exercise of conscience. If voluntary assisted dying is an expression of free will and is an exercise of a patient’s free will and their conscience to end their life if they so choose, surely it is right that conscientious objectors be afforded that same freedom: that medical practitioners who are conscientious objectors should be free from an obligation to be part of a regime that they find counter to their own moral values. We cannot grant freedom to one group of people, those suffering a terminal illness who wish to end their lives, at the expense of the freedom of another group of people—that is, medical practitioners with a strong moral objection to voluntary assisted dying. There are those who will disagree with that statement and say that there is an obligation on doctors to provide information to their patients about all the medical options available to them. I disagree with that. In that is an assumption that voluntary assisted dying is a medical treatment. I do not think it is. It is an alternative to medical treatment. I still think people have the right to do it if they want to, but it is not medical treatment.

There is also an assumption that with a right or a freedom comes an obligation. I think it is a misunderstanding of what freedom really is. Freedom is an absence of coercion. That is not a positive right that government must bestow onto citizens. It is something that government cannot take away from you. Twentieth century political theorist and philosopher Sir Isaiah Berlin summed this up quite clearly, when he said —

I am normally said to be free to the degree to which no man or body of men interferes with my activity. Political liberty in this sense is simply the area within which a man can act unobstructed by others. If I am prevented by others from doing what I could otherwise do, I am to that degree unfree; and if this area is contracted by other men beyond a certain minimum, I can be described as being coerced, or, it may be, enslaved. Coercion is not, however, a term that covers every form of inability. If I say that I am unable to jump more than ten feet in the air, or cannot read because I am blind … it would be eccentric to say that I am to that degree enslaved or coerced. Coercion implies the deliberate interference of other human beings within the area in which I could otherwise act. You lack political liberty or freedom only if you are prevented from attaining a goal by human beings.

It is interesting that in this discussion around voluntary assisted dying, such an importance is placed on preventing coercion—coercion of a vulnerable person being steered towards voluntary assisted dying against their will. There is little discussion about the coercion of medical practitioners by placing upon them an obligation to carry material and pamphlets or an information pack in their office and hand it over on request to a patient. There is clearly a need for those suffering to access information about voluntary assisted dying. However, I do not think we need to do that if we are putting an obligation on medical practitioners. In fact, it seems inconsistent. If there is a desire that medical practitioners provide their patients with every available medical option, why does the bill not include an obligation to inform patients about the availability of palliative care as part of their consultation with someone seeking voluntary assisted dying? No such obligation is in this legislation. It does not exist in any other statute that I am aware of. Clearly, medical practitioners do not currently have a statutory obligation to provide every option to their patients. To do so, I think, would be rather difficult. That is perhaps a debate for another day. It has been put to me that upcoming doctors and medical practitioners will know that there is an obligation going forward; therefore, they will not get into medical practice if they are conscientious objects. That is ridiculous. It is absurd to exclude from medical practice an entire group of people because they have strong moral beliefs and do not want to be part of this regime.

I have always used my vote in Parliament to protect and uphold personal freedom and personal choice and I will do so again to protect the freedom of medical practitioners to be conscience objectors. As I said before, my support for this bill is not a foregone conclusion. We cannot sacrifice the freedom of some people to enhance the freedom of others. Freedom should be mutually beneficial to all. At this stage, I give my in-principle support to voluntary assisted dying. I will vote for the second reading and follow closely the Committee of the Whole House process and will wait to see what bill we have at the end of that process and reassess the legislation at the time of the third reading.

HON KEN BASTON (Mining and Pastoral) [2.17 pm]: This is a very difficult subject to grapple with, even though it is a scenario that nearly all of us will face at some point or with someone very close to us. When considering my position on this legislation, I have endeavoured to be informed by experts in the field of health care, particularly palliative care, and by the numerous constituents who have contacted my office and, I am sure, many others, in an effort to have their feelings on this very contentious subject heard and considered. I will have it noted that approximately 63 per cent of correspondence into my office was against or at least very concerned about the wider effects of voluntary assisted dying, while 37 per cent was in favour of it. For those who do not know, my electorate office is based in Broome.

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Many of the speeches made about the Voluntary Assisted Dying Bill 2019 have been compelling and enlightening and demonstrate a great effort to deal with the incredible complexities surrounding the application of this legislation; that is, people will be able to decide to take their own lives through a process administered by the state.

As a representative of the Mining and Pastoral Region, I am genuinely concerned about how this legislation will impact on the lives of people living in the region. The Mining and Pastoral Region hosts some of the most isolated and underserviced communities in the nation. There are towns and communities that struggle to retain basic services, and they face financial, geographical and often cultural barriers in accessing adequate health care. Interestingly, a few years ago when I visited Rudall River National Park, the nurse at Punmu told me they had been waiting for over two years to get a dentist out to the community. Of course, dentistry was not covered under the patient assisted travel scheme, so they could not take the patient to a larger town.

I am very concerned that this legislation will pass while people living in the Mining and Pastoral Region are left without genuine choices about end-of-life care. I am still extremely sympathetic to the plight of people facing terminal illnesses and completely understand the desire to want control over that process. I have certainly grappled with the tension between my belief that an individual should ultimately have control over their life and my concern about the effect this legislation could have on our society as a whole. This makes it very difficult for me to consider voting for this legislation. However, during the time I have spent considering this issue my concerns and uneasiness have increased. I fear that if voluntary assisted dying is accepted as the ultimate form of pain relief and the way to end suffering, our values concerning life and the desire to protect and prolong life will shift.

There is also the wedge effect to consider. Many of us may feel comfortable with the legislation before us and its apparent safeguards, but are we utterly confident that a future government will not seek to significantly expand the boundaries of this legislation? Are we comfortable opening the door to that possibility? I, for one, am not. In my opinion this Parliament has done a very good job of considering and carefully debating this legislation. The reports on VAD have taken many hours and much brainpower to put together. However, I believe there is a danger that by opening the door to VAD, we invite the possibility of reducing and rendering unnecessary the need to tolerate chronic illness, disabilities and the significant difficulties that some will endure at the final stage of terminal illness.

I am sure many members have read the WAtoday article published on 10 September. It was in the most-reviewed section for a few days. The article describes the experience of a disability rights advocate, Samantha Connor, who attended a rally at the Australian premiere of the film Me Before You. If members have not seen that film, I suggest that they go and see it because it is very powerful. Ms Connor is wheelchair-bound and some friends satirically rattled tins asking for donations to fund travelling to Switzerland to die. By her account, not a single person asked Ms Connor why she wanted to die or whether she was okay. The people who put money in her tin simply assumed that she wanted to die, and by doing so confirmed that they too would want to die if they were so unfortunate as to be in a wheelchair. No doubt these people thought they were being compassionate, generous and understanding, but did they consider what they were really saying to this group of people? A comment under this article, which I will not quote in its entirety, suggests that VAD should be available for those people who do not have “deep pockets” to pay for counselling and treatment, and that if it were available, a person could spare their family additional suffering. I believe this person also thought that their view was compassionate, but I am sure that all members can see the danger in this way of thinking and its implications if you follow it to its logical conclusion.

A number of polls, including one published in The West Australian of 26 August 2019, suggest that community support for VAD is at about 88 per cent. We have heard that said on many occasions. However, when we examine people’s views a little more closely, such as those of the person I just referred to, are we sure that we truly want to encourage and validate this view? Polls that have asked more detailed questions and asked people to consider the issue more carefully have produced far less overwhelming results. For example, the euthanasia and assisted dying Western Australia polling data collected by Sexton Marketing Group found that in the Mining and Pastoral and Agricultural Regions 75 per cent of people believe that palliative care should be improved ahead of legalising euthanasia. I certainly very strongly support that view.

Much of the debate on this bill has centred around supporting the idea of individual choice. It really is much more than that. The implications of this legislation go beyond the individual to the heart of our society. This legislation raises questions about how we deal with life and death, and the effect it will have on the most vulnerable members of our society and those who many of us might assume are not living an optimal life. If this attitude were to become even more common, how could we truly say that people will be making this decision free of coercion? The coercion may not be obvious or spoken, but it will be implied if our attitude towards the often difficult process of dying shifts towards the process being seen as unnecessary and a burden on those around us. I met with a doctor from Victoria who told me that coercion by the family is one of the worst things when someone says, “Mum, it’s up to you. You don’t have to live if you don’t want to.” I will not suggest anything more than that.

As a member for the Mining and Pastoral Region, where people have difficulty accessing basic health services, I know the provision of palliative care is completely inadequate. I do not feel comfortable making voluntary assisted death available if people do not truly have a choice between dying prematurely and receiving adequate palliative care on home soil. This brings me to a speech Western Australian Senator Pat Dodson made on voluntary euthanasia in
August 2018. Although we come from opposite sides of politics, we both represent a very similar constituency, and it would appear we both have similar attitudes to voluntary assisted dying and on the impact its introduction would have on our state’s most remote regions. I would like to quote a small part of Senator Dodson’s speech. He said —

With so many of our people suffering complex health conditions at an early 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 that First Nations people are receiving palliative care within their communities. 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. Paving the way for euthanasia and assisted suicide leaves First Nations people even more vulnerable, when our focus should be on working collectively to create laws that help prolong life and restore their right to enjoy a healthy life.

I encourage members to read the whole speech, which is available in the commonwealth Hansard, to get a different perspective on voluntary assisted dying and how it relates to some of our most vulnerable citizens and people living in our regions. The member for Kimberley, Josie Farrer, also made important points about what needs to be done to improve the delivery of health services in the regions, particularly for Aboriginal people and people who live in extremely remote communities. I can say now that if this legislation passes, a lot of work will need to be done to ensure that there is adequate engagement with Aboriginal communities to make sure that it does not erode the delicate levels of trust that currently exist between health service providers and Aboriginal people living in very remote communities.

Although I hold some philosophical concerns, I am primarily opposed to this legislation because I do not believe Western Australia provides adequate end-of-life care in our regions. I believe there is a need for far more work to be done to provide general health and palliative care services throughout the regions. Clause 4(1)(h) states —

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;

My question is: as a state, are we providing the genuine choice required by legislation, irrespective of whether the person lives in Western Australia, having regard to the person’s culture and language? I believe the answer is no. Considering the house voted to pass a motion in April, approximately six months ago, confirming this, it would appear that the majority in this place also believe that the answer is no. If not, what has changed so dramatically in the past six months?

Much of this debate has been framed as providing people with choice. I am sympathetic to the motive and I believe that people are generally capable of making their choice for themselves and that it will provide a comforting element of control over our lives. But I feel that this has been brought on without enough consideration of what is lacking in end-of-life care. If the state is providing a method of dying prematurely, I believe it must also offer every reasonable way of living well until the inevitable occurs.

We are close to stepping over a very significant threshold where the state will be responsible for administering a person’s premature death without ensuring that we are providing people across Western Australia equal access to services and treatments. Is it really a choice if you have access to assisted dying, but not to comprehensive and good quality palliative care options? I also think the answer to that question is no.

In our regions, many people have to travel significant distances to access chemotherapy after a cancer diagnosis. They must also travel to Perth for numerous other health issues, sometimes even for straightforward procedures, and there are significant restrictions on what the patient assisted travel scheme will provide for. In the Legislative Assembly, the Premier gave a clear and compelling speech about his motivation for introducing this legislation. A point is raised by the Premier that I believe requires some focus. It was posed as a question —

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?

This question led me to reflect on the eloquent words of another Labor leader. Former Prime Minister Paul Keating wrote an opinion piece, published in October 2017, in response to Victoria’s Voluntary Assisted Dying Act. I quote —

This is a threshold moment for the country. No matter what justifications are offered for the bill, 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.

I do not doubt for a moment the sincerity of the Premier’s desire to provide choice and to provide a pathway to the relief of suffering. However, I feel as though the Premier’s question is asking us as a society to take a step away from recognising the value of life—that the value of life is a belief held by only a certain cohort of people. However, it is a value that should, and I believe does, underpin much of what makes us a civilised society. Prioritising relief from suffering over the continuity of life, no matter how grim the outlook, may be something that many feel comfortable with. That is understandable when we are considering the real and terrible suffering that some will


endure at the end of a terminal illness. However, it is our job as legislators to examine carefully not just the immediate implication of this legislation but also the overall and ongoing effect it will have on society. No matter our feelings about or intention to vote on this legislation, none of us can deny that we are stepping into very new territory. If this bill is passed, we will create a very small wedge that has the potential to open the door to broader application of euthanasia and a change in how we value the most difficult stages of our lives. I do not believe that this is a threshold we should cross and I will be voting against the legislation in its current form.

Of course, there are many questions to be asked in Committee of the Whole about the nitty-gritty of the bill: How will it be run? This is a state program but is it federally funded? I have gone through the memorandum of understanding but it was not clear on where the capital and funding will come from. One thing that has been put on the map, which is valuable, from the report and from debate in Parliament today is palliative care. One of the papers indicates that there has already been an increase in funding of millions of dollars to palliative care, and I think that is really important, but it needs more. This is a big state and we have only just started. When I met with carers in Broome some months ago, only five ladies were directly linked to palliative care. That is not enough. I look forward to the bill going through the committee stage.

HON DONNA FARAGHER (East Metropolitan) [2.35 pm]: I stand to make a few brief comments on the Voluntary Assisted Dying Bill 2019. This bill concerns issues that by any measure are the most important and the most profound that we as parliamentarians have been required to make a decision on. I know that for all of us it is a decision that is not taken lightly, irrespective of the decision we make.

At the outset I acknowledge the many Western Australians who have contacted me over the past few months by letter, by email, by phone and through meetings. Like everyone here, I have received thousands of emails both for and against this legislation. Perhaps for me—this is similar to views expressed by others already in this place, whether they have spoken in favour of this legislation or not—it is the hundreds of more personal letters and the many individual discussions I have had that have had the most impact, again irrespective of whether the individual was in support of or in opposition to the legislation.

I would like to thank the various medical professionals and specialists, including those at Bethesda Hospital, who answered my many questions and shared their perspectives, particularly in relation to palliative care. It is fair to say that for some of us, our views on this critical issue are not necessarily ones that are black or white, one or the other. I have listened closely to the contributions that have already been made in this house, the personal experiences that have helped shape members’ views, as well as the individual stories that many people outside this place have been prepared to share with me. I absolutely understand how emotional and personal this debate is and why many in our community are so supportive of this legislation. Equally, I am conscious of the views that have been expressed by those in our community who have significant concerns, some of which I will share later, or who are totally opposed to this legislation. Irrespective of a person’s views on this bill, it is my strong belief that the differing perspectives on this issue should be respected and should not be diminished, demeaned or condemned simply because it is a view that might not be held by someone else. I say that in the context of both sides of the debate. In accepting the arguments both for and against, it is incumbent on me and all members of this house to determine in all good conscience whether such legislation has all the necessary conditions and safeguards in place to enable a truly informed, voluntary and free choice to be made.

In coming to my decision on the second reading of this bill I have to be satisfied in my own mind that the safeguards that have been included are enough—enough to protect the vulnerable; enough for those who may have a voice but who have others around them who speak louder; enough for those with a disability; enough for those who may feel pressured, either intentionally or unintentionally; and enough for those who may feel that they are a burden to others.

I also need to be satisfied on the issue of the provision of palliative care, and although some will argue that this bill is not about palliative care, it is, in my view, absolutely linked. Can I in good conscience say that Western Australians irrespective of postcode are truly in receipt of comprehensive palliative care options? Am I sure that it is truly understood that palliative care is not necessarily a person’s final care option in the last week or three days of their life, but one that can assist a person’s journey over weeks and months, enabling them to die with dignity, as one palliative care clinician put it to me? Hand on heart, I cannot say that I am sure. I do not think anyone can. Specialists in this area have informed me of the various developments and advancements in palliative care over the past few years, yet access is certainly not uniform. It is not universally accessible. Indeed, the report of the Joint Select Committee on End of Life Choices said as much and this has been reflected in other contributions. The committee formed the view that there are —

… a considerable number of people with conditions considered amenable to receiving palliative care, but are not accessing it.

The committee stated clearly that accessibility of palliative care differs markedly across the state and found that access to hands-on specialist palliative care is limited for metropolitan and non-metropolitan patients. The committee found that Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population. It also found that WA Health was aware of “the difficulties and shortcomings in the provision of end of life care”. The department identified 11 gaps and challenges. I appreciate that the government has announced

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further funding for palliative care as recently as this week and that is a very good thing and is absolutely welcomed. But similar to other members who have talked about this, it is true to say that a number of my conversations with palliative care professionals have involved discussions about the adequacy of funding and resources, and I think we need to be very cognisant of those things.

I received an open letter from 150 medical practitioners opposed to this bill, which stated —

What is needed is the urgent correction of funding deficits in the provision of specialist palliative care and support services for those who are approaching their end of life. This applies throughout Western Australia but especially in regional and remote areas, including Indigenous communities.

The letter referred to the need to address significant service gaps, including increasing the workforce, and providing greater care or support services and hospital and community-based palliative care.

I hold other genuine concerns about the bill that have also been expressed by other members in this place, by members in the other place, by members of the medical profession and by members of the community. These concerns will have to be further examined and tested in Committee of the Whole. With all this in mind, ultimately it comes down to whether in my mind this legislation is truly safe and will protect the most vulnerable both now and in the future. I listened very closely to the comments made by Hon Alison Xamon before the lunchbreak in the context of people with a disability. As she knows, I agree wholeheartedly with the comments that she made. In this regard, I, like Hon Ken Baston, want to reflect on a letter that was written by disability advocate Samantha Connor, whom I have met on a couple of occasions. The letter was written during the debate on the Victorian legislation. I also appreciate that within the disability sector there are differing views on this issue. I respect and acknowledge that, but her concerns are not isolated and are certainly similar to some others that have been expressed to me. Her letter is detailed, and I do not intend to read all of it, but she raises a number of issues. She said, in part, as Hon Ken Baston related —

I listen to people talking carefully about safeguarding and the authority of doctors and I am terrified— not just for myself, but for the people in my community. You might not understand that, but that is because you do not know what we know. For us, this is personal.

This is why I’m afraid.

She continued —

In June, we joined with Australian and international protestors and protested the movie ‘Me Before You’ at a cinema in Perth. The film is about a quadriplegic who kills himself at a Swiss suicide clinic, despite having millions of dollars, a supportive family, the love of Emilia Clarke and a castle and jet. The message is that the lives of disabled people are not worth living, that you’re better off dead than disabled. I took a prop tin that said ‘Send me to a Swiss Suicide Clinic’ and jokingly shook it at the nearest able bodied person— half an hour later, I was no longer grinning. Not one single patron asked me why I wanted to die— not a single person asked if I was okay. Not one person refused. Some people told me that they understood that I might want to die, because it would be terrible being a wheelchair user, and that it was ‘my choice’.

It will, of course, be argued that the concerns raised in Samantha’s letter and by others in the context of the risks to vulnerable groups, not only those with disability, are not relevant to the bill given the eligibility criteria identified in the legislation—the parameters that have been set and that the criteria will never be extended. Indeed, although the majority of the parliamentary committee agreed that the warnings about the impact of voluntary assisted dying upon vulnerable population groups should be taken seriously, it believed that the risks could be guarded against. However, can we be absolutely sure that an expansion of the eligibility criteria will never be considered one day when we in this place are long gone? I absolutely and sincerely hope that it will not. But I am not sure that we can guarantee that they will not one day be considered by a future Parliament, not made up by any one of us. No-one can give that absolute guarantee. Indeed, it was probably inconceivable years ago that Parliaments would be debating this very issue today.

I also never thought that I would quote Hon Paul Keating, but I do so today and I want to read a little from his opinion piece in The Sydney Morning Herald dated 19 October 2017. Although he was speaking to the Victorian legislation, it is relevant to this debate. He said the following in response to the claim that safeguards can be provided at every step to protect the vulnerable —

No law and no process can achieve that objective. This is the point … 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. Few people familiar with our politics would doubt that pressure would mount for further liberalisation based on the demand that people are being discriminated against if denied. The experience of overseas jurisdictions suggests the pressures for further liberalisation are irresistible.

That is what worries me. In concluding my remarks, I have chosen not to retell personal stories or experiences that have impacted my family. Perhaps that is because it is too hard for me to do so. Perhaps it is because they are too personal and only for my family to share. But what I can say—and what I say with the greatest of respect—to the small minority of people who contacted me and indicated that if I and others do not support the bill we do not

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understand pain or suffering is that that is absolutely not the case. I respectfully suggest that no-one should presume that because someone has genuine concerns about the safety of people under this bill, they lack compassion, they do not care and they lack empathy and understanding of what it is like to be part of a bedside vigil, to be with someone who is so very dear and loved when they are in the final stages of life due to an advanced, untreatable and aggressive terminal illness. I simply ask: please do not presume that because you would be wrong to do so. I most sincerely recognise both sides of this debate. I completely understand and am truly accepting of the positions put by those who advocate strongly for this bill to be passed. But in all good conscience, and with the greatest of respect for those who have a different view, I do not believe that the bill can truly guarantee that the most vulnerable people will be absolutely protected by the safeguards and conditions included in the legislation.

I go back to where I began and to the questions that I put at the beginning of my contribution. Can I say in good conscience that Western Australians are truly in receipt of highly accessible and comprehensive palliative care options irrespective of postcode? No, I cannot. Am I satisfied that the bill before us has enough safeguards and conditions to enable people to make a truly informed voluntary and free choice in all circumstances? Are there enough safeguards to protect the vulnerable? Are there enough safeguards for those who may have a voice but have others around them who speak louder or for them? Are there enough safeguards for those with a disability, those who may feel pressured either intentionally or unintentionally, or those who feel they are a burden to others? I remain significantly concerned about the bill and I am genuinely worried.

I will conclude on this point. Yesterday, I spoke with a constituent who wrote to me and who kindly consented to me referring to her letter in this place. Her letter states —

Having watch my mother die at the age of 62 from cancer 6 years ago I know firsthand the issues surrounding “dying with dignity”.

She talked about her mother’s illness and her grief, pain and anguish. I do not intend to read that part of her letter into Hansard because that is her personal story that she shared with me. Towards the end of the letter she wrote —

People’s opinion on dying can change as they near the end of life. They may not be able to verbalise it though, and this is my fear.

If this bill is passed, I fear that over the years the laws surrounding the legislation will be lessened. I am very concerned for what could happen to vulnerable people and the older generation in the future if these laws are passed. Once this law has been passed we can never go back.

If I cannot provide a guarantee to one constituent that this bill will provide all the safeguards that are needed to protect the vulnerable, that there will not be one unintended consequence and not one wrongful death both now and in the future, I cannot in all good conscience provide that guarantee to anyone who seeks that reassurance. I therefore cannot support the bill.

HON SIMON O’BRIEN (South Metropolitan) [2.54 pm]: Members, so many of us are going to share personal reflections during the debate on the Voluntary Assisted Dying Bill 2019, and now it seems to be my turn. I do so having done a similar exercise on several occasions in the past. I take a different approach to this debate in my sixtieth year from the one I took in my 30s. My colleague in his 70s knows exactly what I mean because once again, we are forced to confront our own mortality. What would we do in this situation? I am sure that that thought has occurred to every single one of us as we contemplate the very serious matters contained in this bill.

My brother-in-law John Lowe was born 79 years ago. He spent a lot of time outdoors and maybe a couple of decades ago, he started to get skin cancers. He had bits of them cut off over the years and various treatments. But other things happened and things have got worse. I hope he will not mind me mentioning how bad things have become in recent years; how the cancer has caused parts of his bowel to be so dysfunctional that he now has a very annoying colostomy bag; how other cancers have manifested on his chest and people can see some up one side of his face; and how in the course of umpteen operations for different things, he has also developed dementia. In recent years, we have seen him slip away in so many ways. As we all know, dementia is a terrible thing. How much of them is there? Have they really in effect left? It is a very difficult thing for loved ones to come to grips with. But John has been dying and about to die for a few years now. A number of people, family and so on, have gone to New Zealand because they felt they needed to say goodbye. They have done that and he is still there. I went over a couple of weeks ago, not to say goodbye, but to do a range of things. The first thing I did when I arrived was hop in a car and drive 300 kilometres up north to see John, whom I had not seen for many years. I was prepared, as best as people can be prepared, for what I would encounter. Of course, my wife was with me because John is her big brother. It is a shock to encounter someone at that stage of life. They have been suffering for years—they are of advanced years anyway—and they have dementia. Are they really there? Do they know what is going on? Given all that, I found John was in chipper shape. He had the same independence of spirit that he has always had. Of course, we spoke about this afterwards when we were outside. What would his attitude be if he had been asked about this matter 30 years ago? I think he would have said what a lot of people say: “Gee, I hope I never find myself in that position” to which they might add the corollary, which I think a lot of us have probably said—“If I do, somebody

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please shoot me.” We have all heard that said if we have not said it ourselves, and it is said without really thinking through the implications. It is just something that is expressed. What would John say, Joy and I thought, if just for a moment he became lucid and was able to step back from himself? Would he say, “Gee, why haven’t you shot me”? I do not know. I cannot know. He exhibits a determination to keep on living—he really does. All of that strength he has shown all his life is still there. It is still part of his character. But if he were to want to say, “I’ve had just quite enough”, and you could not blame him, he would not be able to be helped by this legislation, because he does not have the capacity to make those sorts of decisions.

I am not trying to out-traumatise anybody who has been good enough to share their own stories with the house. I mention that just to show that, along with other loved ones, that is my story of my brother-in-law at the moment. I want members to know that so that they also know that I get it. I understand the very strong emotions that drive the various participants in the debate that we are discussing now. I want members to know that before I raise my contribution to the debate, which I do now, in these terms.

We are debating the Voluntary Assisted Dying Bill 2019. In the course of this debate, I recall Hon Nick Goiran pointing out to us in his remarks that there have been many, many debates on euthanasia in many, many parliaments and assemblies throughout the world. Indeed, there have been several in this house alone in the last 20 years or so. On each occasion, virtually all of them have been defeated. We ought to think about that and why that has been the case.

Hon Robin Chapple reminded us of October 1997, when Hon Norm Kelly brought a private member’s bill into this place. I was here for that debate and all those that have occurred subsequently. I know and have served with all the members then and since. I have listened to their stories; I have observed their demeanour. To the members of today, I would say this: please do not think that we are any wiser than those who came before us. Perhaps despite everything you have been told recently, those former members possess every bit as much compassion as we now claim motivates all of us; yet, on each occasion, the proposal for euthanasia has been defeated in this house. This time, the proposal is sponsored by government, major media outlets and a professional lobbying and PR campaign, and it appears set to succeed. The arguments, circumstances that brought the issue to prominence and calls for action are the same now as they were then. In 1997, euthanasia became an issue. The government of the day was asked whether something could be done to address the situation whereby a terminally ill person who was in great distress with no prospect of recovery or relief could voluntarily access euthanasia. It sounds very familiar. I recall that the Minister for Health of the day set out to inquire of doctors what needed to happen to address this public clamour. The answer from the doctors came back loud and clear: please do not legislate in this space. No ifs or buts. We had a discussion at that time, and it was interesting to hear Hon Derrick Tomlinson’s contribution to the debate, which members may want to access, in which he talked about what some have referred to as terminal sedation, whereby the process for those facing their own end of life leads, understandably, to great emotional distress. Perhaps we all contemplate how we might react when given a terminal diagnosis, which, of course, in due course, most of us probably will receive. That causes great emotional distress. Also, the physical effects of a terminal condition may cause great pain that requires extraordinary measures to make it bearable. It often happens that people in end-of-life situations undergoing treatment receive narcotics for their pain, but also receive some antidepressant such as valium—I do not know what the up-to-date measures are—to help them with their emotional state. The combination of these two elements can relieve those symptoms for most patients, as I understand it, if not all; then, in due course, it can also have the effect of hastening the drawing to a close of the patient’s life. I do not know that we would see that written down in any statute, but we were told that that is what happens. That is what happens, and that is what needs to happen. It is a matter for judgement and it is something that we cannot legislate.

I can tell members that the doctors as a lobby then and I think substantially now did not want the protection of law in dealing with patients in an end-of-life situation. They did not want the procedures that were to accompany it; they did not want their members to be killers; they did not want their members to maybe be compromised in their own values. Most importantly, they feared that the outcome of some form of regulation would be that end-of-life distress and pain-relief treatments would be less available to patients who needed it because of the advent of a slow-moving prescriptive legal regime that they would be scared to get on the wrong side of. That is the same prospect that exists right now. I sincerely hope that if this legislation succeeds in passing this house, while trying to provide end-of-life relief to a very small proportion of patients, as the proponents point out, it does not have the net result of denying end-of-life relief to a larger number of patients. That would be a terrible thing.

Here we are. We are involved now in another debate about this matter, yet again. Yet again, I wish to acknowledge through you, Mr Acting President, all those who have contacted me. I have over 600 emails that I have carefully put to one side. I have not been able to respond to them all, particularly as they have come in more recently, for and against, in different waves, but I appreciate and acknowledge all those people now. I thank people who have taken the time to contact me and other members. I say to them: you have told me in roughly equal proportions for and against that you expect me to vote for your position. Sometimes, you have told me that with the extra encouragement that your future vote depends on it. It is something of a rock and a hard place, but I have been there before. I just want to say that I appreciate that this is an important issue for people on all sides of the argument. As I said in my
opening story, believe me, I get it. What my constituents—rather fewer than the half million or so who are entitled to vote—may all be assured of is that I seriously consider the interests of all my constituents, whether or not they vote for me, when weighing up any provision that makes it lawful to terminate another person’s life. Those same constituents, with their variety of views, also expect the Parliament to protect society from unintended and, in this case, lethal consequences, and rightly so.

Many health professionals have provided to members their testimony challenging some of the claims of the proponents and supporters of this bill. I have considered at length whether to engage in active debate about some of the arguments raised by activists and keen observers. I have decided not to do so, because I fear it would serve no useful purpose and might indicate a lack of recognition of or respect for the views that are so strongly held by people on all sides of the debate, and I do not want to do that. I do want to put forward, though, the arguments that need to be weighed by this legislature in enacting or rejecting a landmark measure such as the one that forms the core policy substance of this bill.

The core policy of this bill is a declaration of state approval that death is a valid option in medical treatment. That is what it is. Let us not sugar-coat it. It is a declaration that suicide or euthanasia is okay if things get too tough. I fear that the policy will create in the minds of many vulnerable people—the sick, the elderly, the dying, the depressed—a sense that they have a responsibility to die so that they will not be a burden to others. That is a policy of despair. I will not support it. There is also a view put forward by many that the policy contained in this bill is what the overwhelming majority want. Whether it is 80 per cent or 88 per cent or 188 per cent, I am not so sure that that is the case. I have received a number of submissions—members probably all have them—to which I have responded with great and genuine empathy about the circumstances of the individual correspondent, and I am advised that the provisions of this bill would have been of no use to their late loved one, just like it would be of no use to my brother-in-law John.

The provisions of this bill do not apply to many of the situations that many proponents of the bill fear, such as all those situations in which they say, “Gee, I wouldn’t want to end up like this. Gee, if I ever get to that situation, I hope you’re going to shoot me.” That is what the 88 per cent say when asked. If someone is in a terrible situation, they want to, they should be able to access euthanasia. But for many of those people, the provisions of this bill would not apply. Therefore, that leads us to conclude, as Paul Keating has already said a number of times in this debate, that this bill is not going to be the end of the matter. It is only a first step and there will be pressure on future parliaments to extend these measures. It is a slippery slope indeed.

I have told members why I am not going to support the second reading. I have also indicated that I can count. I did not last this long in politics without knowing how to count numbers when votes are being taken, and I think this one might get to a later stage of consideration. I will turn now, though, to some comments on the actual bill. I will do so only briefly, but I will make some comments that need to be placed on the record.

One thing that worries me, and I will raise this again with members on other occasions, is what George Orwell would think about the way our society is heading. I cannot believe the way our world seems to be losing its sense of perspective, and I see so much of it in this bill. On other occasions, we can talk about whether our lives are being taken over by secret government agencies that are answerable to no one. We have seen plenty of newspeak as well, and that brings me back to this bill.

This bill is going to change the law in a number of ways, including that drinking a deadly poison to kill oneself is not suicide, and that killing another human being by injecting a person with the intention of ending life, in the circumstances that we are talking about, is not euthanasia. It will also put into black-letter law the prospect—I think it is quite a scary prospect—that when someone dies by poison, self-administered or administered by another, in accordance with the provisions of this proposed act, the death certificate is to say something else. What is the point of a doctor certifying death and signing something that is false? Surely that must alarm all members and others observing this. What is this world coming to? This is the Orwellian dystopia that I referred to just a few minutes ago. It is happening. It is scary and it should not be allowed to happen, but happening it is.

This bill does a whole lot of things, but there are a few questions that I will be seeking to ask, and I will give the minister some brief notice of them now. I will ask what happens in a situation in which a prisoner who has a terminal diagnosis—possibly a political prisoner or a garden-variety prisoner—is sentenced to a minimum term of imprisonment and their life expectancy is less than the sentence? Will they be allowed to kill themselves with medical assistance, or do they have to serve a minimum term first?

I have already mentioned clause 81 and the falsifying of a death certificate, and I will come back to that on another occasion. I, like others, would appreciate, minister, if I may, some discussion on clause 156, which relates to how this bill would interact with commonwealth law in giving advice and discussing what used to be called suicide, or assisting suicide, via telecommunication devices.

Hon Colin Holt: Carriage service.
Hon SIMON O’BRIEN: Carriage service, as my old-fashioned colleague here reminds me that it is called.

Hon Colin Holt: Very technical.

Hon SIMON O’BRIEN: It is very technical. I thank Hon Colin Holt.

I notice that this bill has a lot of forms attached to it. By gee, it has a lot of forms. I thank the minister for the briefing I received from the relevant agency. I have a flow chart here. No wonder the doctors in 1997 said, “No, don’t legislate for this.” I am just running down all the forms. It is a pretty well set out diagram that I am waving around, which Hansard cannot record as such; it is quite colourful. It includes the first request form and possibly the coordinating practitioner transfer form; the first assessment report form; the consultation referral form; the consulting assessment report form; a written declaration, with two witnesses required; a final request form; and a final review form. That is the first phase. There also needs to be a contact person appointment form, and indeed multiple of those if there are later transfers of a contact person. There needs to be an administration decision and prescription form; an authorised supply form; an administering practitioner transfer form, if required; a practitioner administration form, if required; a notification of death form, if required; and a practitioner disposal form, if required. I must go back to clause 77 and find out what that is. Surely we are not disposing of practitioners!

Hon Nick Goiran: I think it’s if there is substance left over.

Hon SIMON O’BRIEN: Of course it is; thank you.

There also needs to be an authorised disposal form. That is a heck of a lot of bureaucracy. No wonder, as I said, the doctors in 1997 were collectively scared off. There are a lot of things we can get wrong. Without any sense of flippancy, think about what we are talking about. It could not be more serious, yet we apparently have to have a bureaucratic solution. We are also told that there will be safeguards—not one or two safeguards, but 102 safeguards. What does that tell you? Is that a good thing? This must be a really safe bill. Here is a government scheme that is really watertight and foolproof. If so, it would be the first one I have ever seen. Having 102 safeguards does not make this bill watertight; it just shows us how many potential holes there can be. We have to ask the question: if the bill needed 102 safeguards, did it miss any? Maybe it needed 105. Maybe it needed 127; I do not know, but the stakes are pretty damn high.

Looking at the list of safeguards, all 102 of them—they are actually mostly not safeguards; they are various operating and procedural requirements—my attention is drawn now, as it will be if we ever get to the Committee of the Whole House stage, to matters of oversight. I have already alluded to my concerns about all these bodies being set up to run around and do their own thing, answerable to no-one. We have the Voluntary Assisted Dying Board. Dear, oh dear. It will provide an annual report to Parliament. Then what will happen? Who will make sure it is doing the right thing? There is also a provision for a review of the act, initially at two years. I will tell members now what that first review will say. It will say, “It takes a long time to get these processes up and running, so the act has not effectively been in operation for very long, so we haven’t got much to tell you.” The review at five years will be interpreted not as five years from the start, but five years after the first review. What will it say then? What will the review of the act say? What will be the criteria for deeming it a pass or a fail? Will it be how many people who died under these provisions were, upon autopsy, found to have been misdiagnosed and did not have the terminal condition that they were told they had? That has happened elsewhere. How many occasions, for example, will that be allowed? What is acceptable? If we were debating a law to say, “Let’s hang some mass murdering eminently guilty beyond all doubt person whose continued existence on this earth poses a threat for the innocent”, people in this house would be saying, “Ah, yes, but this is something that is too serious. If you made a mistake, if just one person was incorrectly convicted and hanged, that would be so bad that that would justify us not having this law.” You know what? They are right. That is an appalling happenstance, almost too appalling to contemplate. Okay, what about the victim count under this legislation that so many in this house want to support? How many people? How many people will have to become casualties, as reported in the review of the act, before we deem it a failure? Will they just be collateral damage, as the American military would call it, or will zero be the acceptable limit? I do not believe zero will be the outcome. If the minister could give us his view on what the criteria will be for deeming it a pass or a fail—I anticipate it will not take long, because I do not believe that the government sponsoring this bill has given that a moment’s thought—I do not think he will have any sort of satisfactory answer. Perhaps the minister could even tell the house that he just does not know.

I have some concerns about the way the bill is constructed, but overall, with all due respect to the officers who have been involved in creating it and to others, including committee members from this house and the other place, a great deal of work has been done and my argument is not with the processes that have produced the system as it has been produced; my argument is with the policy of the bill that required it to be produced, because I do not think it is the outcome that will serve Western Australia well at all. I think it will lead to victims and, most importantly, it crosses a key threshold whereby we will allow, with state sanction, a declaration to be made that someone’s life is valued and that someone else’s does not matter. If we adopt that as a policy, I think that would be a very sad day for the future of our community and our society. With all that in mind, and with all the respect in the world to those who are motivated to support this bill, I say with great respect that I am unable, once again, to support this measure, because it would be a bad law.

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HON COLIN HOLT (South West) [3.29 pm]: I rise to give my views on the Voluntary Assisted Dying Bill. I have to say that the air in the chamber has been particularly heavy in the last week. It has been a very solemn debate. Obviously, it needs to be solemn and serious and everything we say needs to be taken seriously. There has certainly been heavy air in the chamber in the last week. I do not have any good jokes so I will not be telling any at this point in time. Maybe I will along the track in my contribution.

I first want to say to all members who have spoken so far that it has been a very interesting debate and, across the chamber, it shows the diversity of the views of our community and our society and their development. It makes the chamber richer for reflecting the views of our community. That is exactly how it should be. The other aspect is the respect for the variety of views. We should always maintain that, even though it gets a bit boisterous in here on occasion. However, the respect that can be shown for the different views is just as important as the content of the debate itself. I encourage that to continue, especially as we go into Committee of the Whole House, which I would think will be a long and arduous debate for this house. We will probably sit extended periods at some time. I am already feeling tired after a week. Once we get into the detail and the toing and froing of technical argument, it will be a real test for all in the chamber. I encourage members to continue to put their views, as I know they will, but with the respect they deserve and with respect for fellow members.

I rise in strong support of this bill. I do so after having been on a two-and-a-half-year journey, both personally and in a parliamentary sense. That journey has led me to strongly support this legislation. I have come to the conclusion that it is clear that this legislation is primarily about compassion. It is at the heart of my position and the heart of my decision to support the legislation. I put front and centre in my considerations the suffering of those people who are terminally ill and right at the end of their life’s journey, because they are the people we are talking about here. They know they will die and are suffering to an extent that they define their position as being unable to put up with it any longer. My view is based on putting those people front and centre in this debate. Throughout my contribution and when I consider support for the bill and consideration of amendments that undoubtedly will be put forward, I will put those people front and centre in all my considerations. The people I believe want this legislation and this opportunity will be those who are at the end of their terminal illness journey, their cancer journey or whatever it may be, and finally want some relief in the way that they want it.

To reiterate that, this bill is for Western Australians—Western Australians who are suffering. We must continue to consider this. This is about our fellow Western Australians who we know are going on that journey. People will not qualify under this bill unless they have fewer than six months to live or 12 months for those with a neurodegenerative disease. They are at the end of their life and that is when they will want to pursue this option. We must remember that this legislation is also about choice—a choice for those who will meet the strict criteria. Although I agree with Hon Simon O’Brien, I do not think there are 102 safeguards, I think it is more about process in some of those areas.

Hon Simon O’Brien interjected.

Hon COLIN HOLT: No; I am paraphrasing him, if he likes. There are strict eligibility criteria and strict processes for people to go through. However, there is a choice all the way along the process, and we have to remember that. Not everyone will take up this option; it will probably be taken up by quite a small number of people. I do not know that we know what that will be. Certainly, the only real comparison we can make is with the Victorian legislation, although that act has been in operation since only July 2019. There are probably no statistics on it because the implementation of the policy in that state is quite recent. It will be an option for a narrow number of Western Australians. I think that is reflected, for example, in the bill, which is called the Voluntary Assisted Dying Bill. It is voluntary all the way along the process. People can make a choice whether to adopt it.

I completely accept the faith-based objections to that choice. I have absolutely no problem with them at all. I accept and respect that members may have a faith-based objection to accessing the voluntary assisted dying regime; that is fine. I think it is about people who want to access it, and that is why we are trying to pass this bill.

When I was on the Joint Select Committee on End of Life Choices, one thing that struck me with all the letters and evidence we got was that people really want to live. They go to extraordinary lengths to live for as long as they can to be with their family, their loved ones and their community. They fight and go through a range of medical treatments because they want to be cured and continue to live and be part of their family. When I think about who will apply for this regime if it is passed, it will be the people who are really at the end of their tether because they have a terminal illness and are right at the point of saying, “I’ve had enough. I’ve got no chance of a cure. I’ve been through all the options—chemo, radiation—and I’m now struggling. I’m bedridden and I’m in pain.” It will be a narrow group of people. They are the ones who will be driven to take up this option for those reasons—they have had enough. Members, I hope that we in this chamber never have to make this choice and that we live long and happy lives and die peacefully in our sleep in our own beds, in our own homes, when the time comes. That would be a wonderful thing.

I talk to my mum quite regularly. She is 92 now and still living independently at home, but someone comes every day to check on her. She gets meals on wheels delivered and someone comes to help her shower and to clean her house. Living at home at 92 is pretty good going. I often sit down and talk to her. My latest conversation with

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mum has been probably a two-year conversation about residential care. We cannot force people to go into residential care, can we, especially when it is your mum? We have to have a conversation with her that takes her along the journey of thinking about it till we get to point at which she says, “Okay, let’s have a look.” That is how it has been. When we first raised it, she said, “I’m not leaving home; I want to stay here for the rest of my days.”

Over about 18 months, we have come to the point of taking her to look at a few. That is the way it works with her. Whenever I go to see her, she always says a couple of things to me. One thing she says is, “Oh dear, I am getting forgetful.” I always say, “Mum, you are 92; you are allowed to forget things. I am 56 and I forget things. It’s okay; you can do that as long as you don’t forget to do the things you are meant to be doing, like feeding yourself, having a shower, getting up in the morning, being busy doing stuff and taking your tablets.” I had to organise Webster packs for her because she was doing it wrong and ended up in hospital. Another thing she always says to me is, “All I want, love, is to go to sleep one night and not wake up.” I say to her, “Guess what, mum. We all want to do that, but not all of us are going to be that lucky.” I think that is what this bill is about; it is about those people who are not going to be lucky enough to have the option of living until 92 and going to bed one night and not waking up in the morning.

I know that some of us in this chamber have already been unlucky enough to develop cancer and other illnesses that are and have been life threatening. We have heard some of those stories already. Many more people are facing the same situation. Luckily, members of this chamber and many people in the community get the expert treatments that are available. A person’s illness might be recognised very early; they get the right treatment, overcome the illness and continue to live the rest of their days. That is a good thing. Our medical system and medical practitioners are set up to assist people and to ensure that their illness is treated so that they can go on with their life. Our medical system works to sustain life. We know that there is plenty of evidence that not all of us are that fortunate. We know that some people with a cancer die and others do not. The Joint Select Committee on End of Life Choices gathered responses and took evidence during its inquiry and the evidence is clear. Undoubtedly, the letters, emails and notes to members of Parliament reflect heartfelt stories, which we have no reason to doubt, of people who did not get a cure and faced an early end to their life. That is just the way it works. Again, that is what this bill is about; it is about those people have not found a cure, are at the end of their days and are suffering. That is what it is all about. I urge members to keep that in mind during this debate. There is lots of noise and counterarguments, and bits and pieces are being pulled out of the debate that in isolation one thinks could be true. But taken as a whole and by focusing on who this legislation, policy and practice is for, it is clear in my mind that it is for those people right at the end of their life who want the option to hold their loved one’s hand and go out on their terms.

For members’ information, I was a member of this place in 2010, when Hon Robin Chapple introduced a private member’s bill. I think it was in my first year in the chamber. As a fairly new member, in my mind, it was quite confronting to be dealing with a bill of that magnitude. As a younger—a newer member of the chamber rather than a younger member!

**Hon Robin Chapple:** Why does age always come into it?

**Hon COLIN HOLT:** I am talking about my age not yours! I was a newer member of the chamber and I voted against the bill, but my views have changed. The reason for that was, in part, my journey with and commitment to the joint select committee and other things I have done. I would like to put on the record my involvement in the committee. I attended all committee meetings, with the exception of two or three hearings. The reason for that was that my plane from Albany was delayed—unscheduled and unwanted, that was for sure. It was a real shame that I could not make a couple of the first hearings because I think one of them was with the WA Country Health Service or maybe the Department of Health—I will have to go back and look at the records to check. It was a bit disappointing that I could not make the hearing, but obviously the transcript and video were available.

I also want to talk about some of the other things that I have done to inform myself about the debate on this issue before I came to any conclusions. I did a range of travel under my own initiative to explore the issue a bit more. It was never part of any official committee travel. I did it because I wanted to put some effort into the debate on the issue. In November 2017, I travelled to Melbourne with Amber-Jade Sanderson, MLA, who was the chair of the select committee. We met with the Victorian legislators and members of the Legislative Council’s Legal and Social Issues Committee. It is a standing committee; it was not a select committee. The committee had an inquiry into end-of-life choices. When we were in Melbourne, it was the last two days of the Legislative Council’s debate on the legislation. We purposely went to see some of that debate. We wanted to see how the chamber reacted to the debate, the level of scrutiny given to the bill and the government’s interaction and response to it. We were there for two days. The Legislative Council had one all-night sitting, which I did not stay for, to get the legislation through. Amber-Jade Sanderson and I saw the debate, but we also met with the chair and other members of the committee. We wanted to find out the sort of process Victoria had gone through, because the Western Australia Parliament was embarking on its process for its legislative framework. I thought it was important to understand the sorts of issues the committee could face and to get a handle on the process it went through. It was valuable.

In 2018, I went to Switzerland and met with representatives of Dignitas. Members have mentioned Dignitas in the chamber before and probably will again. Dignitas is a Swiss non-profit members’ society providing assisted, accompanied suicide to those members of the organisation who suffer from a terminal illness and/or severe physical

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and/or mental illness. The Dignitas society exists because there are no voluntary assisted laws in Switzerland and no laws preventing someone from assisting a suicide. The Swiss model is a completely different system. People do not often speak about VAD in the context of the introduction of laws because the Swiss model is completely different.

For a number of reasons there is no address for Dignitas on the internet. One reason is to maintain the confidentiality of people who access the service, because it is still quite controversial in some parts of Switzerland and Europe. Dignitas gave me instructions like, “Catch the number 6 train to such and such station and then get on the 34 bus. Get off at the third station, go around the corner and there is a double-storey house. We are on the second storey.” The instructions were quite complex, but I got there in the end.

**Hon Simon O'Brien:** International man of mystery!

**Hon COLIN HOLT:** Yes, that is right. I had to ask someone in the end. Luckily, the Swiss speak English very well. I was told that I was in the right building but I had to go to the eighth floor. There were no signs anywhere.

I thought it was important to go to Switzerland to see what assisted dying was all about in that country. That was around the time that Dr Goodall travelled to Switzerland; he may have gone there just before that. I cannot remember exactly but I think he went there when the select committee met in its early stages. He may have been there three or six months before I arrived, from memory. The Swiss model was on everyone’s lips because of what Dr Goodall had done.

When I was overseas, I also went to the Netherlands to hear from the people involved in the operation of its laws. I met with a number of different people and groups, including the NVVE, a not-for-profit pro-euthanasia organisation—probably a bit like our Dying with Dignity Western Australia. It plays the same sort of role in advocacy. My impression of the NVVE in the Netherlands is that it probably plays much more of a navigator role in its system. It is way beyond advocacy because it has probably moved into a different phase of where the law sits within its society. I met with the Dutch government authorities that are responsible for the operation and the monitoring of the act. I also met with representatives of the regional euthanasia review committees. There are a number of these in different provinces around the Netherlands. These committees assess whether a physician who has performed euthanasia or assisted suicide has complied with the due care criteria set out in The Termination of Life on Request and Assisted Suicide (Review Procedures) Act. One committee’s role is to review how it is working. If I remember rightly, the membership is made up of a lawyer, a medico and an ethicist, which is really interesting.

**Hon Stephen Dawson:** What was that?

**Hon COLIN HOLT:** An ethicist. I am not sure how we define or find an ethicist. I think there are six or eight of these review committees around the country. Most of their members are academics from the university sector.

I will continue with what else I did to inform myself. In May this year, I went to Melbourne for the Victorian Voluntary Assisted Dying Implementation Conference. Obviously, the Victorian bill had passed, and it was going to kick off in July 2019. In May, the final bits of how it would be implemented was discussed. If I remember rightly, it was run by the Victorian nurses federation, and nurses obviously played a major role in the implementation of the service. Members may remember the Canadian doctors who gave a presentation here. They were also at this conference, giving their thoughts on the Medical Assistance in Dying Act, which they operate under, and the process they operate under as well. I really wanted to inform myself. I was always struck by the focus of this bill. I will come back to it because it is important to keep in mind that this is about Western Australians who are suffering from pain that they do not find acceptable at the end of their life. That will continue to be my focus throughout this debate.

The Joint Select Committee on End of Life Choices received submissions from a large number of people—800, from memory. We held about 70 or 80 hearings and heard from 125 to 130 witnesses. It was a wideranging inquiry. We received a lot of evidence from all sides of the debate and heard many different viewpoints. Again, we received a lot of evidence from people about their experiences of dying journeys.

There has been a lot of debate about palliative care provisions. I am the first person to say that we need more palliative care funding. In fact, a major recommendation of the joint select committee was for more funding and more services for palliative care. The committee clearly recognised the role that organisations such as Silver Chain play. One of the recommendations was to ensure further funding for those sorts of organisations. They recognised the need for increased hospice care in the northern suburbs. We also need more palliative care services in regional Western Australia, which I thought was really important. There is a glaring gap in those areas. It has been well documented that as soon as we get away from a major centre, the chances of accessing palliative care are a real challenge. People can be lucky to get the right palliative care nurse visiting their region or home or they may not be. We know that occurs.

Being a regional member, I already know and understand that there is a two-tiered health system. Every former and future government, not just this one, will have to face that challenge of a two-tiered health system. People living in Perth have a much better opportunity to access the health services they need than people living in regional}

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Western Australia. That was reflected in the committee’s report on palliative care outcomes. Although we welcome the funding increase to regional palliative care and palliative care generally, the opposition will be monitoring that and what it means for action on the ground. That will be the measure of that outcome. I am lucky enough to visit Albany regularly. It has one of the greatest hospices in the state. The people of Albany and the surrounding districts are well looked after. But we do not have to go too far from Albany to see that there will be limitations in the services delivered. Everyone will be watching that space. We need not only increased numbers of palliative care specialists in country areas, but also more dentists, general practitioners, cardiologists, oncologists, physios, nurses and gastroenterologists. If we are serious about providing services for those people in the bush, that is where it has to get to. We have to keep driving that as regional members and keep reminding the government about that.

I do not want to see the implementation of a voluntary assisted dying regime, if this bill passes, that makes that two-tiered system even worse. I know that there has been some discussion around some of the potential amendments to be put forward. We want to make sure that we double-check everything and put another safeguard in there. One of the amendments relates to referrals to a specialist, being the consulting practitioner. We have to think very carefully about that because of the consequences it has for country people. If one of the steps involves people needing to see a specialist who agrees to help that person on their journey, we have to keep a couple of things in mind. One of them is that they are ill and in the final days of their life, or a maximum of six months away from predicted death and in reality probably much closer. As I said, they are ill and they probably find it difficult to get out of bed. I am making some generalisations, so I ask members to bear with me. Once they have found their consulting GP, hopefully that GP is not a conscientious objector because they might have to go to a neighbouring town to find another one. Then, the second stage is that they have to find a non-conscientious objector specialist. They will probably need a referral from a GP to do that. Then people start to think that things are getting really hard. I think that is one of the challenges. We want to make sure that there are no wrongful deaths so we want a specialist in that mix, but we have to remember that that is one of the unknown consequences for regional people. I want to come back to a bit of that process down the track.

Earlier, I mentioned taking things in isolation. I want to give a demonstration of a journey that someone might go on in their treatment. I will tell a personal story about my own father. It is actually quite a good story and it really ended quite well—very well. In my mind, the story demonstrates a couple of very important things. People can correct me or they might want to add to those things, but I think the story reflects the typical journey of someone who is caught in the situation of being diagnosed with cancer. Again, members can make that judgement. This is just what I am basing my view on, because that is my experience of this situation. The thing I really want to show is that once someone is diagnosed with a potentially life-limiting illness, they have an enormous amount of contact with the medical profession, from GPs to specialists. They go back and forth between specialists and GPs getting referrals, blood tests, scans and biopsies. There is an enormous amount of interaction with the medical fraternity. That is exactly what happened with my father. Very recently, I was talking to mum and I asked her about his passing, because I wanted to explore whether she thought he had been in pain. Much to my surprise, she got out this notebook in which she had written everything that dad did at the time of his illness. In fact, there were a thousand things in it that were not even related to dad’s illness. Things like when they bought a car or a new washing machine were written in the notebook. I have some photocopies of the pages that were pertinent. It is amazing. I said to mum, “We won’t lose that.” When mum goes, that could be the eulogy! We could read it out, because it is incredible. It is all mixed up—page 1 follows page 7 and then page 5! Anyway, I picked through the notebook and it tells dad’s story from diagnosis to the end. I briefly want to go through the story, because it gives me context about when people are going to request this end-of-life consequence and journey.

Dad was first diagnosed at 80 years of age with bowel cancer. That was in 2003. I have taken some of these things from mum’s notes, but I have summarised them a bit so as not to bore members too much. On 27 February 2003, dad had a blood test identifying that something was wrong. Two weeks later he had a further test with the result saying he had a growth on his bowel. That was two weeks. Within nine days of finding that growth he had seen a colorectal surgeon and he had the operation to remove the growth. He spent two weeks in hospital recovering and was sent home. His prognosis at that point was very, very good. Things moved really rapidly once they discovered the cancer—really rapidly. In June that year, so a couple of months later, he returned to hospital for a week for a further operation. It was more of a fix-up operation to restore proper functioning, and people can conclude what that means. During that time, he was seeing both a cancer specialist and a surgeon. About a year later, in March 2006, dad again visited a colorectal surgeon after referral from his GP to see a specialist, because dad had been regularly visiting his GP. Mum has every date of every blood test in her book. He had a blood test that suggested that not all was right and in fact the cancer had come back. April and May 2006 were spent seeing specialists and having scans and tests. A scan revealed a spot on his lung, so he was referred to a cardiothoracic surgeon. More tests, more scans and more specialist visits showed cancer cells in the bowel, lung
and liver. Then there was a trip to the hospital for more tests, bone scans and lung biopsies. Members can see the journey he was going on. He was in and out between GPs and specialists all the time. He was referred to an oncologist for treatment at that point, and I think we can see where this is probably going to go. Chemotherapy started in June 2006—dad was then 83—and over the next four months he had eight chemo treatment sessions, often staying in hospital for days at a time, and once he was in for two weeks to recover. By December 2006, he had been referred to a radiation oncologist and he received radiation on 29, 30 and 31 January 2007. Again, I think we can probably work out where this is all going.

In February 2007, he had a number of bone scans and a CT scan. In April 2007, they put him on a new treatment regime with the injection of irinotecan, which is a cancer treatment. He had three of those in April 2007. He was then 84 years old. He had his first diagnosis at 80 years of age and that was four years later. He had had two really good years, but things were going south pretty quickly. By 4 May, a decision was made for no more treatments and to carry on with his tablets, which were MS Contin, an opioid medication with morphine. At that point, the idea was to send him home and make him comfortable. Mum was basically in charge of dad’s tablets. Mum’s notes also show that on 9 August he started taking oxygen, because he had cancer in his lung and could not breathe well. On 10 August, he started using a nebuliser, and then on 17 August, mum’s notes say, “Increase MS Contin and continue to increase at dad’s request.” Basically, whenever dad said he needed another tablet, mum went and got it for him. That was done under the doctor’s instructions and it was all sitting there, so that is what happened. As mum’s notes show, he woke up on the morning of 18 August and asked for his morphine medication. Mum went to get them and by the time she returned at 6.45 am on 18 August 2008 he had passed away. She had that written precisely. The poor bugger. Mum went off to get his tablets and by the time she came back, he had gone. She immediately rang me.

The point of this is that, as we can see, his treatments went on for a long, long time. None of those decisions or treatments were ever done in isolation. Even giving more morphine was never done in isolation. He went through a range of treatments with a range of GPs, a range of scans and a range of specialists. It was not as though the specialist was introduced at the endpoint of his journey; he had been through all that. Everyone knew where the prognosis was heading. All these notes were there to say that is where we were heading and he had been through that whole range of things. I picked up a couple of important things from all that. Up until the point that they sent dad home to be comfortable, the focus of the medical intervention was around extending his life and finding a cure: “Let’s have another crack at this one.” Oncologists are pretty good at that: “Let’s see how this medicine goes” or “We’ll try this and see how you respond to that.” He went through the whole gamut. He probably lost about 30 kilos by the end of it. He was not a tall man, as members can appreciate! By the end, he had lost quite a lot of weight. Dad was like all those guys from that generation—proud, independent and stubborn men who worked hard all their life. One day when I visited him, a nurse came to give him a shower. She could not turn on the tap. I had to turn the tap on because Dad had no strength. He was really embarrassed that I had to go into the shower while he was in there to turn on the tap, which is silly.

Until the point of being sent home, it was all about trying to find a cure. When the decision was made, “Go home and make him comfortable”, it was all about palliative care and making him comfortable for when the time came that his heart would stop. That is the most critical decision point in what we are talking about. I honestly believe that people will go on the journey of finding a cure because they want to live for as long as they can. It is only when they reach the “send home and make comfortable palliative care phase” that this other stuff starts to come up: “Okay. I know I can’t be cured. I’m shitting myself”—for want of a better word—“of the end and what it will look like. When is my comfort going to come?” Dad was extremely lucky because it seemed that the MS Contin had done the trick. Only he would be able to tell us how comfortable he was, but after talking to my mum, the consensus is that he was pretty comfortable. Obviously, he needed morphine to keep him pain free. But compared with the experience of people described in some of the letters that I received and some of the evidence taken by the Joint Select Committee on End of Life Choices, I would say he had a better passing than most. He was one of the lucky ones.

The palliative care that my dad received and the palliative care specialists were very good, even for 2007. Palliative care has come a long way in 12 years. The Silver Chain staff who looked after him were outstanding. Silver Chain has a long history of providing fantastic care.

When I talk about that journey and when I think about some of the potentially too-risky stuff—I am sure there are some potential risks—I always think about the outcome for a person in the last phase of their dying journey. It is just after that bit, “We can’t cure you” and it is about moving onto palliative care and making them comfortable. As an aside, a series of amendments have been flagged by Hon Martin Pritchard. I want to put my story in the context of the journey that most normal cancer patients go through. The amendment I want to talk about deals with GPs initiating the discussion. I am of the belief that all the options should be on the table. If members think about my dad’s story, they will realise that it happened in different stages. When people first see a GP, they do not talk about the end point. The GP says, “There’s something wrong with your blood test here, mate. We’d better send you to a specialist to find out what is going on.” The specialist says, “Alright; let’s have a look at this to see what

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it could be. You’d better get some scans and biopsies and we will check it out.” The surgeon says, “I’ll tell you what we’ll do. We will fix this. We will operate and take the bit out and see how successful it is.” The conversation about palliative care and what happens at the end of life probably kicks in after a person is sent home: “We need to send you home. We can’t cure you. But we’ve got some options for you towards the end.” If we remove a GP’s ability to initiate a conversation about voluntary assisted dying, we take away an option for people when they are at their most vulnerable.

Debate interrupted, pursuant to standing orders.

[page 7890]

Resumed from an earlier stage of the sitting.

HON COLIN HOLT (South West) [5.11 pm]: I think I was talking before about the amendment proposed by Hon Martin Pritchard, and my view that we need to have an extended conversation about all treatment options. I think in practice those things will occur at different times. I picked up something during the speech made by Hon Dr Steve Thomas, which I want to reflect on. I think it has some relevance to this topic. I will quote from yesterday’s uncorrected Hansard of his speech. It says —

People need good end-of-life care. For those who do not want to take that final step, I offer a piece of advice, and this has been available to patients and their doctors for some period. If a person’s pain is extreme and their incapacity is high, they have the capacity to discuss with their medical professionals today the need to increase their dose rates of various painkillers up to the point at which it may be a risk to their life. I say to those people who want to go down that path that if they go to their doctor at the moment and say, “Will you please kill me?”, they have to say no, but if they go to their doctor and say, “I understand that I have a high pain disease and I have a low pain threshold, and I understand that you will need to increase the doses of an opiate of some form to the point at which it will start to have negative impacts and at some point you will most likely have to increase that dose to the point at which it will most likely end my life”, the doctor has the capacity to do that now. Parts of the medical profession talk about increasing the dose — lots of doctors have increased the dose — to the point at which end of life is perhaps not a certainty, but the person will get there eventually. The doses that a person will have to be on will be very high. There will come a point in that process when there will be respiratory suppression, particularly if opiates are used in conjunction with dissociative anaesthetics. I do not propose to go through all the details and the names, because I do not want to talk about a manual for the process, but there is a point, particularly with that combined structure and plan, at which there is effectively a likelihood of the end of life. A person’s medical support crew can put that in place today. It is a conversation that a person has with their medical professionals about understanding the risks.

I point out that because I think it is pertinent that doctors have those conversations now about how we manage end of life, and one of the things they say all the time is, “We can give you an opiate that will make you comfortable, and we can act to give you an opiate that will put you into a deep sedation, a terminal sedation or a palliative sedation.” They know the outcome of that, even though the doctor will talk about the doctrine of double effect and it is for only pain relief. We know the consequence of it, which is death, and that is what happens. We are allowed to have those conversations with that outcome, yet we want to restrict the conversation around a much more controlled and regulated process than it ever was. In my opinion, we must have that open conversation, and we must allow doctors to initiate the discussion. I know that it can be initiated by a patient, but patients do not know all those things. We go to medical professionals to get that advice and to have those discussions. I am obviously going to listen to the debate and the response that comes from the government, and I am happy to hear that, but I think that at this point I am probably of the mind that we need to have a fairly open and trustful discussion between the patient and the doctor.

The other point is that I am not sure how we would police all that sort of stuff. If we make a restriction, how do we find that out and break open that patient–doctor relationship of trust? It is really difficult. Imagine a conversation just skirting around the edges of it. I cannot figure out how we would actually do it. Perhaps some doctors can enlighten us to how they do it now with terminal sedation. They probably say more about making life comfortable with these opiates, until the patient goes into a very deep coma that they probably will not come out of. I am not sure what the difference will be for how they handle that in the future. This is about the patient, and about patient-centred care, and that is where we should be concentrating. Doctors will be talking about that all the time, and that is why they must be allowed to have the full conversation about it, giving the whole range of options, at some point in time when it is appropriate. As I said before, when a person is first diagnosed, they are not going to talk about this bit, because it is not relevant or pertinent yet. A range of conversations about treatment options must be put before them.

The other thing is that it is voluntary. Even discussions around treatment now are voluntary. When dad went through his chemotherapy and radiation, he would have got to the point at which he could not take any more, and even though the oncologist might say that there is a new drug we could give a crack, at some point in time, because they are allowed to, the patient can say, “Thank you, I think I have had enough treatment.” It is all a voluntary thing, even though all those options are in front of them. That is why we can allow it, because it is still a voluntary decision.

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As I said, those conversations are going to occur at the end-of-life phase, which is when there will be that potential request. Up to that point, all the discussions are about cure, not palliative care or making the patient comfortable. In fact, there is a strict line of eligibility in the bill that outlines all that. I want to point that out in the bill, although I am sure all members have seen it before.

Part 2 of the Voluntary Assisted Dying Bill 2019 is headed “Requirements for access to voluntary assisted dying” and the eligibility criteria is listed as —

(1) The following criteria must be met for a person to be eligible for access to voluntary assisted dying —

(a) the person has reached 18 years of age;

(b) the person —

(i) is an Australian citizen or permanent resident; and

(ii) at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;

(c) the person is diagnosed with at least 1 disease, illness or medical condition that —

(i) is advanced, progressive and will cause death; and

(ii) 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 that is neurodegenerative, within a period of 12 months; and

(iii) is causing suffering to the person who cannot be relieved in a manner that the person considers tolerable;

Even though a conversation might occur early on in a person’s diagnosis, they will not qualify to take up the option of voluntary assisted dying until they reach that point. Even if a doctor says at the very beginning of a cancer diagnosis that if they reach the end-point they can access voluntary assisted dying, they do not qualify for it until they go through the process and it is decided, “You’ve got a disease, illness or medical condition that is advanced, progressive and will cause death with the probability of dying within six months and is causing intolerable suffering.” That is the point at which a person will qualify to take it up, even though there has been a conversation beforehand. I think there should be a conversation at that point.

Debate adjourned, pursuant to standing orders.

Legislative Council

Tuesday, 22 October 2019

[page 7964]

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from 17 October.

HON COLIN HOLT (South West) [2.11 pm]: I will not take up too much of the house’s time, but I will make a couple more points. Last week when I contributed to the second reading debate on the Voluntary Assisted Dying Bill, I used the journey of my father, who died from bowel cancer, and I want to make a couple of extra points about that journey. I left it when I was talking about the need for a specialist opinion, as required by the bill. All through dad’s journey, from going through chemotherapy, radiation and bowel operations to the point that it was decided that it was time for him to go home and be made comfortable, there was never a question about his capacity to make decisions—that is, to either consent to or refuse treatment. He saw a range of GPs and specialists who never sent him anywhere for further assessment of his capacity to make a decision. They would have ascertained that he had that decision-making ability, and in my mind that is exactly how it should have been, because he was very clear in his thinking the whole way through. I certainly never questioned his ability to make a clear decision about consent to or refusal of treatment. I will explore this in a bit more detail, because there are a number of other examples in which medical professionals make assumptions about people’s ability to make decisions or whether they have the capacity to make decisions.

One of those is the implementation or development of an advance healthcare directive. Of course, members will know that an advance healthcare directive is a signed document in which a person outlines their future medical treatment if, at a point in time, they cannot make a decision or give an indication about the type of medical treatment they want in the future. The Joint Select Committee on End of Life Choices went into them in some
detail and recommended that there be further investigation on the uptake and promotion of advance healthcare
directives, and the government, through the Attorney General’s department, established a group to look into that.
I want to explore this in more detail because when people make an advance healthcare directive, they can make
a number of different care directives. One example I have come across states, “If I have a terminal illness, I do not
want any life-sustaining treatment. Please just keep me comfortable and pain-free until I die.” People can write in
their advance healthcare directive now. Another one that is often used is, “If my heart or my breathing stops, then
I do not want to be resuscitated.” Members may be familiar with do-not-resuscitate orders. When people make
advance healthcare directives, what is the assumption about their capacity? For all intents and purposes, advance
healthcare directives contain very big life and death decisions.
I turn to a template I got off the Department of Health’s website. One of the template questions is —

1. **Treatment decision**

   In the following circumstances:
   
   People have to fill in the blank lines with the situation —
   
   I consent/refuse consent (cross out or initial one of these)
   
   to the following treatment:
   
   The examples I have given would fit into this template. At the beginning of the template, the notes state —
   
   - To make an advance health directive, you must be 18 years of age or older and have full legal capacity.

   That is the way that doctors assess whether a person has the capacity to make decisions. That is what people need to
   fill out an advance healthcare directive. The footnote says that it pertains to section 110P of the Guardianship and
   Administration Act 1990, which states —

   **Making advance health directive**

   A person who has reached 18 years of age and has full legal capacity may make an advance health directive
   containing treatment decisions in respect of the person’s future treatment.

   That is pretty clear, and reiterates what is in the template. In section 4, “Principles stated”, full capacity is articulated.
   It states —
   
   (3) Every person shall be presumed to be capable of —
   
   (a) looking after his own health and safety;
   
   (b) making reasonable judgments in respect of matters relating to his person;
   
   (c) managing his own affairs; and
   
   (d) making reasonable judgments in respect of matters relating to his estate,
   
   until the contrary is proved to the satisfaction of the State Administrative Tribunal.

   There is the presumption that people can make decisions until someone says, “Hang on a minute. We think there
   are some problems”, and that person needs to prove that that is the case. Advance healthcare directives presume
   that people have the capacity to make their own decisions. There are similar provisions in the bill, although they
   are not directly lifted from that. Clause 6 states —
   
   (2) 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 —
   
   (a) understand any information or advice about a voluntary assisted dying decision that is required
   under this Act to be provided to the patient; and
   
   (b) understand the matters involved in a voluntary assisted dying decision; and
   
   (c) understand the effect of a voluntary assisted dying decision; and
   
   (d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purposes of making
   a voluntary assisted dying decision; and
   
   (e) communicate a voluntary assisted dying decision in some way.

   (3) 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.

   That suggests that there is consistency with what we expect from advance healthcare directives and people making
decisions about their life and how they will be treated, and how this will apply under this legislation. In my opinion,
that is the right way that it should be done. If there are any doubts by the consulting or coordinating practitioners,
there is proposed section 25, “Referral for determination”. I want to paint the picture again. We assume that people who will sign up to or qualify for voluntary assisted dying, after meeting all other qualifications, will have capacity—that is, presumed capacity. But if any doubt exists, proposed section 25 provides—

(1) Subsection (2) applies if the coordinating practitioner is unable to determine whether—

(a) the patient has a disease, illness or medical condition that meets the requirements of section 15(1)(c); or

(b) the patient has decision-making capacity in relation to voluntary assisted dying as required by section 15(1)(d).

(2) 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.

There will be a presumption that a person will have capacity—my dad’s case was a perfect example of that because he had capacity—but if there is any doubt, the bill provides that they must be referred to the right practitioner or specialist for assessment.

I will now take the argument one step further. Think about someone who has been rushed to hospital in a coma. They cannot communicate and, obviously, they cannot consent to or refuse medical treatment. What will the medical team do in that situation? In an emergency, they act immediately, because their first action is to save life. But what will happen when someone in a coma, who cannot give permission for what is about to happen to them, is taken to hospital and they do not require urgent treatment? What will the medical team do? Firstly, the medical team must ask whether the patient has an advance healthcare directive. If they do, the medical team must do what it says in the advance healthcare directive. Remember, the advance healthcare directive was made way back when there was a presumption of capacity. If there is no advance healthcare directive or it does not have the specifics of “If I get this, I want this treatment”, the medical team must go to something known as the hierarchy of decision-makers.

That means that they basically have to ask the patient’s family members to make a decision. I downloaded from the website of the Office of the Public Advocate a page titled “Hierarchy of treatment decision-makers”, which notes—

Where an AHD does not exist or does not cover the treatment decision required, the health professional must obtain a decision for non-urgent treatment from the person in the hierarchy who is 18 years of age or older, has full legal capacity and is willing … to make a decision.

The first person in the hierarchy is an enduring guardian with authority. If there is no enduring guardian with authority, next in line is the guardian with authority. If there is no guardian with authority, the next person is the spouse or de facto partner. Next on the list is an adult son or daughter, then a parent and then a sibling. If none of those people are found or are unwilling to make a decision, the next person in the hierarchy is the primary unpaid caregiver. If they cannot be found, the next one is other person with close personal relationship. That is the hierarchy that applies to an incredibly important decision on someone’s behalf, even for a wife, brother, sister or child.

Within the hierarchy of decision-making, there is still the presumption of full legal capacity. That will only come into question when a medical team asks, “Does this person have the mental capacity to make a decision on behalf of someone else?” If they do not have capacity, the medical team will need to go to another decision-maker. Again, it is making a presumption about decision-making capacity in a life or death situation. I think that that is an important consideration. I know that there has been some talk about the automatic mandatory referral of some patients under the voluntary assisted dying legislation to a specialist psychologist or psychiatrist to ascertain whether they have the capacity to make a decision. That would be a very unusual step, because we do not do that in other life and death situations.

To round off dad’s story, I would say that dad had exceptional palliative care. When I asked mum whether she thought he was in pain towards the end, she said, and I would go along with her, that he was probably one of the very lucky ones. The MS Contin did the trick; any time he wanted more, mum would give him more. I can absolutely say that he was very peaceful at the end of his days and that he was one of the lucky ones who had exceptional palliative care at home. He was able to die at home with mum looking after him in his last few days, with some visits from Silver Chain. That model worked really well.

I have nearly come to the end of my contribution, but I want to finish on another point. I took my twin boys, who were 10 years old at the time, to see dad the night before he died. I talked to him and mum, and while I was chatting, each of the twins held one of his hands. That was the last time any of our extended family spoke to dad. We left and mum was there when he died the next morning. I can say that I am probably lucky because I got to say goodbye to dad. I did not know that it would be the last time I would see him, but I can say I am the luckiest of his six kids, 20 grandkids and his 20-odd great-grandkids because I, and my twin boys, were actually there to say that goodbye. This is another important point: I am sure that my siblings and extended family would have liked the opportunity of at least saying goodbye before he was gone. That is one point around the outcome of voluntary assisted dying—if you are in that situation, and you are dying, you can have your family around you and you can choose the moment you say goodbye to your family. There is no potluck about what other treatments occur. Dad was sedated and went into a deep sleep when the dose of morphine was upped, and no-one had any idea how long...
he would last. When we think about people in those last hours, last moments, of their lives, I am sure that they would like to be surrounded by the people who are the most dearest to them. That is another reason why I support this bill and this policy.

Palliative care specialists say that if the pain gets too great for anyone—we know not everyone is as lucky as dad—they up the medication to put them into a palliative sedation or terminal sedation or, as Dr Anil Tandon likes to refer to it, a “deep sedation”, which is basically putting them into a deep sleep so they do not suffer any pain. Again that is a debatable point, because the Joint Select Committee on End of Life Choices heard plenty of evidence that people in deep sedation can have physical pain, although I would question how people know that. I think it would be based on the observation of those closest to them who sit there and witness it and would give their ongoing evidence to say, “Yes, we believe our loved one was in pain.”

I looked for a definition of “palliative sedation”. CareSearch, a palliative care knowledge network, defined it as —

Palliative sedation is regarded as the use of sedation until death in the terminal phase, for symptoms that are resistant to other treatment measures.

They know the outcome: it is about putting someone to sleep until they die. In fact, there have been some arguments that we do not need voluntary assisted dying laws because we can use terminal and palliative sedation. So why do we need these laws? There is a number of reasons, and one is deciding the time when you say goodbye to your loved ones. Another is that palliative sedation is unregulated—it happens in consultation between a parent and a consulting doctor and their GP. There is not a lot of regulation around it. As I said, we cannot predict the outcome or when exactly that outcome will occur.

To finish off, I will come back to the way the laws are at present in Western Australia. A person diagnosed with a terminal illness who is coming to the end of their days has a number of ways of controlling that endpoint. One of these is refusal of food and water. A person can probably go for about three weeks without food, but lack of fluids can result in death within three or four days. To me, that seems like a very desperate measure for a terminally ill person. We have evidence that this occurs in Western Australia. We have heard other evidence, and other members speaking about taking control of their own lives and committing suicide way before they need to, while they are still capable of taking those things into their own hands. Again, I think that is a desperate measure, and a tragedy. They go way before they need to because they are worried about the endpoint. Often, they do it in isolation, away from their own friends and family, because they do not want to implicate their friends in that.

I think Hon Jacqui Boydell, in her contribution, said that even if someone chooses the voluntary assisted dying pathway, it does not mean that palliative care provision stops for that person. It is the same for someone who refuses food and drink. I found a fact sheet released by an organisation called End of Life Directions for Aged Care, which is a national specialist palliative care and advance health care planning advisory service. The fact sheet is titled “Medication for pain and symptom relief for people with a life-limiting illness”. It states, in part —

Pain relief for a person who refuses food and water

Sometimes, a person who is close to death may refuse food and water. This is legal if the person has capacity to make this decision. Everyone has the legal right to refuse food and water, even if this results in their death.

When a person decides to stop eating and drinking, palliative medication can be given to reduce any pain or suffering they experience from this.

Even though people make desperate decisions, they should continue to receive palliative care to make their life and their passage more comfortable.

One of the other statistics that I found quite interesting was that, in Oregon, 40 per cent of people who go through the process and actually receive the medication do not take it. We have to ask why that is so. I am sure that some of them go through the process to make sure that it is there if they ever need it. That 40 per cent may pass by other means and do not need to take the medication, but the fact that they have it gives a great deal of comfort, and they know that it is there if they need it, and that is an important point.

I believe that we can do better for those who are terminally ill and suffering at the end of their life. I think we can do better as a society and as a Parliament for Western Australians. My support for this bill is not for those who have already passed, although their stories and their evidence have certainly informed my view of this legislation. My support for this bill is for those who will face their final days in pain and suffering in the future. Those are the people who are asking for another option—the choice of a peaceful passing at the time of their choosing surrounded by their love ones. That is what drives me to support this legislation, and I urge members to put patients at the forefront when voting on this bill and any potential amendments. I thank all members, all the members and staff of the Joint Select Committee on End of Life Choices, who did all that work two years ago, the ministerial expert panel, and all the people who wrote to me, from all sides of the debate from all over Western Australia, not just the South West Region, to express their views and tell their personal stories, which informed the debate very well, and helped to focus what I thought this bill was about.
Echoing the final comments of Hon Colin Holt, I would like to make some acknowledgements to begin with. The first acknowledgement is of the Joint Select Committee on End of Life Choices. That includes all its members and the committee staff, who work very hard on all our committees and often do most of the serious leg work. The committee members are very well served by them. I also acknowledge those people who have taken the time to write to me, both through emails and in the old-fashioned way; I think it is the most correspondence I have received through the postbox for a long time. People have written to me earnestly expressing their views. Of course, I have faced the same sort of arguments for and against, the most common one being, “This is my view, and I’m your constituent, so you should do what I tell you to do.” That is plainly impossible. I cannot keep all the 400 000-plus constituents of the East Metropolitan Region happy, as much as I might try. We have had an exceptionally large amount of correspondence—well over 1 000 now—so I would also like to thank my staff, who have had the laborious task of dealing with all that correspondence. Reading the stories and points of view that have come through that correspondence has had an impact on them as much as on me, so I especially want to note my staff. The members of the ministerial expert panel have dedicated themselves with great care and application to the task given to them by the government. I cannot imagine that the process has been easy for them, and, for some of the medical people on that panel, within their own professions. I acknowledge them as well.

Like all members here, I have sought to engage with the community on this issue as much as I can. I met with constituents in my office, but I have also met constituents in and around my electorate. If I go to an event, constituents feel compelled to express their views and ask me how I intend to vote, and at times ask me to explain why I am voting that way. In all instances, that has been done respectfully even when a person has a different point of view. I have met with people who are against voluntary assisted dying, and, again, those people have conducted themselves in a respectful manner, and I have shared my views with them, and they have taken those on board. Dr Tony Buti, the member for Armadale, and I also hosted a public debate in the Kelmscott Hall, which was attended by over 100 people. The debate was between Dr Michael Gannon, former Australian Medical Association president, and Dr Scott Blackwell, also a former Australian Medical Association president and a member of the ministerial expert panel. I thank both Dr Gannon and Dr Blackwell, and my friend Dr Tony Buti for putting that on, and providing an opportunity for this issue to be ventilated in the community. The debate was not so much about presenting an argument in favour of voluntary assisted dying. It was genuinely a debate between two proponents who had different views.

I also had the opportunity to visit the palliative care unit at Kalamunda Hospital with Hon Nick Goiran. I thank Hon Nick Goiran for organising that visit and bringing me with him. I thank the staff at Kalamunda Hospital for facilitating that visit, particularly Dr Andy Hart. That visit gave us an appreciation of what is happening in the field of palliative care within my electorate. The staff at Kalamunda Hospital are doing good work. It is a nice place. It has further capacity. They have grand plans for that, and I look forward to seeing those increases in palliative care funding work their way through the system. If members have not had the chance to go to Kalamunda Hospital, it is a nice spot. It sits alongside the forest. If I were looking for a place in which to spend my last few days, that is the kind of place that would appeal to me. We are not all sand and surf people. Some of us are hills and trees people. We want to provide variety in that as well.

I have also attended the numerous briefings that have been made available to all members. I thank those people who have taken the time to brief us. The most instructive of those briefings were when people came not to advance a particular point of view, but to provide information. From the point of view of the task that we have, I have found that most helpful and instructive.

It was not possible to read every piece of correspondence that I received and I will not pretend that I have, but I tried to read as much as I could. The stories that were presented to me were certainly very compelling, and people eloquently put their arguments for and against.

I would like to talk about what does and does not inform my position on voluntary assisted dying, and the general issue of euthanasia. Of course, I am instructed by my values. One of those values is the idea of personal autonomy, and the person’s right to have their autonomy respected. Having gone through a number of highly complex medical scenarios, the idea that the patient comes first is particularly important to me. When people start to make decisions for us, the outcomes tend to not be as good as they should be. For me, personal autonomy in any environment is particularly important. That extends to children. Children should also very much be at the centre of any medical model. I have spent many nights at Princess Margaret Hospital for Children and have spoken to nurses who have been in the system for a very long time. They often describe the good old days, in one sense, when parents were permitted to visit their children at the hospital only on a Wednesday and Sunday afternoon. There was no sense...
that the parents and the family should be involved in the needs of the child who was sick and in the hospital. I do not think any of us could contemplate the thought that we would be given such restricted access to our own children in a medical environment. The focus at the new Perth Children’s Hospital is on family-centred care. The patient is at the heart of that. That is opposed to the paternalistic idea that existed in the past and that was imposed on patients—that doctor and matron know best. Patients did not get a great say in their treatment course. They were not informed of their options and what their treatment path would be. It would be fair to say that the medical profession as a whole—doctors, nurses and allied health professionals—has moved a long way past that. There is now an overwhelming recognition that patients and their wishes must come first. For me, in the voluntary assisted dying debate, that does not change. The person who has the terminal illness or neurodegenerative disease must come first and their wishes must come first. Nothing should be able to overcome that in these circumstances.

As Hon Aaron Stonehouse said in his contribution, it is a matter of liberty. I listened very carefully to his contribution and I appreciated it very much. A couple of members have made contributions that I particularly appreciated. That includes Hon Tjorn Sibma, who is out of the chamber on urgent parliamentary business. The way in which he characterised voluntary assisted dying was very helpful for me. Unfortunately, I missed the substance of Hon Jim Chown’s contribution, but parts of it had some influence on me as well.

I am not a religious person. I have never been a religious person. Therefore, religion does not inform my position. I want to be very clear about that. It is important that people understand that that is not one of the biases that I bring to this debate. I have my own biases, of course, but I am not a religious person. Having said that, I accept that some people have those particular points of view. I respect their entitlement to be informed by their religious beliefs. I would hardly be one to respect personal autonomy if I were then to impose on others that they could not hold their own particular beliefs about certain things.

I also hold very dear the belief that people who have capacity are entitled to make their own decisions. That is particularly the case for young people, the frail, the elderly and people with disability. Having been involved in the inquiry into elder abuse, it was put front and centre of us that we should never lose sight of the fact that the elderly have agency—they have the right to make their own decisions, good or bad. That is an entitlement that we cannot take away. That comes back to the sense of paternalism that sometimes permeates our culture, with the idea that, “I know what is best for you, because you do not have all your faculties.” If people have their faculties, regardless of their other attributes, they should be able to make decisions for themselves. That includes people with disability. I especially detest paternalism and the “I know what is best for you” mentality. That is not to be confused with the idea that those who are experts in their field and who are trying to help others prevent harm to themselves, through education programs or through the extension of safety measures into our society, are necessarily being paternalistic in their approaches. I would not want people to think that I was casting any kind of aspersion on their attempts to improve the health and wellbeing of people in our society.

I have always generally supported the concept of euthanasia, and that it be voluntary. I am not really sure where that came from. Maybe it was because I was a middle child and hated being told what to do by everybody else. I am not sure whether that was the starting point or the finishing point, but perhaps that is where my sense of independence has come from. The idea that somebody could tell me that I could not take a course of action that I thought was appropriate for me rankles. That is one of the bases for the values that inform me.

I come now to the two core reasons why I support the bill. The first is my brother, Kerry. Kerry Evans was born five years after me. We are both Aries. I do not necessarily believe in astrological star signs, but we used to butt heads a lot, so that is probably where that analogy comes from, because he was five years younger than me. Kerry was a very active, healthy and athletic person. He had a very wicked sense of humour. He got under my skin many, many times. I speak about Kerry in the past tense, because he died three years ago of cancer. He was only 36 when he passed away. His cancer journey started in about 2008, when my youngest son, Darcy, was born. Kerry had had indigestion. He had a number of different kinds of symptoms. He became quite hyperactive. He would wake up in the middle of the night and do odd things like gardening. He had a tumorous mass growing on his kidneys. It was not small; it was the size of a cricket ball. There were other tumours in his body as well. These were a special kind of tumour called paraganglioma tumours. They emit what is in effect a kind of adrenaline around the body, which causes the person’s blood pressure to go up and the heart to race, hence his activities. The adrenal levels in the body are astronomical. The neuroendocrine effect of these tumours are so powerful that if someone is in surgery and there is a push from these hormones, it can take them out of anaesthetic. He was in hospital for a couple of days. When they were preparing him, they had to lower his blood pressure and get control of the hormones in his body. Once they had done that, they did surgery and removed his kidney and took out some additional tumours that I think were in his lungs. It was 2009 by this stage. As I say, Kerry was a very athletic, healthy person. I was always the overweight one and he was always the one giving me a hard time about it. It was therefore very strange to see this younger brother in the intensive care unit at Fremantle Hospital. I do not think the image of seeing him so helpless and in a different state will ever leave me.

Extracted from finalised Hansard
Unfortunately, not a lot is known about these kinds of tumours. They are genetically based and do not come from any outside causes. There is a mutation in the SDHB gene, so that people who have that mutation have the propensity to grow these tumours. Kerry’s tumour had metastasised so he underwent a series of radiation and chemotherapy procedures over the next several years. There were times when we thought he was going to be cured. He would go into remission. However, I do not think I will ever forget the day—I was working at the Construction, Forestry, Mining and Energy Union—that he called me to tell me that the tumours had gone into his bones. It is a bad thing once they go into the bones; it is painful and difficult. From that point forward it got into his spine as well. It was not anywhere they could do surgery on. If we have tumours in our spine we do not have many options available.

There is no question that Kerry loved life; he loved living. His partner, Nicola, and he married when he was in a sort of remission stage. She was the love of his life. She brought such joy to him and he had a happy life. He lived happily. However, the disease progressed. He got more and more frail and weak. He was staying with us for a little while when he was using a wheelchair and walker. I remember him being in the shower for a long time and I wondered why he was in there for so long. When I went in there, I found that he had collapsed on the floor. He could not hold himself up because he did not have the energy to yell out. I had to pick him up off the floor—my adult brother, naked in that situation, completely vulnerable—and help him in that situation. He did not need that to happen. But Kerry kept going on and on. His disease progressed. He ended up in a wheelchair. He could not walk. Finally, in his last days, he ended up back in Fiona Stanley Hospital. He kept his sense of humour the whole time, but I remember the last few days. Others here have been through that bedside vigil—type thing. I do not know that I ever believed he was going to die. I probably did not. I always thought he might get a little bit better and would come back. But the disease kept progressing and we were there when he passed away. He was being sedated with morphine. He would grumble, groan and cause and the nurse would be called in and would give him another dose, and it would go.

I guess I never wanted to talk about death with Kerry, so we never sat down and talked about it. I do not know what his views were about voluntary assisted dying. However, I would like to think that if he had decided about the time that he wanted to go, I would have been in a position to respect that and to go through that process with him as the young man that he was. He went quietly away. I do not know how quietly it was. I do not know what was going through his mind as he was being sedated with opioids. We do not know what goes through a dying person’s brain when they are sedated. We presume it is some sort of happy dream, but we do not know how they go. He hallucinated during those periods as well. We look at that situation and say, “How would I be there?” I am not sure I would like to have been in the way he was. I spoke about Kerry with his wife, Nicola, and his circumstances. She said they spoke about voluntary dying, not perhaps in the context of this Voluntary Assisted Dying Bill. It was 2016, so it is not as though it was on the cards in that particular way. I do not think that at any point of Kerry’s life he would have given up on living, but I would have liked him to choose the terms in which he went out. He was fortunate in the sense that his family was around him for his death. We were there and the children were there. They got to say goodbye in their way, but it obviously leaves an impact.

The underlying genetic condition that cost Kerry his life is a family condition. We did not know the family had a genetic mutation of this kind and following Kerry’s diagnosis, he encouraged the rest of us to get tested by the Genetic Services of WA. However, we did not really take it seriously enough. In 2015, my middle son, Mitchell, was diagnosed with a gastrointestinal stromal tumour, which are exceptionally rare in children. When I say rare, there had never been a recorded case known in Western Australia. I am not sure that one has ever been found in the rest of Australia.

Unfortunately, his tumour had also metastasised into his bones. This was a very rare cancer. The surgeons had to take part of Mitchell’s stomach away. They got what they needed. Scans were done and a second tumour was found. One tumour was attached to his venae cava, the descending blood vessel from the heart. Another one was in his stomach. The doctors could not tell where it was. Our scanning technology is very good but it is not perfect. In that circumstance, they were throwing up a range of possibilities, so the second tumour was a bit of a mystery. He went into hospital and was given the drugs to bring down his blood pressure and make sure he did not come out of the anaesthetic when he was cut open. The surgeons then did the surgery while we waited for some very, very long hours. The doctors came out in the only way I suppose doctors and surgeons can do. They were quite excited. They had got the first tumour and then they got the second one. It was a gastrointestinal stromal tumour, which are exceptionally rare in children. When I say rare, there had never been a recorded case known in Western Australia. I am not sure that one has ever been found in the rest of Australia. I hope there is never another one. The surgeons had to take part of Mitchell’s stomach away. They got what they thought were safe margins of that tumour. It has been discovered that those types of tumours do not respond to radiation or chemotherapy, so he does not receive those kinds of treatments; he can just have surgery.

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Mitchell’s tumour was removed and we went through a very long period of him recovering. To achieve what they needed to the surgeons had to cut his little body open and go right in, so we had that sort of stress. He has been up and down with different surgeries. A couple of years later, we had the news that the tumour had metastasised and gone into his liver. That is where the tumours are now. There are several tumours there. His treatment options are all experimental. There is no known cure for his cancer. We have had the discussions with oncologists about the choices we make, the impact of the drugs he is on and where he might end up with that sort of stuff. He is now participating in a drug trial, run by a drug company, out of the children’s hospital in Queensland. We are very fortunate to have that opportunity. That drug seems to have stopped the growth of new tumours and slowed down the growth of the existing ones, so we are fortunate there, but we also discovered that the tumours have now moved into his lungs as well. What happens in this situation—which I would not want anyone to ever have to go through—is that the disease just keeps progressing. When we think that we are winning the fight, we are not—we are just doing what we can.

Mitchell is the bravest and most stoic child I have ever met. I have not met every child in the world—I am sure there might be another one who is—but people just do not understand how brave that little boy is. He never complains. He has never once said, “Woe is me”, or “Why can’t it be somebody else?” He just battles on and continues. That changed earlier this year when he was taking a drug that really knocked him around. He could not walk anymore and he had sores on his hands and feet. He had lost his body condition and was in a wheelchair. He had to crawl around the house because he could not walk. He could not eat, and he was talking about having had enough. We had to take him off the drug. It was the drug that was doing that to him—the supposed cure—not the disease. We took him off the drug and he improved on a new drug. Fortunately, he is doing very well. The new drug does not have the side effects that the other drug had, and we are hoping we can get to a point where we can start to consider surgery to remove the existing tumours and buy him more time. Hopefully we will get to the stage where the medical fraternity and the scientific community understands his kind of disease enough to develop a cure. We hope we get to that point; we desperately, desperately hope that we do.

Mitchell will be 15 years of age in January. He will not be eligible for these laws at 15; he will not be eligible at 16 or 17, but he will be eligible at 18. His journey in life is not one in which he suddenly has a terminal illness and flippantly decides that he has had enough. If he gets to adulthood and can make a decision, his journey will have had so much suffering, so much pain, so much perseverance and so many other things that I could not, as his father, in all honesty deny him the right to choose to go on his own terms when he is ready to go. That is if he gets to that point, and I really hope that he never gets there. But how could I, as his parent, deny him that—to be here today, to vote against this bill? If he lies on his bed and says to me, “Dad, I cannot go on; I have had my time and I’m ready to go”, and I say to him, “Son, I’m sorry; I had the chance, but I let it go, and you’ll just have to wait it out and go when nature takes its course”, I could not do that. I just could not; I am sorry. Other people might be able to, and I am not suggesting that they are lesser people because of that, but for me, this is the compelling reason. When I see him every morning, there is not a moment when I do not think about how truly sick he really is and how I enjoy every cuddle he gives. Mitchell gives the best cuddles, if you ever get the chance. He is not like his older brother, Harrison, who would not touch me with a bargepole! Mitchell has never lost the sense of wanting to be in physical contact with his parents, so he gives the best cuddles. He does not say much, he does not talk much, but when he does have something to say he lets it out. Apparently yesterday he saved a raven in his classroom, so that was a good story to hear about!

As I say, I cannot deny him. I might be a coward because of that, but as a parent you just do not want to put yourself in the position of denying your child the opportunity to be released from pain. I think I speak for many parents who have children with cancer. There is not a day that you do not fight for their life, that you want them to live and that they want to live, but it takes them all. Kids go every year. I am not encouraging members to make these laws available to children; that is not what I am talking about. But some of them make it into adulthood, and they have had their journey and it is in my view, to let them make a decision on the one thing that they have very little control over, to give them some control back again. With those words, I commend the bill to the house.

**HON RICK MAZZA (Agricultural) [3.04 pm]:** Hearing stories like the one that was just expressed by Hon Matthew Swindon is the very reason why a decision on this bill is so difficult. I must confess that I have lost many hours’ sleep struggling and wresting with the issue that is before us. Some of the lead-up to the bill being read in to this place and the debate commencing has been somewhat disappointing. There have been accusations that the Legislative Council was going to run interference on this bill. We are only at the beginning of day four of the second reading debate and there are only a handful of speakers left after me, so I think we have made double-quick time in moving forward on this bill. Having watched much of the debate on the monitor over the last week, I can say that it has been a very respectful debate, and I respect both sides of the argument. The bill before us, the Voluntary Assisted Dying Bill 2019, proposes a process through which a person may access euthanasia, from requesting access to euthanasia to prescription dispensing, administration and disposal of the lethal substance that will end the person’s life. This bill will allow a medical practitioner to either terminate a person’s life, with the person’s permission, or assist a person to terminate their own life. The bill has been promoted to the
community based on the premise that it will eliminate suffering at end of life, bearing in mind that all deaths are different. Some people are very fortunate in that they will nod off to sleep in their late dotage and never wake up; others are not so fortunate, and that is part of the cycle of life. We do what we can to minimise that suffering.

No reasonable person ever wants to see anyone suffer, and polling around this issue can easily have a very populist result, with a few targeted questions. I appreciate and respect the arguments that have been put forward by those who have proposed this legislation, and I think the government and advocates for the legislation have good intentions. But I seriously think there are some very concerning issues that could arise as time goes by. There are alternative ways of reducing end-of-life suffering, and they are what we are currently using in the form of palliative care. The Joint Select Committee on End of Life Choices released the “My Life, My Choice” report in August 2018. It revealed that we have inadequate and substandard palliative care systems, especially in rural and remote areas of the state. Palliative care is about improving the quality of life of those facing life-limiting illnesses, through the medical treatment of symptoms that may be physical, emotional, spiritual or social.

According to the report, specialist palliative care is provided across 28 government and non-government services through inpatient community and consultancy models in WA. Unfortunately, the models of care can vary, and the level of palliative care is not equal. For example, four of the WA Country Health Service regions have access only to consultant specialist palliative care. Without access to inpatient or community specialist palliative care, patients do not have the same level of choice as patients in other parts of the state. Finding 16 of the report found that access to hands-on specialist palliative care was limited for metropolitan and non-metropolitan patients. Finding 17 found that Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population. Finding 18 found that there is a gap in care for people who are seriously unwell but not close enough to death for admitted inpatient hospice care. Finding 19 found that there is limited access to palliative care medical specialists in regional WA, and finding 20 found that there is limited medical oversight coordination or governance of medical palliative care services in the WA Country Health Service.

According to the Western Australian Palliative Medicine Specialist Group, palliative care in regional Western Australia is as follows. The Kimberley has six specialist visits per year with each visit lasting one week. The Pilbara has one specialist visit per year. The midwest has 10 one-day visits. Geraldton has each visit for one day; two in Carnarvon. The wheatbelt has 12 visits per year, with three each to Northam, Narrogin, Merredin and Moora. The goldfields gets 12, with four in Esperance. In the south west, there are two resident specialists in Bunbury, but no adequate care in surrounding towns. In the great southern there is one resident physician in Albany, with two visits to Mt Barker, Katanning and Denmark. Looking at that list, palliative care in remote WA is nearly non-existent. I have experienced before my family’s experiences with palliative care services, or lack thereof, in regional Western Australia and the fact that family and friends often take on many of those roles.

An article published in WAtoday on 28 August this year entitled “‘West Australians should not ponder euthanasia due to lack of care’: End of life specialists” states there are only 15 full-time palliative care specialist in WA, with most senior end-of-life care specialists worried that the state’s most vulnerable people might consider euthanasia because of an alarming lack of resources available in palliative care, especially in the regions.

Recommendation 13 of the “My Life, My Choice” report called for the Minister for Health to ensure regional palliative care be adequately funded to meet demand. I would be very distressed to find that people may elect to access voluntary assisted dying as an alternative to palliative care simply because the services are not available to them. I know the government has put some investment into palliative care, which I am sure many people will be very grateful for. A state government media release of 9 May titled “Palliative care package to support sickest Western Australians” reported —

The 2019–20 State Budget includes a $41 million investment for extra support and enhanced community-based palliative care services across the State. This package brings the total investment by the State Government for palliative care services over the next four years to $206.2 million.

Coincidentally, five days before the Voluntary Assisted Dying Bill 2019 was to be debated in this house, the government also issued another media statement on 10 October titled “Massive boost for palliative care services across Western Australia” stating that it was putting further money into palliative care. This time it is $17.8 million on top of the extra funding delivered in the 2019–20 budget. That consists of $9 million towards 10 inpatient palliative care beds in north metropolitan suburbs, $6.3 million for the expansion of community-based services across metropolitan and regional WA to better meet demand, and $2.5 million for enhancing rural and regional palliative care services by improving governance. The investment over those four years will be as follows. There will be $3.6 million to the goldfields. There are currently 4.1 full-time equivalents in the goldfields, and there will be an additional 8.35 staff there, giving a total of 12.45 staff. They will obviously be welcomed in the goldfields. There is $3.5 million for the great southern. There are currently 2.7 FTE there, and that number will be lifted to 11.45 after the investment. There will be $4.4 million invested in the Kimberley. There are currently 3.5 FTE, and that will be increased to 13.45 FTE after the investment. There will be $4 million invested in the Pilbara. There is currently only 1.65 FTE, which I think is quite alarming for...
the Pilbara, but there will be an additional 11.8 FTE, giving a total of 13.45 FTE. There will be $2.5 million invested in the south west. Currently there are 11 FTE in the south west and that will be lifted to 16.9 FTE. There will be $2.7 million invested in the wheatbelt. There are currently 5.3 FTE and they will be lifted to 11.45 FTE. We will see a total investment of around $224 million over a four-year period, which equates to around $56 million a year. In the view of the University of Notre Dame’s chair of palliative medicine research, Professor David Kissane, the state needs an extra $100 million a year to be spent on palliative care on top of the extra $41 million announced in the state budget. The amount of $41 million equates to just $10.25 million per annum, and we need a total of $110.25 million per annum. At the moment, we are looking at $56 million per annum, so we have a shortfall of around $54.25 million each year. Clearly, we are short of the extra investment that we need in palliative care.

In an article on WAtoday of 3 September 2019, titled “Polling reveals that country voters want palliative care fixed before euthanasia legalised”, Dr Anil Tandon, chair of Western Australian Palliative Medicine Specialist Group, and a visiting palliative physician in regional areas of WA, is quoted as saying —

“Regional Western Australians should be incredibly concerned by the current level of funding directed to palliative care …

“WA has the fewest number of palliative care specialists per capita, 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.

It has been well documented that states with the worst palliative care systems are often the most supportive of euthanasia, and this is clearly evident with Victoria legalising assisted dying this year and WA not far behind with the introduction of the bill before us.

The “My Life, My Choice” report quotes Associate Professor Ian Haines, MBBS, a medical oncologist and palliative medicine specialist. He wrote —

As an oncologist with 35 years’ full-time experience, I have seen palliative care reach the point where the terminally ill can die with equal or more dignity than euthanasia will provide. It is now very effective and increasingly available for two of the three possible ways of dying, outside of sudden unexpected death, which are advanced cancer and chronic relapsing and remitting organ-specific disease such as heart or lung failure. Palliative care is also available for people with chronic progressive cognitive diseases such as dementia. This is the fourth way of dying and perhaps the most feared of all. Like Andrew Denton and others who have observed unbearable suffering in loved ones and the terrible failures of modern medicine in the past, I had once believed that euthanasia was the only humane solution. I no longer believe that.

Before we consider legalising euthanasia, we must first have a well-funded, well-functioning palliative care system in this state. This sentiment was echoed clearly in a study conducted by the WA Palliative Medicine Specialist Group, which found that 73 per cent of people living in the agricultural, mining and pastoral regions believed that palliative care should be improved before the introduction of assisted dying legislation.

In a WAtoday article published on 3 September this year, Dr Anil Tandon was reported as saying —

No terminally ill person should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted dying.

This is one of my primary concerns, members: the election to access euthanasia is predicated on a lack of comprehensive palliative care. People see what their loved ones go through as they die in a system that is not resourced to support them. It is an end that they do not want for themselves, and therefore they see assisted dying as a better alternative. A poll conducted for The West Australian in November last year revealed that nine out of 10 Australians supported euthanasia. An overwhelming 93 per cent of people aged between 50 and 59 years said that they would want to be allowed to end their own lives with medical assistance if they were terminally ill with a condition causing intolerable suffering; however, only one in five people aged over 70 surveyed said that they would not want to have that option if they were terminally ill and suffering—the highest rate of opposition of any age group. It is interesting to point out that the poll supporting euthanasia was run in November last year, which was eight months before the bill was introduced into Parliament in July this year. It is also interesting to note that people aged 70 years and over, who would be expected to support such legislation, were less likely to want to have the option of assisted dying available to them if they were terminally ill and suffering. They counted for the highest rate of opposition of any age group in the poll. I have significant concern about supporters of assisted dying who have referenced polls and said that between 80 per cent and 88 per cent of our community support the proposed legislation. To my knowledge, prior to the release of this bill, two polls were conducted; one by Go Gentle Australia, which indicated that 81 per cent were in favour, and the second by Dying For Choice, which indicated that 88 per cent of people are in favour of euthanasia. Both organisations are dedicated to euthanasia legislation. I do not know what questions were asked in the survey or how the participants were questioned about the bill, but I can safely say that neither of those organisations are independent. As Hon Martin Pritchard said in his contribution on Tuesday evening last week, polling questions are often designed according to the desired outcome. I do not put a lot of weight on polling results. If we believed the polls, Hillary Clinton would be the US President and we would

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have a federal Labor government. The polls got those things wrong. My office carried out its own assessment by collating all the correspondence it received, and the results were quite surprising. The number of people in support of assisted dying, but not necessarily of the bill because I got a lot of emails prior to the introduction of the bill, is 37 per cent. Sixty-three per cent of correspondence that I received is against assisted dying, which does not seem consistent with what a lot of other members received, but that is what my office received. Of the 37 per cent of correspondents who support assisted dying, more than half referenced the polls and the alleged 80 to 88 per cent in support as a reason for me to support the bill. Ironically, a number of supporters of assisted dying have urged me to support and respect the view of my constituency. I have had the same emails as other members demanding that I vote a particular way because they are my constituents. But, of course, constituents have varying views and they all have to be weighed up. Some who support this bill believe that they should be able to access assisted dying for loved ones because of the anguish they themselves go through while watching them go through the dying process in the last six or 12 months of their life. Many members received hundreds of letters and I am sure some members have received this particular one, but because it stands out to me, I will put it on the record in this place.

I received the letter in September this year from a registered nurse. It states in part —

... I have, over all my years of nursing, cared for people in their last days, and for those who had reached the limits of possible treatment and needed care to alleviate their suffering. Over these years the vast majority of dying patients have had peaceful and gentle deaths without intervention to hasten death; in a minority of patients death has been painful but in most of these instances this has been due to either intervention by families refusing to accept the reality that death is imminent and demanding active treatment which has become burdensome for the patient, or failure of doctors to perceive that the limits of treatment have been reached.

It has also been my experience that in many instances the family suffer far more than the patient, and they tend to project their suffering on to the patient. I have on occasion counselled family on this and had conversations about their impending loss, and on occasion families have thanked me after the death, for the conversation.

In this day and age people do not have the stoicism which we saw in previous times; people want outcomes, one way or another, at once. I have had on the odd occasion a patient ask me if we can hasten the death, and I tell them honestly “no”, but then I tell them what we can and will do to make it easier and I always promise them that we will not let them suffer. In every instance, in my own experience, the patient has been reassured and has died peacefully not long afterwards. More frequently I have been asked by family at the bedside “Can’t you hurry this up?” They know they are losing their loved one so now all they want is for it to be over; very often the patient is not conscious and is painfree and undistressed.

It used to be accepted wisdom that we should not make important decisions swayed by emotion. From the very initiation of this proposed legislation, Mr McGowan, the media, some doctors, so called celebrities and other advocates of “assisted dying” have used emotion to try to persuade the public and the Parliament that this is the “compassionate” thing to do. It is not, and it is open to abuse in spite of Mr McGowan’s assurances. Already he has boasted that this legislation goes further than the recommendations of his Ministerial Expert Committee, and further than the Victorian legislation. The proposed legislation has been brought forward through its various stages in haste, minimal publicity or opportunity for comment has been provided to those who do not support the legislation and we are told that “88%” of people support it; I have my doubts about that as I cannot find one person in my workplace who does!

The bill has been presented on the premise that people do not want to suffer at the end of life. I am sure that no-one wants to suffer at the end of life and I am sure that their loved ones do not want them to suffer at the end of life. I feel that palliative care can play an important role in minimising that suffering.

A 6 July 2017 article titled “Viewpoints: Should euthanasia be available for people with existential suffering”, which was published on The Conversation website, states —

A 2011 study of Dutch patients who requested euthanasia indicated that “hopelessness”—the psychological and existential realisation one’s health situation will never improve—was the predominant motivation of patients who requested euthanasia.

And a recently published Canadian study of requests for medical assistance in dying stated “loss of autonomy was the primary reason” motivating patients to end their lives. Symptoms also included “the wish to avoid burdening others or losing dignity and the intolerability of not being able to enjoy one’s life”.

There have obviously been quite a lot of news articles about this issue in recent times. On 7 August, in an ABC news website article titled “Voluntary euthanasia legislation appears likely to be passed”, Mr McGowan was reported as saying —

It’s time for the Parliament to do the right thing by people and families who are going through enormous pain, who are terminally ill …

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In a 25 September *The West Australian* article titled “VAD laws clear first hurdle”, Premier Mark McGowan urged the public to pressure their local members to make their voice heard. The article states —

“Tell them you do not want this issue to drag on unresolved,” …

It also stated —

“When you look back on your career as a parliamentarian, make sure you look back with joy, that you did something good, that you believed in. —

I will comment on that a little later in my contribution —

That you were not bound by party lines. That you did not give in to those that would bully or intimidate. The factional powerbrokers.”

I am not quite sure who he is referring to.

In a 25 September WAtoday article titled “Euthanasia bill survives Lower House intact as Premier raises spectre of ‘factional powerbrokers’, the Premier is quoted as saying —

The euthanasia legislation did not require amendment or “further frustration and delay from an additional inquiry”.

The fact of the matter is that the Legislative Council has a role to play in reviewing legislation. I find it appalling that it has been indicated that we should let this bill sail through without scrutiny. Our job is to review legislation. Quite a lot of legislation has come to this place over the last couple of years to which amendments have been made and the legislation improved to better serve the Western Australian community and it has gone back to the Legislative Assembly. I do not know why we should rubberstamp this bill. WAtoday’s follow-up story on 26 September is titled “WA euthanasia debate: Premier accused of lying over bullying comments” and it quotes the Premier as saying —

“Make your own mind up on this, do what you think is right and listen to your community.”

I have listened to the community.

A 14 October *The West Australian* article, “Assisted dying critics are ‘cowards’”, quoted Premier Mark McGowan. I find that very disrespectful in this debate. He is quoted as saying —

“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.”

I take great offence to that. The democratic process in here means that people can have differences of opinion. We debate that in this place and we scrutinise legislation and things are put to the vote. That is how it works.

An article in *The West Australian* dated 13 October, headed “Backbenchers cop raw deal”, includes comments from Labor MP Margaret Quirk, who stated that there was clear “implicit” pressure on herself and her colleagues to support the bill’s smooth passage. I must say that Margaret Quirk has a very strong political backbone for being able to stand up to this. She said —

“Certainly I know of a number of occasions where members sought to speak in favour of the Bill and were asked … not to speak to expedite the process of the Bill through the Lower House,” …

That really highlights to me that a lot is going on when it comes to this being a conscience vote.

Contrast that comment with the Premier’s comment published on 25 September, in which he warned against being bound by party lines and not giving into those who bully or intimidate. A 15 October ABC news article headed “Crunch time as assisted dying Bill goes to Upper House” quotes Premier McGowan; he said —

“I urge people to vote for it, the public is overwhelmingly in favour and that the Parliament should reflect the view of the public,” …

The Premier tells us to make up our own minds, and then in another breath calls us cowards. This bill is being pushed by a government in an environment in which increasingly a number of baby boomers are aging and being diagnosed with diseases, illnesses and medical conditions for which there is inadequate infrastructure in place for them as far as palliative care is concerned. According to the federal Treasury, the number of Australians aged 65 years and over is expected to increase rapidly from 2.5 million in 2002 to 6.2 million in 2042. For Australians aged 85 years and over, the growth is even more rapid—from 300 000 in 2002 to 1.1 million in 2042. It has been reported that by 2042, there will be only 2.5 people of working age to support every person over aged 65 or over.

The Australian Medical Association (WA) has been opposed to legislation that allows for the termination of life. On 6PR on 6 August the immediate past president of the WA AMA, Dr Omar Khorshid, stated that this bill is a rushed job; it looks a little unworkable; and it looks a little naive. He said that it is clearly not written for people

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who understand how our health system works, and that there is a long way to go before we can make this both safe and effective legislation. On 23 August 2019, on page 9 of The West Australian, the Australian Medical Association WA’s new president, Andrew Miller, said —

“We don’t want to see this Bill passed as it is now because we don’t feel the safeguards are anywhere near as good as Victoria.”

I know the government has cited the many safeguards and latches that are in this legislation to make it safe from exploitation, but there are far greater risks in the massive cultural shift that we are about to embark on from what we currently have, which is the preservation of life to one that is a government-sanctioned termination of life. I will talk about that a little later.

The government assures the public that it has consulted widely, yet many medical practitioners of this state are not comfortable with what they will be mandated to perform. Nonetheless, we have this bill in front of us, and, as such, we must address it. Clause 4(1)(f) reads —

a person should be encouraged to openly discuss death and dying, and the person’s preferences and values regarding their care, treatment and end of life should be encouraged and promoted;

I have a fundamental problem with the doctors of the state being able to start the conversation about assisted dying with patients as that in itself could make vulnerable people choose this option for a number of reasons, such as fear, not wanting to be a burden on their family and the fact that they might not have a lot of savings to pay for treatment. Hon Martin Pritchard has some amendments on the supplementary notice paper, one of which proposes to prevent medical practitioners from raising it. I call it the “Buti amendment”, because that is pretty much what it was in the other place, and it was defeated. But I foreshadow that should the honourable member move that amendment, I would certainly support it.

Merely having legislation that allows, encourages and promotes assisted dying, opens it up to abuse at many stages of the process—abuse in terms of coercing patients to end their life by medical institutions, doctors, insurance companies, family and carers. The coercion will be unpoliced, unreported and unmanaged.

According to an article in the Internal Medicine Journal, a 1998 study found that doctors who are cost conscious and practice “resource-conserving medicine” are significantly more likely to write a lethal prescription for terminally ill patients, which suggests that medical costs influence doctor’s opinion. Paul Young, a paediatrician in Wisconsin, in his testimony against physician assisted suicide on 8 April 2008 for Wisconsin Right to Life, stated, according to my notes —

The single greatest pressure on healthcare today is financial.

As we seek to grapple with the staggering costs of healthcare, we need to avoid undermining the very ethical principles that promote good patient care.

If we allow physician assisted suicide, we may find out that we have effectively limited our approach to the palliation of chronic illness.

Unfortunately, it is cheaper to help a patient to die than to provide good end of life care.

Physician assisted suicide could encourage a patient to die as a ‘duty’ to his or her family, in the face of financial pressure.

Likewise doctors could find their end of life care options curtailed by third party payers …

On 31 May 2017, The Washington Times, reported that a Nevada physician said that insurance companies in states in which assisted suicide is legal have refused to cover expenses. An associate professor of internal medicine at the University of Nevada tried to transfer two patients to California and Oregon for procedures not performed at his hospital. Representatives from two different insurance companies denied those transfer requests by phone. In both cases, the insurance medical director said, “We are not going to cover the procedure or the transfer, but would you consider assisted suicide?” The patients were not terminal but would have become terminal with that procedure.

Members, vulnerable people within our community need to be protected. It concerns me that this bill will not prevent or limit the power that some people might be able to use for coercion. I will focus my comments on the elderly within our community, but the same argument can be used for other at-risk groups. To illustrate my concerns, I will use, as an example, the older baby boomer generation we have today. Most of those individuals have the status of older person as defined in the final report of the Select Committee into Elder Abuse, “I never thought it would happen to me’: When trust is broken”, released in September last year. For Aboriginal and Torres Strait Islanders over the age of 55 years and non-Aboriginal and Torres Strait Islander people aged 65 years or older, according to the World Health Organization, elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person. It can be in various forms—physical, psychological, emotional, sexual, financial or simply reflect intentional or unintentional neglect. It is estimated that between 2.2 per cent and 14 per cent of older people in high or middle income countries experience elder abuse in the community, excluding elder abuse that may occur in institutional care.

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According to the elder abuse report, potentially 75,000 older people in WA are affected by elder abuse. Financial elder abuse accounts for 34.2 per cent of cases; psychological elder abuse accounts for 34.2 per cent. Research suggests that both forms of abuse frequently occur simultaneously. So who are the perpetrators? According to Seniors Rights Victoria, two-thirds of elder abuse incidents that occurred in Victoria were perpetrated by a son or daughter of the older person, with over 92 per cent of perpetrators being related to the victim—40 per cent were sons, 26.8 per cent were daughters, 4.8 per cent were husbands, 3.3 per cent were wives, 3.1 per cent were de facto partners, 4.4 per cent were grandchildren, 3.3 per cent were sons-in-law, and 3.1 per cent were daughters-in-law. The committee identified seven main risk factors, with an older person being more likely to experience elder abuse if they are a woman; are an Aboriginal or Torres Strait Islander person; have a cognitive impairment or disability; are a member of a culturally and linguistically diverse community; identify as lesbian, gay, bisexual, transgender, or intersex; are experiencing social isolation or loneliness; or are being cared for by a person who is experiencing carer stress.

According to the elder abuse report, enduring powers of attorney and enduring powers of guardianship are significant tools that can be used as a means to perpetrate elder abuse on vulnerable older people. This is supported by the Office of the Public Advocate’s submission to the committee, which indicated that 211 allegations of elder abuse were investigated during the 2016–17 financial year. Allegations of abuse were a factor for 124 represented people in guardianship applications, and 51 people in that group were 65 years of age or older. Older people are also more likely than younger people to have a disability or severe core activity limitation. In 2015, just over 50 per cent of all older people had a disability, and 36.4 per cent of those adults had a severe or profound activity limitation. According to the Australian Institute of Family Studies, as the proportion of people aged 65 years and over increases over time, the overall population of older people vulnerable to abuse is expected to increase with it. The Australian Institute of Family Studies report titled “Elder Abuse: Key Issues and Emerging Evidence”, in Child Family Community Australia paper 51, states—

The abuse of older people negatively impacts the victims in a range of ways … elder abuse has the common effect of reducing an older person’s quality of life.

The impact of abuse, like the abuse itself, can often go undetected and is difficult to quantify … victims of elder abuse experienced higher rates of depression, post-traumatic stress disorder, anxiety and poor health …

We might ask what that has to do with voluntary assisted dying. We know that elder abuse is happening. We know that it takes place on a financial and psychological level, and we know that it is taking place in family settings. The bill provides a perfect environment for a patient to be subjected to the ultimate elder abuse, which is their death. Although the bill does not allow a family member or someone who may benefit from a patient dying to be a witness to the patient requesting access to assisted dying, I have not identified anything in the bill that prevents a family member or someone who may benefit from the death from being a contact person. I do not know whether a family member or someone who will somehow benefit financially from a person’s death is excluded from being a contact person. The role of the contact person under clause 66 is to receive the prescribed substance from the authorised supplier, possess the substance and supply the substance to the patient. The bill does not make provision to ensure that the contact person, who will play a crucial part in the patient’s end of life, is of sound mind, does not suffer from carer fatigue and will not financially or otherwise benefit from the patient dying. Clause 15(1) of the bill provides the following eligibility criteria for a person to access assisted dying—

(a) the person has reached 18 years of age;
(b) the person—
   (i) is an Australian citizen or permanent resident; and
   (ii) at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;
(c) the person is diagnosed with at least 1 disease, illness or medical condition that—
   (i) is advanced, progressive and will cause death; and
   (ii) 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 that is neurodegenerative, within a period of 12 months; and
   (iii) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;
(d) the person has decision-making capacity in relation to voluntary assisted dying;
(e) the person is acting voluntarily and without coercion;
(f) the person’s request for access to voluntary assisted dying is enduring.

Clause 15(2) reads—

A person is not eligible for access to voluntary assisted dying only because the person has a disability or is diagnosed with a mental illness (as defined in the Mental Health Act 2014 section 4).

I will expand on that a little further on in my contribution.

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Most people who will support this bill would do so with the above provisions, but would they support this legislation if the criteria for eligibility were loosened, as has been the case around the world? In a WAtoday article on 16 September, Professor David Kissane, a prominent psychiatrist, was quoted as saying —

“...We’ll see gradually the development of what happens in other countries, where in Canada there is now a debate about the mentally ill accessing euthanasia.

“In the Netherlands and Belgium, the mentally ill do access euthanasia and it’s given to adolescents with autism, it’s given for people with anorexia, it’s given for schizophrenia and depression.”

I think it would be naive to think that this bill will not be open to future pressure to expand the scope of those who would qualify for euthanasia. If we truly support the clause 4(1)(a) principle that every human life has equal value, it will just be a matter of time before assisted dying will be available to any person of any age, with any condition they felt was unbearable. This is my primary concern with the legislation before us—the major cultural shift from the absolute preservation of life that we have now to one in which we will have government-sanctioned termination of a life. I have no doubt that in the future—it will not be this Parliament but it may be the next Parliament or the one after that; some of us might still be here, and some of us will no longer be in this place—interest groups will be lobbying the government to be included in the groups eligible for access to euthanasia. This has taken place in other countries. The Netherlands legalised euthanasia, including physician-assisted suicide, in 2001. Four years later, in 2004, the Groningen Protocol was created, containing directives with criteria under which physicians can perform child euthanasia without fear of legal prosecution. Belgium legalised euthanasia for terminally ill adults in 2002. Twelve years later, in 2014, it amended this legislation to allow euthanasia for minors, regardless of age. In 2019, it was reported that three children had been killed by euthanasia in the past two years. In February 2010, a citizens’ initiative called Out of Free Will demanded that all Dutch people over 70 years of age who feel tired of life should have the right to professional help to end their lives. In 2016, the Dutch health minister announced plans to draft a law that would allow assisted suicide in cases of terminal illness if a person feels they have completed their life.

Although this bill does not allow a mentally ill person to access assisted dying, I am sure that, with time, that will open up to them. Given that there is no requirement for mandatory psychiatric examination of a patient, how can either of two medical practitioners be sure that there is no underlying mental illness affecting the decision to access assisted dying? Sometimes, the decision-making capacity is limited in persons who have a mental illness that is persistent or temporary due to a tragic event in their lives. Those individuals should be given access to professional mental health care rather than a highway to assisted dying, which, in their desperate state, they would no doubt take.

A special report by Dr Laura Dunn published in the Psychiatric Times in 2017 found that the three most frequently mentioned end-of-life concerns were decreased ability to participate in activities that made life enjoyable, loss of autonomy, and loss of dignity. Dr Dunn claims that these are mental health issues that psychiatrists and psychologists are meant to treat. It has been reported that the desire to suicide often departs once mental illness and pain are effectively treated, even in the terminally ill.

I worry about the future of this legislation, and what that might mean for our community in the years to come. To illustrate that point, in 2018, Aurelia Brouwers, aged 29 years, was allowed to access assisted dying in the Netherlands, which permits end of life when there is unbearable suffering without hope of relief. Her death has triggered a fierce debate in a country that has one of the most permissive euthanasia laws in the world, because not only was she young, but she did not have a terminal disease. She suffered from psychiatric illnesses.

Members, when it comes to mental health, that is something that for me is quite personal. I have heard a number of stories in this place from members who have had loved ones pass away. I feel that those members had a lot of courage to be able to express that in this place. There are a lot of parallels in those stories for me with family members who have passed away over the years, except for one. I agonised over whether I would share that in this place, and, under wise counsel from my staff, I will not, save to say that when someone has a tragic event in their life, and they go to the depths of despair, grief and hopelessness, with what they see as no way out, I am convinced that if the option to end their life were available to them, they would take it. This can go on for years. I have a very raw and personal experience of this. Ending their life would deny them the opportunity in later years—as has been the case, fortunately, for me—to find joy in life, to find love and live a good life. It really, really worries me that, in time, the scope of this bill would be opened up to people who are experiencing severe depression and mental health issues. I had more to say about that in my contribution today, but I will leave that there, members.

I have looked at some of the Hansard debates and at some of the commentary around Australia on the issue of life choices and euthanasia, particularly in Victoria. I know that this has already been quoted in this place, but I will quote it again, because it captures things quite well. I refer to an article in The Sydney Morning Herald of 19 October 2017 written by former Labor Party Prime Minister Paul Keating—that rasical of a Prime Minister, who was very good at capturing situations with just a few words. Paul Keating is quoted as having said —

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.

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He said also—

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. … 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.

…

The experience of overseas jurisdictions suggest the pressures for further liberalisation are irresistible.

Paul Keating concludes the article by stating—

The issue is not how many people will choose to die under this proposed law. It is how many people may die when otherwise they wouldn’t.

I relate to that quite strongly, members. During this debate, I have listened to other members raise certain issues, particularly around Indigenous Western Australians. I note that Hon Ken Baston in his very fine contribution last Thursday touched on that very issue. I refer to Hansard, in which he states—

The member for Kimberley, Josie Farrer, also made important points about what needs to be done to improve the delivery of health services in the regions, particularly for Aboriginal people and people who live in extremely remote communities. I can say now that if this legislation passes, a lot of work will need to be done to ensure that there is adequate engagement with Aboriginal communities to make sure that it does not erode the delicate levels of trust that currently exist between health service providers and Aboriginal people living in very remote communities.

This area certainly needs further investigation. I think there is a gap in the way this has been proposed. I know that the Minister for Health is looking at establishing a task force to try to deal with this. Some work needs to be done on it. Hon Colin Tincknell also made mention of this in his contribution last Wednesday, when he said—

Australia’s two most prominent Aboriginal politicians have opposed this bill and talked about their concerns. They and other government members say that the consultation has not been to the standard they would like. It is not easy to talk about Aboriginal health or culture. Number one, Aboriginal people look at health and death and many other things in society quite differently from us. There are 100 000 Indigenous people in this state and it is not a matter of just consulting with them. We need to help them understand, and until they understand, we have some issues.

I agree with those sentiments. I will back that up by referring to an opinion piece that was published in The Australian in October this year. A lot of this relates a speech in the federal Parliament in August 2018 by Senator Pat Dodson. I am sorry, but members will have to bear with me, because I want to read right through this to make a point. The article states—

Writing in The Weekend Australian, Senator Dodson says legislation passed in the lower house of the West Australian parliament lacks indigenous input and could backfire if enacted.

“Fears and suspicions of ‘whitefella’ medicine will only increase, and the capacity to ascertain informed consent will be difficult,” Senator Dodson writes.

The state is the second after Victoria to bring forward a government-backed bill for voluntary assisted dying … while a parliamentary committee in Queensland is well-advanced on assessing the case for legislation there.

Liberal-governed South Australia is also eyeing reform, two decades after VAD became law in the Northern Territory but was voided by John Howard’s federal government.

The Northern Territory experience in the 1990s suggests that the mere presence of this legislation may be a barrier to First Nations peoples receiving healthcare,” Senator Dodson writes.

He says supporters of the bill—“most with good intentions and compassion for loved ones”—are building their case on an individualist rights agenda.

“Such a perspective emphasises the rights of an individual and ignores the wider influence of such decisions on those around them—families, friends and communities,” he writes.

“Individual choice is an important component of this but it should not be the only significant factor because other humans are going to be required to live with the consequences of their part in ending the life of another.

“In an increasingly atomised world, we are finding it harder than ever to understand the interconnectedness of our social structures and the political choices that hold them together.”

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Asked how a VAD law in his home state of Western Australia would compromise indigenous medical services, Senator Dodson said: “People are very suspicious of the whole (health) system generally. If they find it is associated with potentially the capacity to end your life, as much as to save it, I am fearful people will then, despite their need, start to move away.”

Senator Dodson said his thinking on euthanasia bridged his life experience as a onetime Catholic priest, his spirituality as a Yawuru man and the founding role he played in the reconciliation movement. He agreed it was at odds with progressive sentiment in the ALP.

“I think there are things about my way of thinking that may not necessarily sit squarely with all of my comrades,” the 71-year-old said. “Then again, we live in democracy, so it’s up for debate.”

Putting forward “another avenue to death” was confronting for First Nations peoples when they lived shorter lives than other Australians, had babies that were more likely to die of preventable diseases and lost too many friends, cousins and siblings to suicide. “As representatives and legislators, surely we must be focusing our attention to enacting laws that help prolong life and restore the right to enjoy a healthy life,” he said.

Senator Dodson said the WA legislation contained “significant deficiencies” in terms of content and process. A key provision in the benchmark Victorian law that came into effect in June, banning doctors from raising VAD, had been reversed in an error by Perth’s lawmakers, he insisted.

Asked what was wrong with a doctor broaching assisted dying with a terminally ill patient, he said: “This is a fine line where the reservoir of knowledge is deemed to be in the professional, when in fact this is about someone else’s life. This is about an individual having to weigh up and consider whether this is an option they really want to take.

“Now, to instigate that discussion ... requires a broader context for First Nations people. They are not just nuclear families ... most of us have extended families and not everyone in those relationships see eye to eye. It’s about reaching consensus on the way forward that enables communities to stay together, rather than ones that simply decide they are going to allow individuals to make decisions for everyone else.

“If it’s then removed off to a doctor without any reference to the community about him initiating discussions with the loved one, then I think that also starts to undermine ... the trust you place in a medical system to look after your health rather than find ways to end your life.”

The consultation with indigenous communities was not only inadequate but rushed, Senator Dodson said. “This is a matter that should be clone over a period of time ... one meeting, setting up a forum in one community ... that’s not a way to really consult with First Nations people on a complicated issue like this, that is about the sanctity of life itself, not just about an individual’s life,” he said.

His intervention came after recent polling in Western Australia showed that nearly three-quarters of those living in regional and remote areas of the state supported improved access to palliative care over voluntary euthanasia. The research, for the End of Life Choices Working Group backed by palliative care specialists, found that 56 per cent of the 1900 respondents didn’t believe patients should be helped to die without their loved ones being informed—another point of contention in the WA legislation.

The Anglican bishop of North Queensland, Keith Joseph, told a committee of state MPs in August that remote indigenous communities were strongly opposed to VAD, echoing Senator Dodson on its potential to erode trust in the public health system.

The WA bill cleared the Legislative Assembly last month by 44 votes to 12, but the numbers will tighten in the upper house. Proponents remain confident the legislation will pass, albeit narrowly.

Senator Dodson agreed the debate was being conducted piecemeal, siloed in state legislatures, with no regard to how state regimes would interact.

Members, based on that, I also am very concerned about the impact on communities in very remote and regional Western Australia. I think a lot more work needs to be done around that area. I do not know that having a task force that will visit people is the way to go. I know that this Voluntary Assisted Dying Bill 2019 provides for telehealth to assist with assessing patients but I understand that federal legislation might prevent that, so that if a doctor does that, they could find themselves exposed to litigation. With that, I wish to move a referral.

Discharge of Order and Referral to Standing Committee on Legislation — Motion

HON RICK MAZZA (Agricultural) [4.04 pm] — without notice: I move —

(1) That the Voluntary Assisted Dying Bill 2019 be discharged and referred to the Standing Committee on Legislation for consideration and report no later than Tuesday, 11 February 2020.

(2) The committee has the power to inquire into and report on the policy of the bill.

Extracted from finalised Hansard
HON SUE ELLERY (South Metropolitan — Leader of the House) [4.05 pm]: I oppose the referral to the Standing Committee on Legislation. This is a conscience vote, and that means that, ultimately, we and only we will have to make the final decision about how we vote on each of the various elements of the bill, be those policy elements or, indeed, procedural elements such as the decision about whether we refer to committee. In any of those matters related to this debate, be they policy, technical, legal, clinical, or in this case cultural, we have all observed there are different points of view. With the greatest respect to Senator Dodson, not only one voice speaks for all Indigenous people. We have observed that there are different views. There are different, deeply thought-out views but, ultimately, different and opposed points of view. Although a committee may collect material, seek submissions and hear from experts or others, no committee can ultimately resolve the points of view that are different between us. It will come back here and we will have to make a decision, and consider what it said and cast our votes ourselves. Equally, this matter, including whether there has been adequate consideration of cultural matters, has been subject to widespread public discussion. Indeed, we have just heard that Senator Dodson himself wrote a public opinion piece. Any member who has had any question or any query about any element of the Voluntary Assisted Dying Bill 2019, as it is before us, has had and still has a very wide range of opinions they can seek and a very wide range of experts that they can contact themselves. They can seek that information directly. They can seek briefings, meetings and advice in all ways. Ultimately, members have to consider that themselves and, ultimately, make their own judgement on how to vote.

The extent of public engagement in this debate has also meant any number of experts, stakeholders or lobbyists can get information to us as individual members if that is what they want to do and they have, be it legal, clinical or technical in the case the honourable member has raised, be it cultural. I, too, have received information and views from representatives of Western Australia’s Indigenous community. Those people have had the opportunity to put that to us directly through all ways. Then again, it will still come back to the individual vote of each of us weighing up that information.

I do not support a referral to the Standing Committee on Legislation. No stakeholder has not had the opportunity to put views to us through their respective representative organisations. They still have the opportunity to put views to us as this debate proceeds over the next four or five weeks that we will be debating this. There are experts and people with strongly held views on each side of each issue that we may want to raise in respect of the Voluntary Assisted Dying Bill 2019, and they are entitled to have those different points of view. But, ultimately, no committee will be able to resolve those differences. The bill will come back here and we will have to consider that material. Ultimately, each of us will have to cast our vote one way or the other, or I suppose we could choose not to exercise a vote at all, but each one of us has to make that decision.

This is hard for many people. For some members, it may be the hardest decision that they have had to make or will make in their parliamentary career. Whatever a committee explores, finds or recommends, nothing will change the fact that there are experts with different points of view and that the decision will just come back to each of us as individuals. I cannot see how a committee could resolve the differences between us, how it could resolve the differences between the experts, or how, in this case, it could resolve the differences between different members of the Indigenous community of Western Australia, who also have different points of view. I do not see how a committee could resolve those issues. Ultimately, it will come back to the 36 people in this chamber to make their individual decisions, and for those reasons, I do not support the referral.

HON NICK GOIRAN (South Metropolitan) [4.11 pm]: This feels like a case of deja vu, because the Leader of the House gave an almost identical speech when the house sought to refer the Human Reproductive Technology and Surrogacy Legislation Amendment Bill 2018. I was the mover of the motion at the time, and I specifically recall the Leader of the House saying words to the same effect as those she delivered just now. In effect, she said to members, “You cannot refer this matter to a committee because it’s a conscience vote. How can a committee resolve matters that are matters of conscience?” I remind the Leader of the House that on that occasion, the report came back from the committee and the government has chosen to never bring that bill on for debate ever again. Members know full well why; it is because there is a fatal flaw in that legislation. It is possible for bills that are subject to conscience votes to be brought to the Standing Committee on Legislation for it to do its work and see whether there are any flaws in the legislation that are worthy of the consideration of members. The threshold issue is a conscience vote; that is true, but that does not abrogate our responsibility as lawmakers to not pass an unsafe law. That is precisely what the legislation committee would be entrusted to do, in the event that members were agreeable to the discharge and referral of this bill to the committee, as moved by Hon Rick Mazza.

Extracted from finalised Hansard
I draw to members’ attention that it is not uncommon for this chamber to send bills to the Standing Committee on Legislation. I have before me a short list of the bills that have been referred to the Standing Committee on Legislation in the fortieth Parliament. I served on most of these inquiries in my capacity as deputy chair of the committee, but on two inquiries I was substituted off for another member. The list includes the Sentence Administration Amendment Bill 2017; the Animal Welfare Amendment Bill 2017; proposed part 12 of the Strata Titles Amendment Bill 2018; the Residential Tenancies Legislation Amendment (Family Violence) Bill 2018; the Residential Parks (Long-stay Tenants) Amendment Bill 2018; the Human Reproductive Technology and Surrogacy Legislation Amendment Bill 2018; and the Ticket Scalping Bill 2018.

I put it to members that for none of those bills that we agreed as a chamber should be referred to the Standing Committee on Legislation were the stakes as high as they are with this legislation. It would say a lot about this chamber if we were prepared to send the Animal Welfare Amendment Bill 2017 to the Standing Committee on Legislation for investigation, but we were not prepared to send the Voluntary Assisted Dying Bill 2019 to the legislation committee for consideration. I might add that we were quite happy to send the Ticket Scalping Bill to the Standing Committee on Legislation for consideration. Whatever people might think about the importance of ticket scalping in Western Australia, I suggest that the stakes are not quite as high as they are in a situation in which a medical practitioner is going to take the life of a Western Australian, whether that be with the consent of the individual or otherwise.

The context of the bill before us is worthy of consideration. I put it to members that that is an additional reason that this bill should be sent to the committee. I remind members that the genesis of this bill was the Joint Select Committee on End of Life Choices’ report “My Life, My Choice”. Members will recall that that committee was asked by this chamber and the other place to consider certain things in accordance with its terms of reference. Members will also recall that I asked the chamber to insert an extra term of reference for the committee to consider the risks of voluntary assisted dying. We were implored by one of the ministers of the Crown to vote against that term of reference. Consequently, it is a matter of public record that the Joint Select Committee on End of Life Choices did not look into wrongful deaths in other jurisdictions. It is also a matter of public record that despite the fact that the committee was asked to do that, it was not done. I remind members that the committee minutes have been kept secret. I remind members that the Ministerial Expert Panel on Voluntary Assisted Dying told Western Australians, “We don’t want to hear from you if you have an opposing view to us. You can only speak to us and provide views if you are going to accept voluntary assisted dying.” The Ministerial Expert Panel on Voluntary Assisted Dying told the people of Western Australia, “Tell us how it’s going to work.” I remind members that the bill that is before the house was drafted by the government prior to the Ministerial Expert Panel on Voluntary Assisted Dying handing down its report. I remind members that Senator Patrick Dodson has said that there has been inadequate consultation. I remind members that the government in the other place refused to accept any amendments to the bill. If members examine their conscience, they know full well that members in the other place were instructed to not accept any amendments under any circumstances.

I point to comments made today by the Minister for Health, Hon Roger Cook, who has proceeded to tell the people of Western Australia, the media and this chamber that if we dare consider the possibility of a specialist being involved in this process, that will apparently be a deal-breaker. To say to this chamber that it will be a deal-breaker "My Life, My Choice" report that look at the intersection with federal law. Despite the fact that the committee was asked to do that, it was not done. I remind members that the committee minutes have been kept secret. I remind members that the Ministerial Expert Panel on Voluntary Assisted Dying told Western Australians, “We don’t want to hear from you if you have an opposing view to us. You can only speak to us and provide views if you are going to accept voluntary assisted dying.” The Ministerial Expert Panel on Voluntary Assisted Dying told the people of Western Australia, “Tell us how it’s going to work.” I remind members that the bill that is before the house was drafted by the government prior to the Ministerial Expert Panel on Voluntary Assisted Dying handing down its report. I remind members that Senator Patrick Dodson has said that there has been inadequate consultation. I remind members that the government in the other place refused to accept any amendments to the bill. If members examine their conscience, they know full well that members in the other place were instructed to not accept any amendments under any circumstances.

Speaking of the Minister for Health, I refer to debate in the other place on 3 September 2019. At page 6311 of Hansard, he said —

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.

That comment alone by the health minister in the other place raises a number of questions that the Standing Committee on Legislation could consider. Certainly, if I had the opportunity to serve on the committee as the deputy chair, I would ask the government what was being done to address the lack of access in Aboriginal communities to culturally appropriate local palliative care, precisely one of the things that Hon Rick Mazza is asking that committee to look into. Has the government established where the gaps in this access exist? Has the government determined the plan to address the issue of lack of access to culturally appropriate local palliative care for Aboriginal communities in Western Australia? Indeed, how many Indigenous palliative care nurse practitioners are there in Western Australia, and in which regions do these palliative care nurse practitioners operate? My guess is that there are zero palliative care nurse practitioners. I understand that there are only about four or five in the entire state, so I still do not know
how it is possible for the Minister for Health to say what he said with all seriousness. Indeed, if the matter goes to the committee, I would ask the government to what extent it had consulted with Aboriginal communities to determine how best the culturally appropriate palliative care services could take into account collective decision-making.

In addition to that, on the same day, 3 September this year, the health minister made these remarks —

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.

That comment by the health minister, Hon Roger Cook, draws the following questions that will need to be considered by the Standing Committee on Legislation: Has the government prioritised plans to establish a care navigator service to assist Aboriginal people in accessing voluntary assisted dying ahead of addressing the current lack of access for Aboriginal people to culturally appropriate palliative care? Has the government considered the conflict that a care navigator service will have with the concerns raised in the final report of the ministerial expert panel, including issues in relation to language and translation services for Indigenous Western Australians, as well as issues of power disparity between health practitioners and Aboriginal patients and the issue of undue influence?

With all due respect to the Leader of the House, it is not only Senator Patrick Dodson who has raised concerns about this matter. I now turn to the remarks made in recent times, indeed reported on 10 October this year, some 12 days ago, speaking to the views of Australia’s first Indigenous surgeon, Kelvin Kong. I refer to the article in The Australian titled “Euthanasia plan ‘terrifies’ surgeon”, and I quote certain extracts of that article. It says —

Australia’s first indigenous surgeon, Kelvin Kong, says he is terrified by the McGowan government’s plan to let doctors suggest voluntary assisted dying, describing patients in remote areas as often so thankful to see a specialist that they are “very compliant”.

Associate professor Kelvin Kong, of the Worimi people of Port Stephens, north of Newcastle in NSW, said the priority should be change that improved the treatment and survival chances of indigenous Australians with life-threatening illness.

…

While Australia’s overall cancer survival rates were among the best in the world, there was a big disparity between the incidence and survival rates of Australians who were non-indigenous and Australians who were Aboriginal and Torres Strait Islander.

“We are jumping to an end-stage conversation when we haven’t got all the pathways in cancer management leading up to palliative care,” he said.

…

Professor Kong, an ear, nose and throat specialist —

I pause there to say that no doubt the health minister will say that the views of this individual are irrelevant because he is a specialist and that it is a deal-breaker for us to even talk about specialists —

who treats cancer patients in cities, rural towns and remote Aboriginal communities, said he was open to the concept of voluntary assisted dying laws but he believed that in terms of priorities in indigenous health, the debate was happening in the wrong order.

“If we are serious about the betterment of our mob, we really need to increase things like early interventions,” he said.

As a member of the Cancer Australia Advisory Board, Professor Kong contributed to a guide for the treatment of indigenous cancer patients that encourages doctors to focus on prevention and early detection, gives them suggestions about how to get indigenous people to feel safe going to a doctor and offers tips for how to talk to an indigenous cancer patient about treatment.

Asked whether he had concerns about the proposed WA law letting a doctor instigate a conversation with an Aboriginal person about voluntary assisted dying, he said: “Yes, it terrifies me because you don’t know who that doctor is.

“There are some I know would handle it well and others not. No, this is not the right thing,” he said.

“Our medical training is really good at teaching us about disease, but it’s not really good at teaching us an understanding of cultural complexities, particularly with our most disenfranchised people.”

…

Farmers and indigenous people were among regional patients who were vulnerable.

“They might have waited two years to see someone. We need to take that with honour and real respect,” he said.
As Hon Rick Mazza has indicated, Senator Pat Dodson has also expressed some concerns about this matter. I will not repeat what he said, because I think Hon Rick Mazza has already outlined the views of Senator Dodson, but I add that it is not only he who has said this. I turn now to an article in WA Today of 11 October, some 11 days ago, which says —

Australia’s two most prominent Aboriginal politicians—one Labor and one Liberal—have spoken out against WA’s draft euthanasia laws, raising questions about the extent of consultation with the state’s First Nations peoples.

I suspect that members are well aware of this article. Of course, not only is Senator Pat Dodson the prominent Labor Aboriginal politician referred to in the article, but the Liberal one is none other than Minister for Indigenous Australians Hon Ken Wyatt. I ask members to consider this for a moment. If the most senior Labor Aboriginal politician in Australia and the most senior Liberal Aboriginal politician both say, “Hang on, something needs to be looked at here. Our people have not been properly consulted”, should that not at the very least make us pause for a moment and consider what they have to say? Or are we so arrogant that we will just press ahead anyway and say to Mr Dodson and Mr Wyatt, “Thank you very much for your input. As key stakeholders, you have had your opportunity; your people have had their opportunity. We will not be sending this to the committee, because we think that the animal welfare bill is more important, we think that the Ticket Scalping Bill is more important, and with all due respect to you two senior, prominent Aboriginal politicians, we are pressing ahead anyway”?

Is that the message that we want to send at this point of the debate? I turn to the content in the so-called Ministerial Expert Panel on Voluntary Assisted Dying and its so-called final report. I am not sure whether it is the final report of the so-called ministerial expert panel, because I received communication late last night and I do not know whether it was a supplementary part to the final report or on what authority that particular correspondence was sent. Perhaps it is not its final report. Who knows how many reports it intends to send. Let us look at what the ministerial expert panel has to say about the interests of Indigenous Western Australians in its final report.

Debate interrupted, pursuant to standing orders.

[page 7994]

Resumed from an earlier stage of the sitting.

The PRESIDENT: Members, we are dealing with the motion that has been moved by Hon Rick Mazza, and the question is that the motion be agreed to. It is the continuation of the remarks by Hon Nick Goiran.

HON NICK GOIRAN (South Metropolitan) [5.07 pm]: I rise to continue speaking in support of the motion moved by Hon Rick Mazza that the Voluntary Assisted Dying Bill 2019 be discharged and referred to the Standing Committee on Legislation. The motion before the house proposes a number of things, including that the committee report by no later than Tuesday, 11 February 2020. As I foreshadowed earlier, it would not be strange or irregular for the chamber to refer this bill to the legislation committee, given that this would be, on my count, the ninth occasion during this fortieth Parliament on which a bill has been referred by this chamber to that committee. As I indicated earlier, if it was good enough for this chamber to send the Animal Welfare Amendment Bill and the Ticket Scalping Bill to the Standing Committee on Legislation, it should be good enough to send the Voluntary Assisted Dying Bill to the committee for investigation.

My only concern about the motion that is before the house is that the honourable member proposes a reporting date of Tuesday, 11 February 2020. I note that the bill that is currently before the committee has a reporting date later than 11 February 2020; in fact, I think the reporting date is May 2020. The problem is that we are currently operating in a highly charged political environment that will not tolerate one moment’s pause in the consideration of the Voluntary Assisted Dying Bill 2019. Therefore, I do not feel at liberty to propose a later reporting date, because, in the current political climate, that will be considered to be utterly intolerable. Can I be so bold as to say that it has almost come to the point of hysteria in certain quarters that the Legislative Council might want to pause and consider carefully the 184 clauses in this bill that will lead to the taking of Western Australian lives. Members may very well say, as members have said, that it will be a voluntary process, but just that voluntary process itself, the decision-making capacity of the individuals and whether genuine consent is provided, need to be examined by the Standing Committee on Legislation. The moment any of that goes wrong, it will result in a wrongful Western Australian death.

Before the interruption to take questions without notice, I was taking members through the views expressed by various individuals in the community. I started by looking at the comments of the Minister for Health, Hon Roger Cook, and at comments made and reported in recent times by Australia’s first Indigenous surgeon, Kelvin Kong, and touched on the views presented by Senator Dodson and federal Minister Wyatt. I now want to turn to the views expressed by the so-called ministerial expert panel in its final report. I draw to members’ attention these remarks made by the Ministerial Expert Panel on Voluntary Assisted Dying on page 24 of its final report, where it states —

Some consultation respondents contended that developing adequate safeguards to ensure that decision-making is voluntary and valid would be challenging.

At the very start of the process by the ministerial expert panel, the chair, Hon Malcolm McCusker, was quoted in the media in Western Australia as saying that this process is a minefield. Again, if the chair of the panel is saying...
that it is a minefield, should we not pause for a moment and consider what could possibly go wrong in a minefield? If the chair of the ministerial expert panel says this will be a minefield and its report says, “Some consultation respondents contended that developing adequate safeguards to ensure that decision-making is voluntary and valid would be challenging”, is that not something the Standing Committee on Legislation should inquire into and report back to the house on? The paragraph goes on to say —

Others noted that there was a need to have a good understanding of cultures that have a collectivist approach to decision-making and for practitioners to better understand how Aboriginal people may choose end-of-life care.

The ministerial expert panel specifically quotes from the submission of the Aboriginal Health Council of Western Australia.

I pause for a moment because it strikes me that sometimes, with some of the advocacy that has taken place, including late last night by the so-called ministerial expert panel, some individuals and advocates think members in this place cannot read! This is straight out of the final report on page 25 —

‘Any guidelines or legislation for voluntary assisted dying must make it clear that autonomous, voluntary decision making for Aboriginal people is not precluded by a collectivist approach, and should be accepted’.

(Submission by the Aboriginal Health Council of Western Australia)

That is what the ministerial expert panel said the Aboriginal Health Council said in its submission. What did the ministerial expert panel have to say about that? This is its discussion at page 25. I ask members to consider whether this response and discussion by the ministerial expert panel would pass any academically rigorous test. I quote —

Most decisions, large or small, are made by people in the context of their usual life which includes family, friends and their community. People have the right to include or exclude whoever they choose in their deliberations on their decision and to seek support in their decision-making process. It is important to consider the needs of people from diverse backgrounds who may be from cultures that have a collectivist approach to decision-making.

End of comment. The ministerial expert panel identifies that the collectivist approach to decision-making is an issue for Aboriginal people. It quotes from the Aboriginal Health Council, which says that this should not be precluded and, indeed, should be accepted. However, the best comment the panel can make is —

It is important to consider the needs of people from diverse backgrounds who may be from cultures that have a collectivist approach to decision-making.

One of the things the Standing Committee on Legislation will clearly need to look into is how a medical practitioner should assess whether the individual’s consent to voluntary assisted dying was voluntary and free of coercion or undue influence if the decision can be made by a collectivist approach? That is the type of thing the ministerial expert panel should have been wrestling with and should have provided some recommendations on. That is the whole point of having the ministerial expert panel, and it has not done it. That is exactly why we need the Standing Committee on Legislation to look at these issues. We have to fill the gap left by the ministerial expert panel. It clearly has not done it. Again, I challenge members who have a differing view to point to me the page in the ministerial expert panel’s report that does that. It does not exist. This is not some small, insignificant matter. People will have passionate views one way or another on it, and that is fine. However, surely the 36 of us all agree that if the law is passed, it must be safe. What confidence can we have that this Voluntary Assisted Dying Bill is safe when we are told by the government and its chief proponents that there has been massive consultation on this process, including by the ministerial expert panel, when the facts tell us that the bill was drafted before the ministerial expert panel handed down its report? If members take the time to read the report, they will find that it has massive holes in it.

What about the collectivist approach to decision-making for Aboriginal people? Do we care? If we do not care, let us be brutally honest and say that we do not care, we want to ram this legislation through. We do not care what Senator Dodson or federal Minister Wyatt have to say and we do not care what the Aboriginal Health Council of Western Australia has had to say. We do not care that the ministerial expert panel has failed in its duty to address the issues that have been raised. We simply do not care. We think the Voluntary Assisted Dying Bill is a bill of lesser importance than the Animal Welfare Amendment Bill, the Ticket Scalping Bill and the other bills that have been referred to the legislation committee by this chamber in this fortieth Parliament. If that is our view, let us be honest and transparent and say so. However, let us not pretend, as put by the Leader of the House, that we cannot do it because it is a conscience vote. We know that is untrue because that is precisely the argument that was put on the surrogacy legislation and that report speaks for itself.

I turn now to further things the ministerial expert panel had to say on Indigenous interests. On page 27 of the report, the following comment is made by the so-called expert panel —

In some communities, particularly more remote communities, an association with voluntary assisted dying may impact the community’s trust in the local health practitioner or health service. There may be times where the use of an independent navigator would provide additional safety and space for a person to make a decision that reflects their personal choice (particularly if their viewpoint differs from that of their family or community).

Extracted from finalised Hansard
If we pause and read that for a moment, we realise that the ministerial expert panel is throwing up a red flag to us, saying there will be safety issues in the decision-making process in remote communities. If that is the case, and if we have key Indigenous leaders in our state saying they are concerned, do we not have a duty to pause and refer the bill to the Standing Committee on Legislation so that it can do the consultation that has not been done? As much as the government will say there has been massive consultation, would it not be good, members, if we could have a list of the Indigenous Western Australians who have been consulted on this bill? It will not be a very big list. I can tell members, I served on the Joint Select Committee on End of Life Choices and the list is not very big. How big is the list of Indigenous consultation by the Ministerial Expert Panel on Voluntary Assisted Dying? I bet it is not very big. Should not the last gatekeeper in this process, the Legislative Council of Western Australia, do the job that has not been done by others?

I turn to page 28 of the final report of the Ministerial Expert Panel on Voluntary Assisted Dying and its comments with regard to matters affecting Indigenous interests. It states —

> It was evident to the Panel that education, information and informed decision-making are all very important to the Western Australian community … all people must be able to access information in a language or manner suitable to them and that this information should be easily accessible.

That comment by the Ministerial Expert Panel on Voluntary Assisted Dying sits well with clause 4 of the Voluntary Assisted Dying Bill 2019, headed “Principles”. Hon Rick Mazza earlier referred to clause 4, and it touches on exactly this point. It states in part, under clause 4(1) —

> (g) a person should be supported in conversations with the person’s health practitioners, family and carers and community about treatment and care preferences;

> (h) 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;

In that respect, the bill correctly identifies the issue that was spoken about by the Ministerial Expert Panel on Voluntary Assisted Dying, but the report continues, at page 28 —

> Further to this there was context of particular relevance to Aboriginal people:

Again, the report quotes from the submission by the Aboriginal Health Council of WA —

> ‘There are English language terms which have no meaning for Aboriginal people and discussions around end of life care must take this into account. For example, even the term ‘end of life’ is not one that Aboriginal people would use or necessarily recognise as applying to them or their circumstances.’

What are we doing about that? That has been identified by the Ministerial Expert Panel on Voluntary Assisted Dying as a problem, yet there has been no explanation about how that will be addressed. It is no wonder, then, that Senator Dodson and others are crying out for more consultation on this matter. This is no light matter. I remind members again that when it comes to language and the confusion that can be caused on technical matters, we have only to look at the report that was tabled in this fortieth Parliament by the Joint Standing Committee on the Corruption and Crime Commission that looked into the wrongful death of Josh Warneke and the circumstances in which Mr Gene Gibson incorrectly pleaded guilty because of confusion around language and with regard to capacity. We already have an example of this that has happened in our own fortieth Parliament, and now we are having it drawn to our attention by the Aboriginal Health Council of Western Australia, reported to us by the Ministerial Expert Panel on Voluntary Assisted Dying, and there has been no response from the government on how that is to be addressed.

I turn to page 30 of the Ministerial Expert Panel on Voluntary Assisted Dying’s report. It states —

> The Joint Select Committee specifically recommended that a prohibition on health practitioners starting a discussion about voluntary assisted dying was not adopted in Western Australia.

> …

> The findings of the consultation demonstrate very strong opinion that legislation in Western Australia should not limit, impede or seek to censor the conversations that health practitioners appropriately conduct with patients.

It continues, further down the page —

> 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.

The report quotes from one of the consultation stakeholder meetings with Kimberley palliative care —

> ‘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’.

Extracted from finalised Hansard
Are these things that the Standing Committee on Legislation should pause and consider? Or, again, should we say, “These things are not of sufficient significance; we prefer to send matters like the ticket scalping bill and others to the legislation committee for consideration because we’re very concerned that Western Australian might be ripped off for their ticket, but we’re not as concerned that a Western Australian might be coerced or abused or under duress or undue influence with regard to the decision that they make, and we’re less concerned about the possibility of a doctor making a mistake, let alone two GPs, to say nothing of the role of a specialist”, which apparently is a no-go zone, according to the Minister for Health.

I turn now to page 31 of the Ministerial Expert Panel on Voluntary Assisted Dying’s report and its consideration of matters that are of interest to Indigenous Western Australians. It states —

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).

What did the Aboriginal Health Council of Western Australia have to say to the Ministerial Expert Panel on Voluntary Assisted Dying about that? It said, as quoted in the Ministerial Expert Panel on Voluntary Assisted Dying’s report —

‘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’.

Those are not my words and not my view of the world; that is a submission by the Aboriginal Health Council of Western Australia to the Ministerial Expert Panel on Voluntary Assisted Dying. What did the ministerial expert panel do about that? I expected more from the ministerial expert panel than to be just a collator of information, and to then dump the information into a final report. I expected it to wrestle through the issues at an academically rigorous level and provide us with some solid findings and recommendations. Plainly, in the limited time I have had here, we can see that that has not occurred, especially with regard to Indigenous Western Australians. It is no wonder that Hon Rick Mazza is therefore concerned and asks us to pause for a moment and contemplate a referral to the Standing Committee on Legislation.

As I said earlier—I know the honourable member was out of the chamber on urgent parliamentary business—if there is any point of concern I have with the motion, it is the expectation that the committee report by no later than Tuesday, 11 February 2020. But as I indicated earlier, we are in a highly politically charged environment, and despite the fact that it is a conscience vote, I feel constrained to even propose that there be a later date than February 2020, in circumstances in which the most recent referral of a bill to the committee—Hon Aaron Stonehouse’s private member’s bill—has been given a greater period for proper consideration by the committee.

I will finish on this point. If any member in the chamber this afternoon might not want to vote for this motion by Hon Rick Mazza simply because I am on the committee, I say to them that I will be prepared to stand down from this inquiry if that were to be a stumbling block for members. I made it very clear in my contribution to the second reading debate that I have been researching this matter for 10 years and it is my view that it is a legal impossibility to create a safe system. If members then say that it is therefore not appropriate for a member holding that view to be involved in this inquiry and to carry out consultation with Indigenous Western Australians, I will be prepared to consider that very seriously. I do not want that to be the stumbling block, because the stakes are simply too high.

Members have said during the course of this debate that there is no more difficult decision to make than the one on this bill and this will be the hardest decision that they will have to make. If that is the case, should the committee not be looking into the issues? It seems counterintuitive to me that in one breath we can say this is a very difficult matter to deal with, on which people hold very strong views, and in the next breath say that we do not want a committee to look into it—under no circumstances should the committee to look into this. Why would that be? What are we scared of? Is it the fact that on each and every other occasion in this fortieth Parliament when a bill has been referred to a committee, the committee has suggested some amendments and found some issues, whether it is, with all due respect, on a more innocuous piece of legislation such as the Ticket Scalping Bill? Maybe there are members who are very passionate about animal welfare and they feel it is at a higher level than ticket scalping, and that is fine. I do not wish to cast any judgement about the weight that members personally give to any piece of legislation, but surely out of all those bills the one with the greatest gravity, the one with the greatest amount of consequences, is this one. Why would we not want the committee to look at it? If members examine their consciences, the reason cannot be that the government does not want any amendments. We have to rise above the attitude in the other place, otherwise there is no point in having a Legislative Council. We should not bother having this chamber if we are simply going to be the chamber that rubberstamps what comes from the other place. It does not matter whether the government wants amendments; our duty as lawmakers is to ensure that the bill before the house is safe. Is it safe or not? Have Aboriginal people been consulted or not? They are the issues that need to be considered by the Standing Committee on Legislation, and it is for those reasons that I support the motion moved by Hon Rick Mazza.

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I thank him for his courage in moving the motion, because inevitably he will be criticised for having the temerity to even suggest that this bill go to a committee. I stand with him by indicating to those who would criticise him that the stakes cannot be higher than the Voluntary Assisted Dying Bill, and it is entirely appropriate for this bill to go to a committee.

HON ROBIN CHAPPLE (Mining and Pastoral) [5.32 pm]: I will be brief. I will not support this motion. I take on board what has been said by Hon Rick Mazza about Indigenous people. I am not going to preclude anybody, but I know that Hon Kyle McGinn and Hon Colin Tincknell have a large connection with Indigenous people, as I do. One of the problems if we want to go down this path is that we are going to have to talk to 128 different tribes that all have different views about this process. There are 90 languages spoken in Western Australia, and from the discussions I have had through the Kimberley and the desert, there is a vast array of views on this matter, in exactly the same way that we have a vast array of views in this chamber. I think it is important to put on the record that Ms Kate George was on the Ministerial Expert Panel on Voluntary Assisted Dying. She is a Martu woman—she is actually a Putijarra woman from the desert. She was the first Indigenous woman to study law and get a degree at the University of Western Australia, and she specialises in human rights, international law and Indigenous matters. Whether it be the saltwater people, the desert language groups, the Murchison bioregion groups or the goldfields Wongutha groups, there are going to be completely different views expounded by all these groups and people. I think that having Kate on the expert panel provided it with that voice, in essence. She is highly respected throughout the Pilbara, Port Hedland, through the Kimberley and down to the goldfields. This is the woman who was put on the expert panel for that very purpose. I will not support the motion. We have to be very, very careful when we go down this path of saying “Aboriginal people”. It is one of the fallacies that we fall into. There is no such thing as “Aboriginal people”. There are lots of Aboriginal tribes and they are all different; they all have different cultural approaches to a whole range of things. I think doing things in that way is almost belittling to Aboriginal people.

HON AARON STONEHOUSE (South Metropolitan) [5.35 pm]: I will be brief. In the lead-up to this debate I spoke with stakeholders, and many of them asked me my views on discharging this bill to the Standing Committee on Legislation. At the time I spoke frankly and I said to them that I thought such an effort was likely be little more than a delaying tactic and I would not see the value in such an effort as the committee would probably not be able to tell us much more than we already knew. I said that the issue of voluntary assisted dying had already been subjected to the Joint Select Committee on End of Life Choices and then to the Ministerial Expert Panel on Voluntary Assisted Dying. However, I note that the motion moved by my learned friend Hon Rick Mazza is far narrower in scope and his intention with this motion seems to be to garner evidence and consult with and receive feedback from specific groups of people. Part (3)(a) and (b) make specific reference to Indigenous persons and part (3)(c) requests that the committee report on whether the bill provides culturally appropriate end-of-life choices for Indigenous persons. It is far narrower in scope than what was being proposed earlier to me by stakeholders, which would have been to discharge the entire bill and have the entire policy of the bill examined. I note that part (2) of the motion mentions that the policy of the bill should be looked at, and I have some thoughts about perhaps amending this motion, which I will discuss later in my contribution.

In my contribution to the second reading debate I spoke about a need for legislators to be vigilant, critical and sceptical of what was brought before us. Even speaking from the position of someone who supports the bill, at least thus far, and is willing to vote for the second reading so we can continue into the Committee of the Whole House, there is still a responsibility for members of the Legislative Council to leave no stone unturned and to examine every aspect of this bill. It is a large and complex bill with 184 clauses. During my second reading contribution, I raised concerns about cultural differences in attitudes towards capacity and consent. Indeed, this was even raised by the Ministerial Expert Panel on Voluntary Assisted Dying. Most of us, having grown up and lived in a liberal democracy with a healthy scepticism for authority and an individualistic identity, likely have no problem questioning advice from a medical practitioner or directions given to us by our family or friends. That may not be the case in different cultures. Other cultures may have very different views about where the individual sits in society, and they elevate community above individual. They may have family-based or community-based decision-making processes rather than individual-based decision-making processes. There may be concerns about language barriers. What do we do with someone with English as a second language who does not quite grasp the technical language used by the medical practitioner when discussing voluntary assisted dying?

It has been put to me that questions about this might best be addressed in the Committee of the Whole House. I think the Committee of the Whole process would be suitable for addressing most of the concerns I have with this bill; however, when I look around the chamber and at the lack of melanin and the make-up of the Legislative Council, I am not so sure that questions about cultural attitudes towards assessment of capacity and consent will be as easily answered in the Committee of the Whole House. It may be more appropriate in those instances to solicit evidence and witnesses from people from unique cultural backgrounds, who can give the Standing Committee on Legislation their take on what voluntary assisted dying means to them and the effectiveness of the safeguards built into the legislation. As the previous speaker Hon Robin Chapple said, there are hundreds of various tribes, groups —

Hon Robin Chapple: And views!

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Hon AARON STONEHOUSE: — and views clumsily clustered together as Indigenous people. They are not one homogenous group with one view shared across the various groups that can be boiled down into a single view on the Voluntary Assisted Dying Bill and its 184 clauses. There may be merit, therefore, in having a select committee look at the issue of culturally appropriate end-of-life choices for not just Indigenous people but all people. I am mindful that discharging the bill in such a way will result in a delay. It has been put by other speakers that the proposed reporting date of 11 February may be a little too early. I fear that it may be too late. If there is the will, it may be possible to have an earlier reporting date. I wonder whether members would consider amending the reporting date to the end of January, because that will allow members to consider the committee’s report before returning to Parliament in 2020. I am advised that a committee can table a report when Parliament is not in session by tabling it to you, Madam President. If that is the case, that would allow members to consider the committee’s deliberations and report in detail before we resume the debate in February. I will not move that now because I have not had an opportunity to canvass support across the chamber for such an amendment and, to be honest, I am not sure whether it would make much difference. Despite the delay this would cause—I have said this about potential delays caused by the Committee of the Whole House and other Legislative Council processes during other debates—I would much rather err on the side of more than less scrutiny, especially when we are dealing with such a serious matter.

As I said last week, I will support the second reading of this bill. I support the right of individuals to make choices about their own bodies and I support voluntary assisted dying in principle, but it is imperative that we get this right because the price of making a mistake is too severe to pay. If we can get the bill right and address concerns about Indigenous persons, palliative care in regional communities and culturally appropriate end-of-life choices, a delay of four months is a small price to pay and perhaps it is warranted in this case. Therefore—I am doing this from the floor without a prepared motion so let me see whether I can get this right—I will move to address my concern about the scope of this discharge motion by seeking to remove part (2), which makes specific reference to the policy of the bill, so that the scope of the committee inquiry can instead focus on part (3), paragraphs (a), (b) and (c). I am mindful that under the standing orders, the committee may have the power to inquire into the policy regardless of what is in the discharge motion, but I think it might help to provide clearer guidelines to the committee when it begins its inquiry to remove specific reference to the policy. If it begins such an inquiry, the committee would look at the motion to discharge to inform the scope of the inquiry.

Amendment to Motion

Hon AARON STONEHOUSE: I move —

To delete part (2).

Point of Order

Hon SIMON O’BRIEN: I am sure that if you would contemplate this, Madam President, it might be beneficial for all members. I suggest—this is not entering into the debate but is simply a point of order—that if the second reading question has not been resolved, the policy of the bill has not been established by the house. Therefore, I think it is very difficult for you to entertain the amendment to the motion that has been put forward. Indeed, it has been the practice on solid grounds for as long as I can remember—at least my long-term memory is reasonably intact—that a bill referred to a committee for examination and report before the second reading is referred for consideration, including examination of the policy. I understand that the member is very well motivated in what he is proposing, but if the question of the policy of the bill has been decided and after the second reading a referral motion is entertained, that is when the position is that the policy has been decided and is not therefore available for further examination unless so ordered. I throw that in for your consideration, Madam President.

The PRESIDENT: In thinking about the point of order moved by Hon Simon O’Brien and taking into account the proposed amendment to the motion, I refer members to schedule 1(4), clause 4.4, which states —

Unless otherwise ordered, any amendment recommended by the Committee must be consistent with the policy of the bill.

As I understand it, retaining part (2) of the motion will enable the committee to look at the policy of the bill. I listened to Hon Simon O’Brien, who discussed at what stage the policy of the bill could be looked at, depending on whether the referral happens now or after the second reading debate has been completed. I think that if Hon Aaron Stonehouse seeks to remove part (2), that would restrict the committee in terms of what it can look at.

Hon AARON STONEHOUSE: It is certainly my intent to narrow the scope of the committee’s inquiry. If it is not out of order, that is why I have moved my amendment to the motion. I want to narrow the scope of the inquiry to help the committee in its inquiry to understand that the Council’s intent is part (3)(a), (b) and (c), not a wideranging review of the entire policy as allowed for by part (2). There was a point of order, so I am not sure whether I am speaking on my amendment to the motion, but it is certainly my intention to amend the motion. To make it clear to members, my intention is to narrow the scope of the committee’s inquiry, and removing part (2) will help the committee because specific issues referred to in part (3)(a), (b) and (c) warrant further investigation, and I would like the standing committee to undertake that. I leave it there for members to give their thoughts.
The PRESIDENT: I am going to work my way through this, members. I am not going to uphold the point of order, but I am going to enable the amendment moved by Hon Aaron Stonehouse to proceed to see what the view of the house is on the question. I am going to deal with the amendment to the motion moved by Hon Rick Mazza. Hon Aaron Stonehouse has moved that part (2) be deleted; that is —

(2) The committee has the power to inquire into and report on the policy of the bill.

Debate Resumed

HON NICK GOIRAN (South Metropolitan) [5.50 pm]: I rise to indicate to the honourable member my reluctance for the amendment. I understand why the member has moved it and I do not begrudge him moving it at all. I simply make this point: I have a longstanding record, including eight years when we were in government, of saying that if as a chamber we are going to invest the time of members of Parliament to look into a bill, why would we stop them from telling us whether they find a problem? If the Standing Committee on Legislation looks at a bill and identifies a problem—for example, some of the things that Hon Martin Aldridge has been trying to get answers from the government about on the intersection with federal law—why would we block it from saying something about that? I have never understood the need to restrict a committee. My approach has always been, whether in government or opposition, to give the Standing Committee on Legislation as much latitude as possible.

I understand why the honourable member has moved the amendment. I accept that it is moved with the greatest of respect and intent, and no doubt others will have a different view, but if I were to serve on the committee, I would want the freedom to look at all the issues associated with the bill, not just one particular thing. I find it difficult to support the amendment in those circumstances.

HON RICK MAZZA (Agricultural) [5.52 pm]: I rise to say that I will not support the amendment to the referral motion. I understand that Hon Aaron Stonehouse is trying to narrow the scope, but at the end of the day the Standing Committee on Legislation will report back to the house on 11 February, so regardless of whether the policy of the bill is included, the committee will still be subject to that time frame. I am very concerned that if the committee does not inquire into and report on the policy of the bill, some of the other issues may not be able to be properly investigated and there will be no correlation between the policy of the bill and how it relates to Aboriginal people. I will not be supporting the amendment.

Amendment put and negatived.

Motion Resumed

HON JACQUI BOYDELL (Mining and Pastoral — Deputy Leader of the Nationals WA) [5.53 pm]: I rise to indicate to the honourable member my reluctance or opposition, to give the Standing Committee on Legislation as much latitude as possible.

I have never understood the need to restrict a committee. My approach has always been, whether in government or opposition, to give the Standing Committee on Legislation as much latitude as possible.

I attended consultations undertaken by the ministerial expert panel in the Kimberley, Pilbara and Gascoyne, and note that Aboriginal people attended. They did not attend all those consultation sessions, but certainly they were at some of them.

I also believe that the approach to the Voluntary Assisted Dying Bill and the way it has come to this house has been like no other piece of legislation. The Joint Select Committee on End of Life Choices considered the policy intent of voluntary assisted dying and presented its findings to Parliament and the government. The government’s response to the committee’s report was for the ministerial expert panel to consult widely with Western Australians in a way that I have not seen done, certainly in my time as a member of this house, with any other piece of legislation. The ministerial expert panel then reported to government, and members have had access along the way to the findings of both the joint select committee and the ministerial expert panel. Opportunities have been given not only to Aboriginal people, but also members of the public in Western Australia. I am not sure that referring the bill to the Standing Committee on Legislation, under part (3)(a), will encourage any more Aboriginal people than have already done so to engage with government. I agree with Hon Robin Chapple in that, like any other cultural group, there will be variations of what Aboriginal people think is acceptable and what is not. That is eminently the way of human nature, and people have differing opinions. I am not sure how referring this bill to the legislation committee will help the house deliberate on this bill.

I do not believe that referring the Voluntary Assisted Dying Bill to a committee can stop the investigation of palliative care for Aboriginal people who reside in this state. That should be done on an ongoing basis anyway. Is that a reason to refer this whole bill to the legislation committee? I do not think so. We still have the implementation period to go, should the bill pass this house. Those things that have been outlined, particularly by Hon Nick Goiran, as issues raised by the ministerial expert panel, the joint select committee and us as members when we got feedback from people in our electorates, are absolutely valuable and viable issues that should be considered by the
Committee of the Whole House and by the government during the implementation period. We are yet to see that. It is not as though I think they should not be addressed; I do think that the issues that have been raised should be addressed, and the government has set out a plan on how it will do that.

I do not know how the committee will be able to undertake to report on whether the bill provides culturally appropriate end-of-life choices when there are differing versions of cultural appropriateness when managing end-of-life options for Aboriginal people in particular, as the motion refers to, but also for people from other cultural backgrounds. That, again, should be considered in the implementation period, and also, should the bill pass the house, in the management of cultural awareness when health professionals are delivering access to voluntary assisted dying. Those issues will need to be addressed by its navigators, whether they are care providers, GPs or specialists. All health professionals should be culturally aware in the delivery of end-of-life choices.

There has been a lot of reference to Senator Patrick Dodson and his comments published in The Weekend Australian of 5–6 October. I highly respect Senator Patrick Dodson, but he is only one person who represents a view—I say that with the greatest of respect to him—and he has had the opportunity to put that view. I would like him to have put that view to the select committee or the ministerial expert panel because he had the opportunity to do so.

I just want to quote some of his comments in that article that refer to cultural awareness and the viability of cultural appropriateness, in his view. He said—

First Nations have always been about survival and balance. Death is about returning your body to the place in the land your spirit to the sky. Your … essence) —

Or your soul —

may return as part of a newborn member of your people. So, life and death are interwoven with country, community and creation. It is simply not just about the individual leaving this world. It is about being intrinsically interwoven with the dynamic of nature and the powers that sustain it.

There has already been some commentary by members about First Nation people’s collectivist approach to life, which all members of the house respect highly. I have no doubt that Aboriginal people will consider cultural appropriateness when making a decision to access voluntary assisted dying should the bill pass the house. Those are considerations for individual people—I come back to the fact that this is a voluntary process—and I do not believe that this house could ever provide culturally appropriate delivery of end-of-life care services or palliative care services that address fully all issues of Aboriginal people, and also other cultural issues. Therefore, I cannot support the motion.

I thank the member for the discussion. It is entirely appropriate, relevant and sensitive, so I have tried to give it due respect. But I believe that a consultation period has been offered and Aboriginal people were at the consultations of the ministerial expert panel that I was at. I believe that the implementation phase was a way to address some of those issues. I thank members, but I will not be supporting the motion.

Sitting suspended from 6.01 to 7.30 pm

HON TJORN SIBMA (North Metropolitan) [7.30 pm]: Before the suspension, I did not have the opportunity to make a very brief contribution to the motion moved by Hon Rick Mazzza. I do not feel restricted by the time constraints that I may have laboured under previously, but nevertheless I will keep my remarks brief.

At the outset, I do not support this discharge and referral motion. I say that while acknowledging the great respect that I have for Hon Rick Mazzza. Certainly he is a person of integrity, and I believe that the motivation for this motion is absolutely well placed. However, for three very short and sharp reasons that I will outline, I disagree with it and I question the wisdom of it. First of all, in my previous speech, a lot of my position was arrived at by an assessment of the public will. That is an imperfect measure but, nevertheless, I think it is very clearly the public will across all of Western Australia that this bill be passed and that it be subject to appropriate scrutiny here, but that that scrutiny not unduly delay the passage of the bill. Irrespective of the time period that may be set for this committee to report—I reflect on the attempt to amend this motion by Hon Aaron Stonehouse, who made a sensible contribution to this amendment—I believe that any delay to this legislation is, frankly, unwarranted. I believe that the issues that are canvassed in the motion can be appropriately dealt with during Committee of the Whole.

To do it some credit, the government has engaged in an extensive consultation process. I am not necessarily convinced of the merits of opening this up further. I think the prospects through which that inquiry might deliver a product or review are highly questionable. I just reflect on part 3(b) of the motion, which deals with the notion of palliative care for Indigenous persons residing in regional and remote communities in the state. I make the observation that, as I have said in this place before, a key consideration for me in arriving at my position to support this bill was an agreement with the Minister for Health that in the next health budget, a clear line of sight will be provided about palliative care funding, as an individual service line. I do not consider that further investigation of the provision of palliative care in the regions will contribute much more to the exercise than the government has already provided. Frankly, I did that for a reason—to bind future governments to honesty and to appropriate service
provision of much-needed clinical care at the end of life to all Western Australians from the next budget onwards. I did that for a very important reason. It was a key consideration of arriving at that position. With the greatest of respect, I do not see part 3(b) of the motion contributing much more than that.

Other speakers, including Hon Robin Chapple, reflected on the very homogenous view that we have taken of Aboriginal and Indigenous people in this state. I am by no means a sophisticated appreciator of the Indigenous legacy in this land. That is to my shame. But I know as much not to put all Aboriginal people into one group. I think that is a great injustice. I think that is unsophisticated and naive and it undermines another reason I have chosen to support this bill, which is the upholding of the notion of individual agency and autonomy. I do not agree with grouping people into ethnic blocks. It is fundamentally why I have a problem with the general way in which we transact multicultural policy across Australia and in this state as well. I say that as the grandson of two different migrant streams and the father of a son who is half Lebanese.

That is where I will leave it. I agree with the intent of the motion—I think it is well placed—but I do not support the effect. I will not be supporting the amendment moved by Hon Rick Mazza.

HON KYLE McGINN (Mining and Pastoral) [7.36 pm]: I rise to briefly put on the record my comments on the motion moved by Hon Rick Mazza. I will reflect pretty quickly on the speakers who have already spoken to this motion. Hon Jacqui Boydell, who is obviously in the same electorate as me, very clearly touched on the fact that there had been plenty of consultation and the Ministerial Expert Panel on Voluntary Assisted Dying travelled throughout the Mining and Pastoral electorate. There has been so much discussion about the inquiry from every parliamentary office across our electorate. I have put out surveys and have received plenty of feedback.

During my speech on the second reading, I spoke about an Indigenous navigator. I am waiting to hear a response from the government when it replies to the second reading. I acknowledge that we need to tread very carefully in this space and make sure that there is an understanding. When a minority group has a history of disadvantage within the health system, the last thing I want to do is be part of a bill that creates a bigger issue. I also think we have a really good capability within the regions, with plenty of Aboriginal organisations that work closely on the ground within communities. Bega Garnbirringu Health Service in Kalgoorlie is a prime example. The work it does in the Indigenous space is second to none. It has a really good understanding. I am hoping to hear from the government. If I do not get a response in the reply to the second reading, I will be pressing further during the committee stage to ensure that when the implementation is carried out, all the Indigenous groups are brought in, not the select groups, with some missing out. As Hon Robin Chapple said, there are heaps of different groups and some talk to each other and some do not. That needs to be considered at the implementation stage. I believe that it will be. I think the government is taking a very responsible approach to it. The main thing is that when someone is in need of a navigator, it should be culturally appropriate and not, say, a Noongar from Perth dealing with Martu out in Kalgoorlie. They are some of the key things that I am hoping the government will commit to. I do not think that taking the legislation to a committee to look at again will be much clearer than what will occur at the implementation stage when the resources are on the ground.

Listening to a lot of the speeches throughout this debate, I have come to realise that regardless of how great palliative care is and whether people receive the best palliative care ever, it will not help some people with pain et cetera. Looking into palliative care specifically, I think we will find the same things that we already know about palliative care. As other members in this chamber have already said, there will continue to be a focus on palliative care moving forward if this bill passes. I think it will be under the microscope a lot more than it has been and I think that is a great thing for palliative care, particularly in the regions. I cannot support the motion. I will leave it there.

HON PETER COLLIER (North Metropolitan — Leader of the Opposition) [7.39 pm]: I rise as a humble member for the North Metropolitan Region to make a few comments on this motion. Members of the Liberal Party, as with the bill itself, have a conscience vote on this motion, so I am not aware of how my colleagues will vote on it. I feel duty bound to say that because of what I, quite frankly, regard as the intemperate and at times insulting comments of the Premier about this bill. His comments about intimidation and bullying that is apparently going on on this side of the chamber are completely unfounded. From my perspective, I personally feel insulted. That will mean nothing to the Premier, but it means a lot to me. I am making these comments as an individual.

The construct of this bill has been given thorough assessment over a number of years. It has been made quite evident through the reports that have been provided that there is an extraordinary number of disparate views on the issue we are dealing with from members of the legal profession, the medical profession, the Aboriginal community, and the community in general. There are a large number of disparate views, and never the twain shall meet. I am not sure that referral to the Standing Committee on Legislation will resolve those issues. In fact, I know that it will not; it simply will not. Having said that, I applaud Hon Rick Mazza for having the courage and conviction to move this motion because, again, comments made in the other place have been insulting to almost every one of us in this chamber—saying that we should somehow just rubberstamp this legislation. No amendments whatsoever were countenanced in the other place, which is extraordinary for a bill of this magnitude. It will change the fabric of a tenet of our society, but somehow we should not assess this piece of legislation thoroughly and meticulously. I take on board the motives of the mover of the motion. The bill is imperfect in a number of ways and is made

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more defective by the notion that no amendments were countenanced in the other place. That disappoints me. Most pieces of legislation that come to this place are amended in some shape or form. We do that because we improve the calibre of the legislation. It goes back to the other place and in two minutes—bang!—the amendments are accepted. As I said, this piece of legislation, which will shift a fundamental tenet of our society, deserves due scrutiny, and I think we must give it due scrutiny.

Having said that, one area brought up by the motion is to do with Aboriginal people. Members who listened to my contribution to the second reading debate will know that I brought this up. As a former Minister for Aboriginal Affairs, I am very conscious of the extraordinary disparity that exists between the quality of health care that is provided for Aboriginal people—particularly in the north of this state—and non-Aboriginal people. That in itself is problematic. If general health facilities are lacking for Aboriginal people, members can imagine the deficiencies that must exist in palliative care. As a former Minister for Aboriginal Affairs, that pains me. We went through an entire process with the regional services reform. I personally went up to the Kimberley and right throughout the state on a number of occasions to access the views of Aboriginal people, which are as disparate as any cultural diversity that exists in our community. Ideally, as a result of changes that will be made as a direct result of commitments that have been made as a result of this bill, things may just improve. Coupled with the regional services reform, I like to think that in five, 10 or 20 years it will not matter and we will not talk about the quality of life of Aboriginal people and non-Aboriginal people because we will be in the trenches together and the quality of life for all Western Australians will be the same.

Having said that, I think that the bill has been given a significant amount of consideration in its construct. I have made my position clear that I will not be supporting the second reading, but I think that the most effective manner in which we can scrutinise the bill from this point forward is through the Committee of the Whole House stage as opposed to referring it to a committee. For those reasons, I will be doing my fair share of scrutiny of the bill during the committee stage, but I do not think we need to refer the bill to the Standing Committee on Legislation. I do not think we should delay the second reading or the scrutiny of the bill any further. For that reason, I will not be supporting the referral.

HON COLIN TINCKNELL (South West) [7.45 pm]: During my second reading contribution I gave my reasons for my position on this issue. I will be supporting this motion and the referral to the Standing Committee on Legislation. I talked about the concerns I have about this bill and the gaps in it. This is one of those gaps. I would like to see further consultation with Aboriginal groups. I have listened to members’ contributions; they have been very valuable and pointed out very pertinent and important matters. That is the value of debate in this house, which will continue with this bill. I would like to see further evidence of consultation with Aboriginal people on this bill. I do not believe there has been enough. I have said before that I would like to see greater palliative care in Aboriginal communities. I know that it is virtually non-existent.

We talk about cultural appropriateness. Hon Aaron Stonehouse brought up an amendment to the motion and I could see what he was about. It was a worthwhile discussion. We often say that we listened to this group or that group. When it is convenient for us, we group them all together, but when it is not convenient for us, we separate them and say that it is too hard because there are too many groups and too many diverging views. That is true in the case of Aboriginal people. I understand that, but that is the business that we have been charged with in this house—to look at this bill and, if it is to go through and be approved, to make it as safe and —

Hon Colin Holt: Effective?

Hon COLIN TINCKNELL: Effective is one word, but I am thinking about vulnerable groups, and Aboriginal people are certainly one of those groups who will be in a vulnerable position if this bill goes through. If we do not consult with them well enough, their understanding of this bill and the ramifications of voluntary assisted dying will be less than it should be. I will be supporting the referral to the Standing Committee on Legislation.

HON MARTIN ALDRIDGE (Agricultural) [7.48 pm]: I rise as a member who supports the second reading of this bill to indicate that I will be supporting the motion moved by Hon Rick Mazza to refer this bill to the Standing Committee on Legislation. I do so with a long-held view that as we approach the consideration of this bill, which has been anticipated for many months, if not years, I would find it very difficult to find a reason to be compelled to vote against closer scrutiny and examination of a bill of this nature in the context of the many other bills that we have referred to the legislation committee. I do not have the confidence that other members have professed so far during the debate that this bill is as close to perfect as perfect can be. I think there would be no harm in referring this bill to the legislation committee, which has proven itself to be a body of members that has, time and again, if not on every occasion during this Parliament, suggested amendments that improve the substance of the bills that the House has referred to it. I am certainly not convinced that this bill has been through a process of consultation like no other and therefore has no faults. My concern is that addressing those faults on the floor of the Committee of the Whole House will, in itself, flaws and faults. Members need only look back at some of the bills that we have considered in the last two years and the way in which amendments were rushed together on bits of paper. I think that has resulted in some less-than-ideal outcomes when we reflect on those decisions in the cold, hard light of day. I suspect—to some extent, we have seen already—that significant amendments to this bill will be brought forward

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by a number of members. I strongly believe that the best way to sort some of those areas on which we may have different views is to have a committee of this place examine those issues more fully and make recommendations to the house, where it can, for improvement.

Regarding part (2) of the motion, my initial view was that my motivation was to have the bill subjected to a technical examination to make sure that it will do what the government intends it to do, and where it is deficient, to make recommendations for improvement. I was initially inclined to support the amendment moved by Hon Aaron Stonehouse to this motion, but I think that there were some good arguments to keep the original wording in place. When we were dealing with the Human Reproductive Technology and Surrogacy Legislation Amendment Bill, I argued that we did not want to restrict the legislation committee if it found a matter of substance that it wished to report upon. We need to keep in mind that part (1) of this motion confines the reporting date to 11 February 2020. Obviously, the committee’s overriding constraint will be that reporting time frame, to allow the Legislative Council to then consider the bill post-report. In some respects, that may well assist, if not expedite, the Committee of the Whole’s consideration of this bill by us being able to rely upon the work of the legislation committee in navigating some of the very complex issues.

I, for one, have been a member who has tried to attend all the forums that have been held in Parliament House by the subject-matter experts who have presented on this bill, including today, when we heard from two neurologists about their experience with motor neurone disease. It was quite a compelling presentation by those two individuals. I thought that they had probably articulated a way forward in dealing with the issue of having specialist expertise without unnecessarily restricting the operation of, or access to, voluntary assisted dying in Western Australia. Perhaps some of that middle ground can be better navigated in the environment of a legislation committee examination versus on the run in the Committee of the Whole stage, when we seem to have a time constraint put on members to have this matter settled by Christmas.

On the policy of the bill, I take Hon Simon O’Brien’s point that we have not yet had a second reading vote; therefore, the policy of the bill is not yet formally settled. But I think all members can count. This bill has had very significant input by nearly all members of this house, and I suspect that by the time we get to a second reading vote, there will have been input by all members. Most members have been very explicit about the way in which they are going to vote. Those people who have been having that follow-up that progress will know that a clear majority of members intend to support the second reading vote of this bill—some 22 to 23 members, on my count.

I find it difficult that for others who have obviously had the value of the Joint Select Committee on End of Life Choices inquiry, which I understand took some 12 months, the Ministerial Expert Panel on Voluntary Assisted Dying process and cabinet consideration, this journey has taken some two and half years, but we, as a house of review, are now expected to consider and settle this matter in six sitting weeks. Some comparisons should be drawn between the expectations of others about the way in which this house should expedite this bill in a very quick fashion, and the view that the primary motivation of any move, such as this motion, to provide some further examination or scrutiny is one of unnecessary delay. I refute that. That is certainly not my motivation in supporting the motion moved by Hon Rick Mazza.

I am not confident that when we get to the Committee of the Whole stage, we are going to able to examine the issues that will confront us all as we proceed through the course of this bill in the same way that the legislation committee would be able to examine them. The legislation committee has much broader scope to deal with these issues—it can consult with others, summons documents, hear from witnesses and correspond with the commonwealth government and other key stakeholders on a range of matters. Obviously, we cannot do that in the confines of the Committee of the Whole process, which is now likely to be fewer than five weeks in length.

We also do not have the opportunity of having the minister responsible for this bill in this house. Although I have enormous respect for Minister Dawson, he has not had the carriage of this issue from the beginning and he will be limited in the way in which he can respond to some of the answers in Committee of the Whole. It is no criticism, but we have seen those limitations on ministers in this place who represent ministers in the other place—sometimes undertakings are made and sometimes undertakings are not kept. We have that inability to perhaps go as deep as the other place with respect to having ministers at the table who have had direct responsibility for this bill.

I do not want to delay this matter any further, but I want to finish with two points. One is that members will be aware that I have been pursuing the issue of the intersection of the federal Criminal Code and the Voluntary Assisted Dying Bill 2019 since early September. For those members who think that I am being pedantic on this issue, I am not: it has very serious consequences for the way in which the government implements the regime in Western Australia. Indeed, potentially there could be limitations placed on its implementation in Western Australia. As far as I can tell, this matter was raised with the state only as late as 21 August 2019. I am not quite sure when the bill was introduced into the Legislative Assembly but I suspect it might have been around or before that time, so I am pretty certain that these matters were not fully contemplated when this bill was drafted by parliamentary counsel, with the support of the ministerial expert panel and the approval of cabinet. That is one aspect that I think remains outstanding. On four occasions, I have requested that the government provide its legal advice or a summary of its advice or, indeed, even the correspondence between the state and the commonwealth. I recognise that the Leader of the House is
assistant me and we have had conversations behind the Chair as late as today on this matter, and that has been helpful. But the answer I received in question time today was that the Minister for Health regrets that he is unable to provide to the Parliament the information that I seek. I am not sure whether that situation is going to improve when we get to the Committee of the Whole stage. Certainly in my mind, that is a very significant issue that will affect my constituents and, indeed, constituents of all members who represent regional or remote Western Australia in terms of being able to reasonably access this legislation.

There is another matter that I want to reflect on. Although I have not seen this and I may be mistaken, standing order 128 is the section of our standing orders on referral to a committee. As I read it, that standing order anticipates that a referral to a committee may occur at any stage once the second reading is moved and prior to the third reading being moved.

Obviously, if Hon Rick Mazza’s motion does not succeed this evening and if members are not satisfied with the way in which the government engages during the Committee of the Whole House, when members appear to have some confidence in the government’s ability to undertake the scrutiny on the floor of the house that this bill requires, it appears to me that under standing order 128, the house would have further opportunity, if matters remain unresolved, to consider a further referral of the bill at a later stage in the consideration of this potential law. With those few remarks, I outline why I support this motion to refer this bill to a committee. My comments have referred largely to parts (1) and (2) of the motion. I listened carefully to the debate on part (3). I must say that my experience and engagement with the Aboriginal community in my electorate does not necessarily reflect the views that members have put. But I respect those views and I am certainly not in a position to provide a view on whether that consultation process has been thorough enough or whether further accommodations need to be made to sections of the community, such as those outlined in part (3) of the motion. Thank you.

**The PRESIDENT:** Visitors in the gallery, I ask that you resume your seats, thank you.

**Division**

Question put and a division taken with the following result —

**Ayes (6)**

Hon Martin Aldridge
Hon Nick Goiran

**Noes (29)**

Hon Ken Baston
Hon Jacqui Boydell
Hon Robin Chapple
Hon Jim Chown
Hon Tim Clifford
Hon Alanna Clohessy
Hon Peter Collier
Hon Stephen Dawson

Hon Colin de Grussa
Hon Diane Evers
Hon Donna Faragher
Hon Adele Farina
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTieman

Hon Charles Smith
Hon Aaron Stonehouse
Hon Colin Tincknell
Hon Rick Mazza (Teller)

Hon Colin de Grussa
Hon Diane Evers
Hon Donna Faragher
Hon Adele Farina
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTieman

Hon Kyle McGinn
Hon Michael Mischn
Hon Simon O’Brien
Hon Martin Peichard
Hon Samantha Rowe
Hon Robin Scott
Hon Tjorn Sibma

Hon Colin Tincknell
Hon Rick Mazza (Teller)

Hon Dr Sally Talbot
Hon Dr Steve Thomas
Hon Darren West
Hon Alison Xamon

Hon Dr Sally Talbot
Hon Dr Steve Thomas
Hon Darren West
Hon Alison Xamon

Hon Pierre Yang (Teller)

Question thus negatived.

**Second Reading Resumed**

**HON ADELE FARINA (South West) [8.05 pm]:** The Voluntary Assisted Dying Bill 2019 has generated a great deal of community debate, as it should. Wherever I travel throughout the south west, people want to stop me to tell me their views and urge me to support their particular position on the bill. The bill raises a number of really complex issues and understandably has polarised the community. If the bill passes, it will present a significant shift in our society. It will provide a lawful option for some at the end of their life to terminate their life earlier than would otherwise be the case. Every member in this chamber bears a heavy responsibility in our consideration of the bill. I have lost much sleep over this bill and how I should vote. I have no doubt after listening to other members’ contributions that every member in this place is motivated by good intention in reaching a position on the bill, regardless of whether they support or oppose the bill. The fact that members have reached different positions is not a reflection on whether they are doing the right thing, but rather a reflection of the complex issues addressed by the bill and the different personal experiences members bring to this place. It also reflects an understanding that this bill delivers a significant shift to the current situation; once this door is opened, it is very unlikely to be closed again.

I have really struggled to form a position on the bill. For a person who is usually pretty decisive, this is new and not a very pleasant experience. I have oscillated between support for and opposition to the bill, and I continue to struggle in making a decision. People have suggested that the question is very simple: do I want choice in determining how I die? My answer to that question is: yes, I would like to die peacefully in my sleep. I think most people want to die peacefully in their sleep; however, few of us will. Perhaps due to the wide reporting that I am undecided, I have been inundated with people wanting to meet with me on this issue. To the best of my knowledge, I have met with...
everyone who has contacted my office asking to meet with me over the past year or so, perhaps with the exception of any requests that have come in over the last few days while Parliament has been sitting. Like other members, I have received thousands of letters, emails and phone calls to my office. The majority of representations I received in my office have been in opposition to the bill. In recent weeks, the gap has closed somewhat, with 55 per cent opposing and 45 per cent supporting the bill. I want to thank everyone who took the time to share their views with me on this important bill, both those in support of and those opposed to the bill. Many people shared very personal stories of the harrowing death of a loved one. For many, that experience was still very raw and it was very emotional for them to tell their story. I most sincerely thank all those who shared their personal stories with me. I appreciate how difficult it was for many of you and your stories moved me, often to tears.

I would also like to thank the many doctors, both those supporting and those opposing the bill, who took the time out of their busy schedules to inform me of their views, answer my many questions, and give me the benefit of their medical and lived experiences. In the main, I found people to be genuinely motivated in the position they held and moderate in putting their views to me. Of the people I spoke with who asked me to support the bill and had experienced the suffering of a loved one at the end of their life, most had not discussed voluntary assisted dying with their loved one and did not know whether their loved one would have accessed voluntary assisted dying if it had been available. Despite the view expressed by many that there has been extensive consultation on the bill, I have been surprised by how many people supporting voluntary assisted dying do not know the details of the voluntary assisted dying scheme proposed by the bill. Some thought the bill provided choice to every person nearing the end of their life to choose how and when they would die, regardless of whether they had a terminal illness, with some saying to me, “I want the right to choose when and how I die”, or, “When I can’t do things for myself anymore, I want to choose to die with dignity.” In some cases I found myself having to explain that voluntary assisted dying, as proposed by the bill, would not have alleviated the suffering of their loved one at the end of their life as their loved one did not have a terminal illness and therefore would not have been eligible to access voluntary assisted dying. When I ask people in support of the bill about their views on various aspects of the bill of concern to me, many said that they were not across the detail of the bill and that it was Parliament’s job to consider the details and make the necessary amendments to improve the bill.

I have been surprised at how quickly those in support of the bill have been to characterise those opposed to the bill as religious zealots, and dismiss their views. This is neither helpful nor respectful. Although some of the people I spoke with who opposed the bill did so from a strong religious base, not all who oppose the bill do so on the basis of their religious views. Many expressed genuine concerns, and these included the risk to the vulnerable in our community; that no safeguards can be rigorous enough to ensure that not one wrongful death would result; that they sought an inevitable subtle pressure on those at the end of their life to use voluntary assisted dying and not be a burden on their family; that faced with an inability to access appropriate end-of-life health care, people would view voluntary assisted dying as their only option; concern about the lack of rigour in the assessment of decision-making capacity and the assessment of the loss of decision-making capacity; and, that legalising for the termination of life crossed a threshold that should not be crossed. Although not everyone may agree with these concerns, it does not and should not diminish these concerns genuinely held by people opposing voluntary assisted dying. I concur with Hon Donna Faragher’s view that people should not presume that members who vote against the bill lack compassion, do not care about or understand what it is like to see a loved one suffer a prolonged and difficult death at the end of their life.

My dear dad had many health issues, including prostate cancer, lung cancer and early stages of asbestosis, among a long list of other health problems. He experienced a prolonged end of life and suffered a lot of pain. The medications for his pain really knocked dad about, causing hallucinations, depression and, at times, aggression, and they were not always effective in managing his pain. As the lung cancer progressed and his breathing became more laboured, dad required oxygen. Dad was unconscious for three and a half weeks, slowly dying of dehydration, starvation and organ failure. I was by his bedside throughout, and my family and I experienced great anguish seeing dad suffer and struggle to breathe. I understand why proponents of voluntary assisted dying use the phrase “dying with dignity” to promote their cause; however, I have difficulty with what this statement implies. It implies that my dad and those who died a difficult and painful death did not die with dignity. I challenge this. I think my father died with dignity and great bravery. With his final breath he went gently. Dad died at home, as he wanted, with the love and support of his family. Although watching dad suffer a prolonged death caused me and my family great anguish, I was more than willing to care for him and spend this time with him and I would do it all again.

Andrew Denton of Go Gentle Australia, in advocating for voluntary assisted dying, put to me that not everyone’s pain can be palliated, and that even though it is a small number of people whose pain cannot be palliated, surely I would not want them to suffer agonising pain at the end of their life and surely I would support voluntary assisted dying if that was the only way to alleviate the suffering. It is very difficult not to be moved by this argument. It is important to note, however, that the bill does not mention pain or pain that cannot be palliated. If this were a criteria in the bill, I may be more comfortable supporting the bill. The relevant eligibility criteria in the bill refers to the person having a terminal illness that is causing suffering to the person, that cannot be relieved in a manner that the person considers tolerable. The bill provides no definition for the words “suffering” and “tolerable”, and the truth
is that under the bill, a person with a terminal illness that is likely to cause death within six months and whose pain is being well managed but says they are suffering and that their suffering is intolerable could access voluntary assisted dying. The cause of the suffering could be a loss of will to live; no longer being able to participate in the things in life that gave that person enjoyment; not wanting to be a burden on their family; fear of future pain and loss of control or dignity; or an untreated mental illness or depression. This widens the group of people who may be eligible to access voluntary assisted dying to many more than the small but important number whose pain cannot be palliated. The fact is that aged people at the end of their life who do not have a terminal illness may experience that same range of suffering. They could experience suffering due to the loss of a will to live; no longer being able to do the things that gave that person enjoyment; not wanting to be a burden on family; fear of future pain or loss of control or dignity; or an untreated mental illness or depression. This begs the question of why greater weight, and therefore access to voluntary assisted dying, should be given to the suffering of a person with a terminal illness that is not related to the pain that cannot be palliated as opposed to similar suffering of an aged person without a terminal illness. This question has been put to me, and it is difficult to answer. Both are at the end of life, although in the latter case the time of death is unknown and may be longer than six months. It is this desensitising of voluntary assisted dying in order to make it more palatable that causes my unease with the bill.

The use of the term “loss of dignity” is understood to be a loss of toileting control or requiring assistance with toileting. Are we really saying that a person with a terminal illness and expected to die within six months who is experiencing intolerable suffering due to a loss of dignity should be able to terminate their life? Hon Alison Xamon expressed her concern about the language used by proponents of voluntary assisted dying and how use of the term “loss of dignity” in this way may be offensive or cause fear to people with disability who need assistance with toileting. I concur with those views and it is awful that this debate has caused people with disability these concerns. My position until about midday today was that I would feel more comfortable with the bill if it referred to pain that cannot be palliated rather than suffering. Then I attended a briefing on motor neurone disease and voluntary assisted dying organised by Hon Colin de Grussa, with two specialists in this field. The specialist explained the sorts of suffering experienced by people with motor neurone disease, and it was brought home to me that restricting the definition of suffering to pain would be too restrictive. However, surely we do not intend that a person who is suffering due to a loss of toilet control or depression should be able to access voluntary assisted dying. We need to be clear about what we intend the bill to do and who we intend should have access to voluntary assisted dying and be certain that the wording of the bill does not extend that group of people who can access voluntary assisted dying beyond this point.

Also, we need to ensure that the bill safeguards the vulnerable in our community, including people with disability, the elderly and people with mental illness.

Much has been said about palliative care in this debate, and rightly so. The joint select committee acknowledged the lack of adequate funding and resourcing of palliative care in our state, and it is shocking that in a state like WA many people at the end of life who would benefit from palliative care simply cannot access it. The recent announcements of additional investment in palliative care are welcomed. However, the truth is that palliative care in our state needs a massive investment of funding to bring it to the level that it needs to be at and to increase the number of palliative medical specialists from 15 to 50, which is the appropriate level for the state’s population. As a regional member, it deeply concerns me that palliative care services in regional WA are seriously lacking. Generally, people can access a palliative care bed in Bunbury or Busselton only if they are in their last days, being the last week or so of life. This is far too late. Due to insufficient beds, many cannot access palliative care even in their last days. However, I acknowledge that those who can access the beds get excellent care.

Despite most people expressing the wish to die in their own home, 24/7 palliative care is not available in regional WA. In the greater Bunbury area when home palliative care was provided by St John Ambulance, it did provide 24/7 home palliative care. However, under the previous government, the WA Country Health Service took the palliative care contract away from St John of God and decided it would deliver the services itself, and as a result 24/7 home palliative care ceased. It now operates only during business hours. This is less than satisfactory for families who are caring for a loved one with a terminal illness and suffering pain. If there is an incident after hours, they need to take their dying loved one to emergency, and only those who have cared for a dying person understand how difficult this can be and the distress it causes the patient. More palliative care beds are needed in regional WA and we need a plan to roll out home palliative care throughout regional WA. Although I do not necessarily agree with the argument that the focus should be on palliative care and that only when this has been delivered at the appropriate level should we look at voluntary assisted dying, it is disappointing and not at all reassuring that it has taken a debate on voluntary assisted dying for additional investment in palliative care. Other members have referred to the palliative care recommendations of the joint select committee and questioned the implementation status of those recommendations. I endorse these comments and ask the minister in his reply to inform the house of the implementation of those recommendations. I also endorse efforts to ensure separate transparent reporting on palliative care in future budgets.

Before I can support the bill, I need to be satisfied that people living in regional WA will have access to voluntary assisted dying equal to that of people living in Perth. I want to hear from the minister how he will ensure that this is the case. People living in regional WA at the end of life and with a terminal illness should not have to travel to
Perth to access the voluntary assisted dying system. Other members have raised concerns about the provisions of the commonwealth Criminal Code Act that make it an offence to use a carriage service for suicide-related material. The bill provides at clause 156 for audiovisual communication to be used by doctors in discussing details of voluntary assisted dying with patients. The same provision states that the provision does not authorise the use of a method of communication “if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth”, thus leaving doctors and their patients at risk of breaching commonwealth law. Hon Martin Aldridge has been working hard to get clarity on this issue, with little success. Hopefully, clarity on that issue will be forthcoming in the minister’s response to the second reading debate. The minister needs to clarify the legal situation and explain how it intends to ensure that people living in regional WA will be able to access voluntary assisted dying without having to travel to Perth to do so.

Some members have talked about the terrible reality that around 10 per cent of suicides in WA are people with a terminal illness choosing to end their life early while they are physically capable of doing so, and that those who cannot complete the attempt are sometimes left with disabilities. I am sure that all members find this deeply concerning. However, I caution members against suggesting that these suicides could be reduced or eliminated only if voluntary assisted dying is available. There could be a number of reasons why people with a terminal illness suicide at the end of life. Perhaps they were depressed, overwhelmed about how they could cope when things got worse, knowing that appropriate palliative care was not available where they lived and if they had been able to get timely and appropriate treatment and palliative care, they would not have suicided and would not choose to access VAD. VAD should not be advanced as the only answer to reducing or eliminating these suicides. In a state like WA, we should be able to do better. We should be able to provide people at the end of life with the health care and supports that they need, regardless of where they live, so that they are able to enjoy quality of life in their remaining time. We should not leave them to feel that they have no choice but to accede to an early death.

The bill provides that a person must make at least two verbal requests and one written request to access voluntary assisted dying as well as obtain two independent medical assessments, and that this should not occur in a period of less than nine days. It is argued that these requirements establish that the person’s request to access voluntary assisted dying is enduring. I really struggle to see how this can be viewed as enduring. People are provided with a 30-day cooling-off period for certain financial agreements and it concerns me that we are setting the minimum period for going through the voluntary assisted dying process to such a short period as nine days. Like Hon Nick Goiran, I am of the view that assessing decision-making capacity is not as straightforward as proponents of the bill would have us believe or think. There is a real risk that the person could be led in answering questions, thereby suggesting the decision-making capacity when one does not exist. Equally, it is not that straightforward to assess whether a person truly understands what is being put to them. Vulnerable people could be led to access voluntary assisted dying not fully understanding what they are doing and this concerns me.

A couple of years before dad was diagnosed with lung cancer, which resulted in his death, he was suffering after yet another period of prolonged urinary tract infection due to his aggressive prostate cancer treatment. Dad was admitted into hospital and the doctors wanted to perform a procedure that, in their view, would reduce the risk of further urinary tract infections. Dad made it very clear to me that he did not want the procedure. While dad was in hospital, his treating doctor told me that he intended to talk to dad to persuade dad to have the procedure. I explained that dad did not want the procedure. I also explained that English was not dad’s first language. Dad was blind in one eye and did not have his reading glasses with him in hospital, so he could not read any information sheet that may have been provided to him. Dad was also hard of hearing and, like every typical Italian male, refused to wear his hearing aids; he usually agreed with everything people said to him because he did not want to admit that he could not understand what they were saying or could not hear them, and also he liked to please people.

I was concerned that dad would not necessarily understand what the doctor said to him and he would simply agree with the doctor in an effort to please the doctor. It was a Thursday night and I was leaving the hospital to travel down south for meetings in my electorate the next day. I asked the doctor to assure me that he would wait until Monday, when I was back in Perth, to discuss the matter with dad, as I wanted to be present when he talked to dad, so I could assess whether dad truly understood what was being said to him. As far as I was concerned, there was an agreement that he would hold off.

I returned at the weekend to find a very angry and distressed dad. Not only had the doctor had the conversation with dad without me, but also he had performed the procedure on dad. As you can imagine, I was shocked and very upset about what had happened, believing that I had put everything in place to ensure that it would not happen while I was not around. Dad assured me that he did not agree to the procedure. When I raised the matter with the doctor, he informed me that he and a colleague, another doctor, had had a lovely chat with dad and explained the procedure to him. Dad had agreed and signed a consent form. As there was an opening in the theatre, they performed the procedure the same day. He showed me the signed consent form, duly witnessed by his colleague. I let him know in no uncertain terms that I was very unhappy and would be taking the matter further, so he arranged for the other doctor to come and talk to me and assure me that dad had indeed signed the consent form. Dad agreed that they did have a lovely chat. However, from dad’s viewpoint, he had not agreed to the procedure but had agreed that he wanted to go home. He said that after this discussion he was given a form to sign and he thought this was

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necessary so that he could go home. Dad could not read the form without his glasses, so he just signed it. He assured me that he had not agreed to the procedure and did not know that he had signed a procedure consent form. I have no reason to disbelieve dad and I know from our discussions that he would not have knowingly signed a procedure consent form because he did not want the procedure.

Although I am prepared to accept that the doctor did what he felt was in dad’s best medical interests, regardless, it was not for the doctor to decide this. It was dad’s decision. Some people would call this a clear case of elder abuse or just simple assault, but it should not have happened, and it should not have happened in a hospital in Western Australia.

When advocates of voluntary assisted dying tell me that doctors will not persuade or influence patients to the view that voluntary assisted dying is their best option, I am sceptical, because I know this may actually happen. I want to ensure that no vulnerable person finds themselves in a similar position to my dad. The doctor–patient relationship is not an equal one. Doctors can and do exercise significant power in this relationship, and this power can be abused, whether intended or not.

Hon Nick Goiran talked about the fact that doctors make mistakes when making a diagnosis and prognosis. Some argue that this is very rare, and it is the case now, so why should it be a concern with voluntary assisted dying? The answer is that a person wrongly diagnosed with a terminal illness and with the wrong prognosis of death within six months could access voluntary assisted dying and take their life long before they would otherwise have died. One hopes that the requirement for two independent medical assessments means that the likelihood of this occurring is minimised, if not averted. However, without knowing the details of the training that medical practitioners are required to undertake before they participate in the voluntary assisted dying process, it is difficult for us to accurately assess how big a problem this might be. The training information is not currently available. We are told that this will be worked out in the next 18 months as part of the implementation phase. However, this means that Parliament is being asked to approve the bill on trust and has no opportunity to determine whether the training will in fact be adequate.

In Victoria, this trust resulted in a six-hour online training course being developed, which focuses on the processes, how to fill out the forms and the time frames for doing so, rather than training for assessing decision-making capacity and other critical skills that a doctor would need for the assessments they would need to make under the legislation. When I raise this concern, I am often asked, “Do you know anyone who has been diagnosed with a terminal illness and received a prognosis of death within six months, and both the diagnosis and the prognosis have been wrong?” The person asking this is usually highly sceptical and thinking that this is a highly unlikely situation. When I say, “Yes, I know of one”, they usually respond with a scoff, saying, “But that's only one person.” Even if it is only one person, and I doubt that is the case, it should not be dismissed.

Just under three years ago, a good friend of mine, Garry, began experiencing health problems, which deteriorated at an alarming rate. Garry is an academic, an author, and he loves to write poetry. He is a thinker and a wonderful person. He began experiencing numbness in his limbs, multiple ministrokes, extremely painful headaches, memory loss, twitches and spasms in his muscles that got worse with time and muscle wasting. It was not long before he could not walk without support and eventually he was confined to bed. Garry had difficulty completing a sentence due to memory loss. He could no longer concentrate to write or read, which frustrated him greatly. He suffered terrible pain and the medication did not seem to alleviate his pain. Garry was diagnosed with a neurodegenerative disease and was told he had seven months to live. At the time of his diagnosis, Garry told me that if voluntary assisted dying were available, he would have accessed it. Almost three years later, Garry is still with us and is feeling much better. Although he is still confined to bed, his memory has improved significantly. He can read and write things, and that gives him great joy. The ministrokes, muscle spasms and extreme headaches are much reduced and his pain is largely managed. About two and a half years after his original diagnosis and prognosis and after a range of tests, Garry was told that the original diagnosis had been wrong, and the cause of his health problems was most likely a virus rather than a neurodegenerative disease.

A few months ago, I visited Garry and his wife, Jeni, to talk to them about the Voluntary Assisted Dying Bill. Garry told me that his views on voluntary assisted dying had changed. He said that had voluntary assisted dying been available when he was first diagnosed, he would have accessed it. Had he done so, he would not have been around to enjoy those three years of life with family and friends. He would have cut short his life journey and he would have hated to miss out on this time with family and friends. Although Garry is still confined to bed, his pain is largely being managed and he can sit up, look out the window, see the sun and the birds and spend time with his beloved dogs, family and friends—all things he would not have been able to do if he had opted for voluntary assisted dying. It is difficult for me to ignore Garry’s story. If voluntary assisted dying had been available, Garry would have ended his life early. I find this deeply disturbing. Balancing Garry’s story with the stories of pain and suffering experienced by people with a terminal illness at the end of life is extremely difficult and I have struggled with this.

We are told that the Voluntary Assisted Dying Bill is tight and that only those people who meet all the eligibility requirements will be able to access it. However, we are also told, based on the experience in other jurisdictions,

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that about 30 per cent of people to whom the lethal substance has been dispensed do not take it. Hon Colin Holt said during his contribution that this should reassure us that voluntary assisted dying works—that simply knowing they can access a lethal substance if they need it has provided people with the comfort they need, and, in the end, it was not necessary for them to take the lethal substance. To me, that rate of 30 per cent is startling. I cannot help but question whether the lethal substance ought to have been dispensed to those 30 per cent of people, and whether they should have been assessed as eligible to access VAD. Were they really experiencing intolerable suffering? Surely, if their suffering was insufferable at the time that they accessed voluntary assisted dying, they would have taken the lethal substance, or at least this rate would have been much lower than 30 per cent. Based on the experience in other jurisdictions, we also know that at least one person took the lethal substance more than two years after it had been dispensed, which illustrates that wrong prognoses do happen.

On the question of whether medical practitioners should raise voluntary assisted dying with patients diagnosed with a terminal illness, I agree that there should be no prohibition on medical practitioners raising the topic of voluntary assisted dying with their patients. However, I do not support the position that medical practitioners, including those who object to voluntary assisted dying, should be required to raise voluntary assisted dying with their patients and to refer their patients to another practitioner. I met with a number of doctors who are really disturbed by this provision in the bill. One doctor in Bunbury told me he could not believe that in a democracy like Australia, members of Parliament would pass a law requiring doctors to do something that they deeply did not agree with. He told me that he would consider ceasing practice if the bill were to pass with this provision in it. If we argue that we need to respect the right of people with terminal illness to make a choice about how they die, I think we should equally respect the rights and views of doctors who object to voluntary assisted dying. The amendment moved by Tony Buti in the other place and foreshadowed to be moved by Hon Martin Pritchard in this place seeks to address this concern and, in my view, is worthy of our thoughtful and favourable consideration.

Another issue in the bill that concerns me is that the bill provides that a medical practitioner must not include any reference to voluntary assisted dying in the certificate of cause of death. I do not think that we should be passing laws that require a person to falsify a state record. If 80 per cent of members of the community support voluntary assisted dying and it is their personal choice, I do not accept that this is necessary. If the purpose of this provision is to ensure that life insurance contracts are not voided, it is my view that other options should be explored to address this matter. We should not ask public officers and medical practitioners to falsify state records.

I also have concerns about aspects of the bill that in my view are underdeveloped. The safe storage of the lethal substance once it has been dispensed to a patient is one of those areas of concern to me. The lack of information provided to members about the safe storage requirements of the lethal substance is more than a little concerning. It is not clear to me how we can be satisfied that the safeguards in the legislation are adequate if we are not provided with information about the safe storage requirements. This should be included in the bill or, if not in the bill, in the regulations. However, I understand that the Premier has said that although the bill contains a regulation-making power, the bill does not require any regulations to be made and that it is sufficient for directions to be made in relation to safe storage of the lethal substance. This means that Parliament will not be able to scrutinise the safe storage requirements and satisfy itself that these are adequate. This does not sit well with me.

In addition, I would like some clarity about the safe storage requirements that will be imposed for people living in a nursing home or an aged-care facility. Will there be a requirement on managers of nursing homes and aged-care facilities to safely store the lethal substance to ensure that other patients who may wander into the person’s room cannot take the lethal substance, or will the person still be able to keep the lethal substance in their her room so that they have easy access to the lethal substance and can administer it at the time of their choosing, as is intended by the bill? Surely these circumstances and the safety of others in that nursing facility warrant safe storage provisions being either incorporated into the bill or set out in regulations.

Further to my concerns about the safe storage of the lethal substance, I am inclined to the view that a medical practitioner should be present when a person administers the lethal substance to ensure that the person does not suffer unecessarily if they manage to ingest only part of the lethal substance. This would avoid concerns about safe storage, as the lethal substance would be held by the medical practitioner, who would bring it with them when it was time to administer the substance.

Not only am I disturbed about the lack of safe storage details in the bill, but also when a person elects to self-administer the lethal substance, there is no requirement for a witness to be present and to verify that the person self-administered the lethal substance and did so voluntarily and to put beyond question the possibility that the lethal substance was administered by another person. I am concerned that as a result of the absence of safeguards in the bill at this point, it may be possible for a family member to administer that lethal substance to the person without the person’s knowledge or consent, and I would be interested to hear the minister’s view on this and the views of other members. If, however, the person elected for a medical practitioner to administer the lethal substance, the bill provides that a witness must be present when the practitioner administers the lethal substance and, before he does so, he needs to make a further assessment and be satisfied that the person has decision-making capacity and is acting voluntarily and that the person’s request for voluntary assisted dying is enduring. This further assessment at the time of administering the lethal substance is not required under the bill if the person elects to self-administer. I wholeheartedly agree with
the safeguards in the bill for when the substance is administered by a medical practitioner, and I view those as necessary and appropriate. I am concerned, however, about the lack of safeguards if the person elects to self-administer. It seems to me that the safeguards in the bill for the end of the process are not sufficient.

I am also concerned about the oversight that is provided under the bill and the adequacy of the oversight that will be provided to the board, which, due to a lack of time, I will discuss in greater detail when we go into the committee stage.

Although I generally support the right of a person with a terminal illness whose death is imminent to choose when and how they die and in the past I have supported voluntary assisted dying bills, I have really struggled on this occasion to support this bill. I am not sure why—whether it is my experience with dad and others, whether it is my friend Garry’s experience and his change of heart on voluntary assisted dying, whether it is that I am now a more experienced legislator and better understand that safeguards are not guarantees or whether it is my genuine concern with certain aspects of the bill. I am not sure, but I have really struggled this time to make a decision to support this bill. I think the bill is being rushed. I think the bill is underdeveloped in a number of critical areas. With a bill of this importance, I do not think it is good enough for the executive to tell us to trust it with critically important detail that it tells us will be developed over the next 18 months. This should have been worked out before the bill was presented and preferably incorporated into the bill to allow proper scrutiny by Parliament.

After much consideration and oscillation, I have decided to support the bill in principle at the second reading stage so that it can be thoroughly scrutinised during the committee stage and improvements to improve the bill considered, as I believe this is what the community expects us to do at this point. I trust that concerns that have been raised will be addressed, and there is capacity to improve the bill by appropriate amendments, although I hold reservations as to whether amendments agreed in this place will be accepted by the other place in light of the comments that have been made in the other place. I think it is a concern that we should all share. Whether I support the bill at the third reading stage will depend on what amendments are accepted by government, the minister’s response to my concerns and those of other members, and ultimately being persuaded that this is a step we should be taking and that the safeguards are adequate.

HON DIANE EVERS (South West) [8.47 pm]: As I understand our current situation, when in unbearable pain and with a very limited expected life span, it is legal for people to starve themselves. In fact, it is legal for a person to take their own life through whatever means available. It seems to be generally accepted that a doctor, at the doctor's own decision, can prescribe pain-relief medication in an amount high enough to end a person’s life. What entitled hypocrisy! How can we possibly say that that is the way to do it? Our social conventions put doctors in a situation in which they not only can make this decision, but also sometimes are expected to take responsibility for it. I just do not see how we can say that that is the way to carry on.

I will not kid myself and think that I will influence anyone in this place with my comments, and there is little reason to expect that I will make any points more clearly than they have already been said, but still I speak to get my voice on the record, to speak for those who have dedicated much of their lives to get this legislation debated and hopefully passed, and to speak the voice of the 80 per cent or more of my electorate who want this legislation passed. I know we have talked a bit about whether that poll is accurate, but I find a poll like that much more accurate than saying, “I had six people write to me who said yes and seven who said no, so that must be okay.”

No-one in here can say that that is an adequate poll. It is interesting that that poll showed that 80 per cent were in favour. In the Legislative Assembly, the vote was 45–11, or 80 per cent for the legislation and 20 per cent against. So very close to that 80 per cent for and 20 per cent against. That is interesting. It would show that we are representative of the state.

It seems to me that the safeguards in the bill for the end of the process are not sufficient. Rather than a conscience vote, as Hon Colin de Grussa suggested, it would be very interesting if all members had a free vote to represent their constituents, with no pressure from their party. If we had a free vote, we could represent the people who want the autonomy and the right to self-determination in choosing the time, location and other circumstances of their death. That is what I thought we came in here for—to represent those people.

I have empathy for the members in these chambers as we are making a decision not for ourselves, but for the entire state. We have religious, political, community, cultural and family affiliations, and all these are guiding our decisions. All of us in this chamber are likely to be able to access the best of care and the best of palliative care, and I guess that our families and most of our friends could access that best of care as well. But I cannot imagine that anyone in here believes that the state will be able to provide the hospital care of Sir Charles Gairdner Hospital and I guess that our families and most of our friends could access that best of care as well. But I cannot imagine that anyone in here believes that the state will be able to provide the hospital care of Sir Charles Gairdner Hospital or Hollywood Private Hospital to people in Port Hedland or Halls Creek. I would certainly be surprised if someone thought that the hospice care that is available in Albany, which has been mentioned many times here and which I wholeheartedly support, could be provided everywhere. I went through a situation at Albany Health Campus with my father-in-law, who nearly passed away, but the people there ensured that he was well enough to fly back to Orange, where he is from, to die peacefully amongst his family. If we all had the strength that he had to survive.
long enough to say goodbye and then go to sleep peacefully, how ideal would that be? That would be nice. I do not expect that the hospice care that is available in Albany could be replicated in Exmouth, Paynes Find, Norseman and possibly even in the city. It would be lovely if it could. To wait until that point, we would be waiting the rest of our lives and then some, and I still do not think it would happen, although I really hope that it does.

This bill is not about euthanasia. The Greek “eu” means “good” or “well”, as in “euphoric”. The Greek “thanatos” means “personification of death”, so it is a good death. We are looking for a good death, but this bill is not about euthanasia. The current usage of euthanasia as a term indicates that it is causing a good death by taking the life, thus implying that a person other than the one dying is taking the life, and that is not what we are looking at; we are looking at people having the autonomy to make their own decision about their own life. Nor is this bill about suicide, as the cause of death has already been acknowledged. The cause of death is from the condition that the person has. The cause of death is not the final step that we are talking about here. How often do we hear that “pneumonia” has been written on the death certificate when the death was not caused by pneumonia; that was just the last thing that caused the person to lose that final breath? So many other things could have led to the point when they were in hospital and contracted a respiratory virus that caused the pneumonia, after 10 years of suffering in other ways.

I do not have a problem with putting the cause of death on the death certificate. I think the cause is that thing that comes along early in the process. I have seen cases like this when the grieving happens long before the person takes their last breath. For many people, the grieving usually begins when the diagnosis is made, when we first realise that our loved one is going to pass in a certain time and we know that that death is imminent. Even though we all live with death being the final point, when we get the disease or the diagnosis that means it will be a little quicker than expected, that is really the tough time.

When death is imminent, the choice of the person is only to end their pain or suffering, to speed up the pace of their ongoing slow death, to maintain their dignity and to go gently in peace. That is what they are trying to do. They know it is coming. Why should they have to fight and suffer longer just because of the way our laws are written or not written?

Peace is significant in many religions. I was raised as a Catholic and I still find it natural to respond to “peace be with you” with “and also with you”; it just flows. Forever and a day, tombstones have always said “rest in peace”. I remember years ago, whenever we were speaking to someone who had recently lost a loved one, it was very usual to ask, “Was it a peaceful death?” because that is what we are hoping for, not just for ourselves, but for everyone. For me, and for many people I know, their wish is to live in peace, to die in peace and to rest in peace. I see the legislation that we are looking at affording that opportunity to many people.

I have been sheltered from death pretty much throughout my life. Maybe this was out of good luck or possibly I just do not dwell on the people I lose. I lost my father when I was only 14. It was quick. He was there and then he was not. I have those lasting memories. I did my grieving quite quickly, and it is ongoing. But he is always with me. Having lost him quickly, I learned very early on to carry him with me, to carry him inside me, and to be able to look up at the stars and feel him looking over me. But it was not a long, drawn-out, painful process. I have probably been to fewer than 10 funerals in my entire life. As I said, I have been sheltered from death. The few funerals that I have been to were for people who died in their older years—yes, maybe 10 or 20 years before they could have if they had hung on in some way. It was not that grief that I have seen people face from losing a child or a young parent.

When I am speaking here about death, it is not from a lot of personal experience. In fact, the mother of a good friend of mine lived in the Netherlands. Her mother was dying and chose to determine the time of her own death, with her family around her in a safe environment. It was beautiful. I have heard her story. I understand the love, compassion and grief. She still feels the pain of having lost her mother. Being able to be with her, knowing ahead of time that this was going to happen, being there with her family, and being able to hold her mother’s hand as she passed, how lovely is that? I have been thinking about this and wishing that I could go back to that time when my father had his heart attack and fell. Maybe he hit his head. I was too young to ask questions and did not necessarily know the exact details. I just wish somebody had been there to hold his hand as he breathed his last breath because it would have been comforting to me and I hope it would have been comforting to him.

Other than this experience with my friend, as I said, I have no direct experience with someone who may have taken the opportunity to access voluntary assisted dying, but for some reason I have empathy in spades for people who find themselves in an unbearably painful, ongoing and terminal situation. I have probably given suicide too much thought over the years, but it was not in my cultural landscape. I was 13 before I even heard of someone taking their own life. I remember thinking about death as a young child and always hoping that mine would be quick and painless. I was fascinated when I heard that drowning can be a relatively peaceful way to die—a good death, a quick death, a peaceful death. The reason we are discussing voluntary assisted dying now and not many decades ago may have something to do with the advances made in medicine. We have talked about it here. It has come up. Many people have been trying to bring forward legislation on this issue and it kept getting knocked back, but every year our advances in medicine give us more ways of keeping people alive. This world is not what it was years ago. We now have medical treatments to keep people alive regardless of their quality of life or, rather, their lack of quality of life. Sometimes they have no quality of life whatsoever but we can keep them alive.
This issue must not be equated with how we treat animals, because we do not use every medical procedure possible to maintain the life of an animal once it is known that its death is imminent and the animal is suffering. It is outrageous to think of it that way. We want to keep our loved ones around and our medical systems can keep them alive, but in our society, where competition is celebrated and medical advances are viewed from a scientific perspective rather than a human perspective, sometimes we forget that the point of life is not just to keep taking breaths, keep a heart beating, and keep a brain receiving signals. Life is so much more than that, and I know that everyone here knows that. This legislation has been drafted with much consideration of legislation in other jurisdictions. My reading of the bill has assured me that it will allow individuals to have control of their own deaths to a degree that may be able to offer them some comfort. That is what I would like at that point. I would love to have the comfort of knowing that if it got too hard for me, I could release those last breaths and the last beats of my heart.

I live in Albany and my community is well supported with palliative care. The people and facilities at the Albany Community Hospice are without parallel. That is not the case for everyone. Steps are being taken to improve and extend palliative care to others in the state, but at this time it is not feasible in anyone’s imagination that the government will be able to deliver that service throughout the state. To suggest that we aim for such unachievable ideals before legislating for voluntary assisted dying ignores reality and the expectations of 80 per cent of our community.

If I were dying, I understand that it might be easier to say, “I don’t want to be a burden on my family.” That line has been used here and we have heard it in many places. I can understand that somebody might say, “I don’t want to be a burden on my family. Just let me go.” The other option at that point is to say, “I can’t tolerate the pain. I give up. Let me go.” Like many of you, I grew up with the idea that you should grin and bear it. You never give up. You do not say that it hurts or that something is too hard. You just do it and keep going. You grin and bear it and go on. I can understand that people may say, “Look, I can take this. It is fine, but look what I am doing to my family. Let me go because I don’t want to be a burden on them.” When people are at that stage of their lives, rationality may not be the first thing that comes to mind. There are a lot of emotions going on when people get close to death, or I assume that is the case. One of the eligibility requirements to access voluntary assisted dying is that the person will need to show that their condition “is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable”. This bill does not allow for a person to simply say, “I don’t want to be a burden.” On its own, that will never be the reason for somebody to be allowed this option.

People have talked about wrongful death occurring. As I said, doctors currently prescribe morphine at a level that will not only relieve a person’s pain, but also end their life. Would we not consider that a wrongful death? The practice goes on and it is well known that it does.

I refer to suicides that happen when people feel there is no other option. Imagine if a person had the option of being able to say, “This is getting really hard, but I’d like to stick around until my next birthday or my grandchild’s birthday” but they have the option and they have the medication in their house so that if it gets to that point, they can let go. They will have the comfort of knowing that it is there if they need it, but otherwise they can soldier on and keep going and wake up each morning and try to get through to the end of the day. Let them have that option.

It has also been discussed that people need a prognosis of under six months to live and a diagnosis of terminal illness. Even if they said that they would like to make use of the option of voluntary assisted dying because they are going to die in six months and it is going to be horribly painful, that does not mean that they will take the medication as soon as it arrives. It will be there to provide comfort for them, so they know that if it gets bad, it will be available. When we hear stories of people who have a prognosis of less than six months to live and have a terminal disease, just because they make use of this process, it does not mean that they will take the substance. It is an option. It will give them comfort and some relief so that they can carry on living each day at a time, trying to live their life and do the things they would like to do, and being a part of it—being alive, not just breathing with a heart beating and a brain to receive signals, but actually living and knowing that they have the comfort of that option. I think that option is a good thing.

Members have talked about the possibility that we will start with this legislation, but that it can change and other things can be added along the way. But that has not happened much around the world. People are not picking up more things and changing the legislation. Besides, what are we doing here now? If that legislation has to change, it will have to go through this house, whether it is us or other people. They will be representatives of their communities and reflect the needs and desires of the people who put them there. We have this legislation before us, and this is the legislation that we are voting on. We are not voting on what may become of it 10, 30 or 50 years from now. We are voting on what is before us, and that is what we should be looking at.

I refer to the free vote. Hon Dr Steve Thomas had the honesty to state that political pressure has been put on people to use their so-called conscience vote and to vote as per the party line, and that seems like such a shame to me. I understand party politics to some degree. I understand that there are pressures and affiliations outside of our individual representations of our communities and regions. That is why I appreciate his honesty in acknowledging that. He also suggested that we are binary creatures. I want to get on the record that I disagree; we are not naturally binary creatures. That paradigm has been created by humans to control other humans and keep us as adversaries. We do not need to be adversaries. I know we can do better than this.

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My comment on the bill being debated here is that it feels like the first time that we have been a room full of adults. 
It has been impressive. I expected that we would always be a room full of adults, but over the past two and a half years there have been numerous times when that was not exhibited very clearly—but in this debate, it has. I want to thank all of you and I appreciate all of you for being able to have a debate in which we were able to respect each other’s opinions. It felt really good. I would love to be able to move forward from this point and continue with that maturity.

I refer to amendments. I have not been convinced yet that any amendments are necessary to the legislation as it stands, but I will be listening. I appreciate the contribution of Hon Colin de Grussa. He covered many of those issues very well and at this point I agree with the comments that he made. I would also like to state that as a regional member, I am looking to make sure that we have appropriate regional options available for people who do not want to come to the city and be away from their families, their homes and their communities and want to stay in the regional area. I look forward to the government showing me just how well this can work when a resident in a distant location takes this up and how we can manage to make sure that that person has the best of care in their last few days.

It is time for this bill to be passed. It is time to give people choice in determining when, where and how they will die and who will be with them when they die, when their life is being taken by a terminal condition and they have only time to pass before they take their last breath and their heart stops beating.

HON DR SALLY TALBOT (South West) [9.09 pm]: As many honourable members will know, I have long been in support of legislation to legalise voluntary assisted dying. Tonight, I will outline the reasons why I strongly support the Voluntary Assisted Dying Bill. Before I start, I want to acknowledge one of the speeches that we heard earlier today. Many, many members have spoken so eloquently, particularly about their support for this bill, right throughout the debate. But I want to single out Hon Matthew Swinbourn. I do not think I have ever heard a speech like that in my time in this Parliament. It was really quite an extraordinary speech and I can only admire the member’s courage and determination, and I know that it did take courage and determination to come in here and make that speech. What we heard earlier today was an outstanding contribution to the worldwide debate on this subject, and I am very proud to have been here in the moment it was delivered.

It has been one of the great privileges of my time in this Parliament to have played my part, a small part, in bringing us to the stage at which we have in front of us a bill that has been passed by an overwhelming majority in the other place after having been tested for more than two years by the most intense and extensive legal and clinical scrutiny available in our community. This scrutiny, as other members have talked about, included the year-long inquiry by the Joint Select Committee on End of Life Choices, of which I was a member, and another extremely thorough investigation by the Ministerial Expert Panel on Voluntary Assisted Dying, which was headed by Malcolm McCusker, one of the most prominent legal figures in our country.

The last time I spoke on this subject, and I have certainly spoken several times in the 14 years that I have been here, was when the joint select committee tabled its report. In my speech during the tabling of that report, I paid tribute to the people who I regard as the real heroes of this battle to decriminalise voluntary assisted dying. I know that I am not alone in thinking that the real heroes of this story are the people who had the courage and the conviction to provide a really important component of the evidence on which the joint select committee’s report is based.

To recap very briefly, during the tabling of that report I mentioned Dr Robert Edis in particular, and I think Hon Adele Farina referred to the fact that Dr Edis was one of our guests at lunchtime, who talked about the experiences of patients with motor neurone disease. I thought it was a very powerful and indeed unforgettable session. When Dr Edis appeared before the joint select committee, he gave what, for me, and I am sure other members who were present, was an unforgettable account of the experiences of his patient Melanie, who, when life with motor neurone disease became unbearable, had to battle the system before she could even start to have a conversation about how to die. I also mentioned Nigel Haines, who comes from our electorate of the South West Region. Nigel shared the story with us about what he called the gut-wrenching, living nightmare, lasting many years, watching his wife, Suzie Haines, die of Alzheimer’s. I spoke also about the evidence presented to us by William Philip, whose wife, after an unsuccessful attempt to take her own life, eventually died in what Mr Philip described as terror. One of the interesting things about the evidence that we heard was that in many of the cases, and I include Mr Philip’s wife amongst the case studies that we heard about, the people who were present, was an unforgettable account of the experiences of his patient Melanie, who, when life with motor neurone disease became unbearable, had to battle the system before she could even start to have a conversation about how to die. I also mentioned Nigel Haines, who comes from our electorate of the South West Region. Nigel shared the story with us about what he called the gut-wrenching, living nightmare, lasting many years, watching his wife, Suzie Haines, die of Alzheimer’s. I spoke also about the evidence presented to us by William Philip, whose wife, after an unsuccessful attempt to take her own life, eventually died in what Mr Philip described as terror. One of the interesting things about the evidence that we heard was that in many of the cases, and I include Mr Philip’s wife amongst the case studies that we heard about, the people who were making the decisions were nurses or had worked in the medical profession and so knew exactly how they were likely to die when they received their final diagnosis.

In talking about heroes, I must mention Belinda Teh, who spent an enormous amount of time in the gallery and is still with us here tonight. Belinda walked home—"home" being Perth—from Melbourne to draw attention to the plight of people like her mother, who, despite having access to the best palliative care, died what Belinda describes as a horrific death. Here is what Belinda said about her walk, and I quote —

Walking from Melbourne to Perth symbolises for me the way our journey to life’s end should be—long and arduous, sometimes painful, yes, but supported all the way by empathetic, loving people who reflect on what it might be like to walk in the shoes of others.

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In 2010, I spoke in support of the private member’s bill introduced by Hon Robin Chapple. I ended with these words —

Fundamentally, what we are talking about today is whether we will respect the decisions of those who decide that a gentle and peaceful death at a time that they choose is the way they want to end their lives. I cannot vote to deny anyone the right to die in this way—not you, and not me. That is why I am supporting the bill.

In the nine years since then, my resolve to regulate for voluntary assisted dying has, if anything, been strengthened by the mass of evidence and testimony collected as part of the process of bringing this bill before the Parliament. Because I have already outlined in previous debates my views on this matter, I will focus here on several specific issues that the current debate in the community and amongst us as members of Parliament have brought to the fore.

I want to start by saying that first and foremost I have been very much struck by how frequently all of us who have been talking about the question of how we die have talked about it in terms of our values. In other words, we talk about the kind of society we want to live in. We are talking about life. We are talking about how we live. For me, there is no contradiction here. We recently heard from a doctor who came to talk to MPs about voluntary assisted dying. I think it was humorous and it sums it up completely. He said, “The one statistic that has remained static since the time we began collecting statistics is that 100 per cent of people die.” It would do us well to remember that. Death is not a strange thing; death is part of life. The cause of death is life. It sounds like a cliché but the truth is that, according to me, we will live better if we can contemplate our death.

Our thoughts about how we die are intimately bound up with what we think about life and how it is best lived; therefore, it is important to listen very closely to this talk about values, particularly when the debate gets heated and emotional. It is important because if we really try to understand what everybody is saying, and I mean everybody, both when they support and oppose measures like this, we will make better arguments ourselves. For example, I was quite shocked—genuinely shocked—to hear opponents of this measure say that one cannot logically and consistently oppose capital punishment and yet support VAD. As someone who does precisely that, what do I say? The argument seems to go like this: we reject capital punishment because legal practitioners make mistakes and execute people who are subsequently found to be innocent. Might it not then be the case that medical practitioners also make mistakes and wrongly approve people’s access to voluntary assisted dying?

Those members who have made any sort of study of disciplines like philosophy will know that there is a particularly pernicious form of argument, well known to people who argue for a living, such as lawyers and philosophers, where we are led inexorably to a conclusion because all the premises appear to be true even when the conclusion is not one we accept. In the case of capital punishment and voluntary assisted dying, looking at the values or principles that guide thinking is helpful. Although I certainly agree that the execution of an innocent person is a tragedy, this possibility is not the reason why I oppose capital punishment, and it cannot form the basis of a rejection of measures to regulate voluntary assisted dying. Go back to the question about what sort of society we want to live in. For me, that question is answered in terms of dignity and respect. It involves thinking about the way we treat each other, about acting always to promote love and regard over hatred and fear. I do not want to live in a society that executes offenders, because I believe that there is a better way to deal with those offenders by embracing a rule of law that sees imprisonment and loss of liberty as an ultimate punishment. Similarly, I do not want to live in a society in which people who are dying are forced to suffer unbearable pain or are sedated until they die, because I believe there is a better way. What is that better way? What do we want to be able to say to those people who want to decide for themselves how to spend their dying days rather than allow others to make those decisions? This legislation is about that better way. It will enable us to say yes rather than no to somebody when they ask to be able to actively end their life when their suffering, their pain and/or anguish is unbearable to them and there is no chance of a cure for the cause of that suffering. The concept of asking is central to the safeguards included in the bill. These safeguards are a direct result of the legal and clinical scrutiny to which the select committee and the ministerial expert panel have subjected the measures contained in the bill. We will hear a lot about coercion, or to use a term coined by our colleague Hon Nick Goiran “steering”, from opponents of this bill. The bill’s absolute insistence that nobody will be coerced into requesting voluntary assisted dying is manifest in the creation of specific criminal offences making any action intended to coerce a crime. That is right, just as are the measures to ensure that those who ask for voluntary assisted dying have the mental capacity to know what they are asking for and are right. This bill is not for people who are not dying. It is not for people who are suffering because someone they love is suffering. Its terms of application are very, very narrow. It will not include people like Dr David Goodall in its scope. It will also not include someone who is dying if they have any form of dementia, even though, for more than two years, the select committee heard—I am sure the ministerial expert panel heard the same thing—very eloquent and passionate arguments that dementia sufferers should be included in the bill. I know that is something that arose frequently in the many forums that Belinda Teh held as she walked across Western Australia. To those people who would like dementia sufferers to be included in the bill, I simply say this: we could not find a way of making the ability to request access to voluntary assisted dying in an advance health directive consistent with the key principles around decision-making capacity in this legislation. That is why we have excluded dementia sufferers and that is why they will not be included in the future.

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This brings me to another specific matter that is likely to be discussed in great detail by opponents of the bill if we move into the committee stage. In any debate about reform of this kind, the conservative argument will always be about the slippery slope. I know other members have raised this issue in their contributions to the debate. The slippery slope argument is the “give them an inch and they will take a mile” fallacy about the inevitability of certain outcomes being precipitated by an initial action. I call it a fallacy because unless it is supported by evidence, that is all it is. When we look for evidence of the slippery slope in relation to voluntary assisted dying laws around the world, it simply is not there. It is extremely rare for legislation to be changed once it is in operation. I will give members an example. In Oregon, where laws relating to voluntary assisted dying have been in operation for more than 22 years, there has been one single amendment. That amendment, which had to go right through the parliamentary process, made a change to the statutory waiting period for people with less than 15 days to live. In the Netherlands, laws on assisted dying have not changed at all since they were introduced in 2002. The joint select committee report presented to this Parliament found —

The published evidence does not support claims that legalisation of assisted dying results in an inevitable move toward the erosion of safeguards and an increase of non-voluntary euthanasia. Indeed, the evidence supports the opposite conclusion …

I will go further and say that it is not even common for legislators to try to change the legislation. No legislature anywhere in the world has ever taken lightly the step of introducing voluntary assisted dying. Legislators, like us here tonight, are under an obligation to get it right—to make sure that the laws passed by Parliaments are sound and workable as well as supported and understood by the community. Although some jurisdictions, such as Victoria, have introduced their voluntary assisted dying laws relatively recently, others have had laws for decades. If there were evidence of legislation becoming more liberal—of categories being expanded, criteria being widened or safeguards being watered down—we would see it, at least in the jurisdictions that have had voluntary assisted dying laws for a considerable number of years. Members, we do not see it, because it is not there. It is not true that laws like this change over time to expand their scope or weaken their sanctions and safeguards. As lawmakers, we should not be swayed by false arguments and we should not vote on the basis of fears that are not justified.

I will say something about how we might understand the evidence that both supporters and opponents of this bill have put before this house. The fact is, and I use the term “fact” without irony, that not all evidence is sound. I was discussing this matter in a different context recently when the person with whom I was speaking put it very succinctly. He said, “Not all evidence is created equal. Some is created to sell things.” That is not exactly the charge I would bring against those attempting to undermine the bill, but it does highlight the wariness we should all have when it comes to the evidence for some of the claims being made to substantiate the case against voluntary assisted dying.

I will make some general points and then I will move on to some specifics. I go back to my earlier comments about values and particularly the values that guide our thinking about death and dying. It is really important that we start with a clear understanding about what is a factual claim and what is a moral claim because, Madam President, there is a difference. A factual claim depends on evidence. A moral claim depends on values. It is the failure to make this distinction that leads to confusion and we should be wary about some of the more outlandish claims made in relation to this topic. I suggest to honourable members that what may carry weight as a moral claim—for example, that all life is sacred—can be substantiated only in terms of values. What would be the values underlying the statement that all life is sacred? They would be something like: life is a gift and it is always wrong to throw it away. That is a moral claim. What carries weight as a factual claim—for example, that it is not possible to design a safe voluntary assisted dying law—must be substantiated by evidence. What counts as evidence? Honourable members would be aware of some of the material written by Ben White, Andrew McGee and Lindy Willmott. They have done extensive academic examinations of how arguments work and point out that if we are serious about gathering evidence, we should give little weight to anecdotes, opinion pieces, editorials and letters to the editor, and only slightly more weight to single individual and small group case reports and series. It is only when we get to epidemiologic studies, meta-analyses and systematic reviews that evidence becomes robust. It is only at this level that we find evidence that is tested by courts, expert panels, non-partisan parliamentary committees and peer reviewers.

The proposition has been put in this place by opponents of the bill that it is intellectually dishonest to deny the impossibility of creating a safe voluntary assisted dying law. I take very strong exception to this claim. It is a classic case of a failure to be honest about the evidence on which a proposition is based. The conclusion is based on so-called wrongful deaths, which are supposed to have occurred under existing voluntary assisted dying laws. These are not new claims; they constitute the bulk of the joint select committee minority report submitted in the name of Hon Nick Goiran. I suspect there will be plenty of opportunities later in the debate to go into detail about how seriously flawed these arguments are, but for now, I will make three points about these claims. First, these wrongful death case studies were based on the omission of important facts and inclusion of unsubstantiated information and half-truths copied from pro-life websites. This is not trustworthy evidence from any intellectual perspective. Second, most of the authors who put their names to these so-called wrongful death case studies argue solely from the viewpoint of a religious and/or fundamental opposition to VAD. They are not unbiased researchers.

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Third, all cited deaths were legal in the jurisdiction in which they occurred. Not one of them was found to be wrongful by any inquiry in those jurisdictions.

I said earlier that we all need to be wary when it comes to the evidence used to back up some of the claims made to substantiate the case against voluntary assisted dying. Nowhere is this wariness more necessary than in the assessment of claims that coercion is not preventable by having strong legislative measures that criminalise such action. This claim, which is another version of the “impossible to create a safe voluntary assisted dying law” claim, has been tested in the courts of Canada and found to be untrue. Let me be absolutely clear what I mean by this: it would not be untrue if there was a reliable body of peer-reviewed evidence that voluntary assisted dying was being accessed disproportionately by vulnerable people. There is no such evidence. Yes, there are letters to the editor making these claims. Yes, anti-choice websites are full of anecdotes and stories about cases in other places. No, this does not constitute evidence. What the evidence—that is, independent, testable, expert and exhaustive evidence—says is that there are no signs in any of the jurisdictions in which voluntary assisted dying is lawful that there is an increased risk to vulnerable groups or that the laws are being abused to inflict harm on vulnerable people. Those are the facts. They may not suit that particular argument, but they remain the facts.

Perhaps the most preposterous claim made by opponents of this bill is that voluntary assisted dying and suicide are the same thing, or are at least likely to be construed as the same thing in the popular imagination. It is clear to me, both from the evidence and from my reflections and personal experience, that this is not true. Suicide and voluntary assisted dying involve two completely different kinds of death. This does not seem to me to be a particularly contentious or provocative statement. Take these two propositions. The first proposition is that it is acceptable for someone who is very close to death and has no prospect of a cure to take their own life. The second proposition is that it is acceptable for someone who is not close to death and has every prospect of a cure to take their own life. These propositions are not the same; these propositions are not equivalent. To say that they are is simply wrong. For me, the key concept here is hope. The bill is not about removing hope for a cure, hope for an end to the pain, hope for the future or hope for a better life; it is about what we say when hope has run out—when there is no hope for a cure, no hope for an end to the pain, no hope for the future and no hope for a better life.

The report by the Ministerial Expert Panel on Voluntary Assisted Dying addressed this question with eloquence, drawing on similar observations made by the Ministerial Advisory Panel on Voluntary Assisted Dying in Victoria, which reported in July 2017. On page 11 of the Western Australian “Ministerial Expert Panel on Voluntary Assisted Dying: Discussion Paper”, the panel says —

Suicide involves the tragic loss of life of a person who is otherwise not dying, whereas voluntary assisted dying involves a person’s choice about their mode of death when they are already dying. Suicide is usually undertaken alone as an act of desperation, whereas voluntary assisted dying is a pathway involving medical and family support. 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 believes 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.

Let me turn finally to the question of whether this bill would be improved and, indeed, and perhaps more importantly, whether the outcomes for individuals requesting access to voluntary assisted dying would be improved if we were to prohibit doctors from discussing voluntary assisted dying with their patients in the same way that they routinely discuss other medical options. Again and again, people whose narratives we listened to in the select committee inquiry spoke about the moment when a doctor says to a patient, “I have bad news for you.” What we heard came next was always a variation of the same questions. Those questions were: will I have to suffer; and, if I do, what will you be able to do for me? For us in this Parliament to contemplate imposing a limit on the information provided at this critical point would, I suggest, be outrageous. Yes, Victoria has this prohibition, but it is the only jurisdiction in the world to do so. Such a move would be a complete subversion of good clinical practice, which relies as much on patients being fully informed as it does on doctors adhering to high professional standards. I put it to members who are considering this matter that there is no other circumstance whatsoever in which we would consider it good practice for a Parliament to impose a restriction on a doctor discussing lawful treatment options with a patient. In debate in the other place, the proposition was put forward that such a measure was necessary to protect people with a disability, and particularly those whose disability might render them susceptible to suggestion. Such a proposition, I think, constitutes a fundamental misreading of the safeguards contained in this bill, which are specifically designed to ensure that eligibility is confined to those whose decision is their own and nobody else’s. I find such propositions deliberately overlook current practice, which has never found anything sinister in the fact that doctors are allowed to have uncensored conversations about all other treatment options, including refusal of treatment and palliative starvation and dehydration. Indeed, the fact that palliative sedation of terminally ill patients is often administered in the absence of any consent by the patient appears not to have troubled proponents of this argument until now—a fact that at least seriously undermines, if not completely derails, their claims.

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No doubt many of these issues will surface if we proceed to the committee stage, and I will make further comments then should we return to them. But let me conclude by saying that it is my firm belief that we cannot continue as we are. We cannot continue pretending that accounts of people dying in agony are exaggerated and we cannot continue to criminalise the actions of those who seek to help.

The title of this bill is well chosen. Under this law, assisted dying will always be voluntarily accessed. Many will choose not to take that route, and their reasons will be many and varied and must be respected. Evidence shows that amongst the small minority of people who access voluntary assisted dying, many use palliative care services and most die without using the medication. That means that few people in our community will not find themselves in palliative care at some point, and I remain a staunch advocate for improving palliative care services, especially for people in regional and remote communities whose dearest wish is to die at or at least near home.

I want to end with a challenge to those who would oppose this bill. I want to ask whether we can imagine that one day your partner or your child or someone about whom you care very deeply might be close to death and might want to make the choice about how they die. I then ask: will you be prepared, when this person has made that choice, to deny them that choice and to tell them that they made the wrong choice? I ask that question because this is the reality of the law as it stands today. I ask again today the question I proposed to this house in 2010 on the bill introduced by Hon Robin Chapple. I say again: are we prepared to take away from people who have a terminal illness the right to choose how to die? Can you imagine this is a choice that one day you might want to make or that somebody you love might want to make? What we say to people now is that if you make that choice, either you will have to depend on others to break the law or you will have to do it yourself; and, if you do it yourself and you do not want to implicate others, you will have to do it on your own. I am not prepared to contemplate that. I cannot see how it would be right to force that onto people, in any sense, as a result of a decision that we make in this place.

I want to end on a completely different note and I want to share with honourable members, as many members have done earlier in this debate, something that was sent to me by a constituent. This constituent happens to be a woman whom I love very dearly. She is an 80-year-old woman who lives in Pinjarra and she has a close relationship to other members of this house as well, not only people on my side of the house; she is the woman whom Hon Simon O’Brien refers to as Aunty Pat. I share with honourable members a poem that was sent to me by Trish Briggs, also known as Aunty Pat. Aunty Pat writes a lot of this poetry and I think it is just a lovely way of summing up how many people in our community feel about the nature of this bill and the fact that they just want it to happen. These are Pat’s words that I want to end with. Here is her poem V.A.D. —

Ive lived until I’m eighty
I’ve earned the right to choose.
Don’t take that choice away from me
For if you win, I lose.
Your view of life is positive
At present mine is too
But I want death with dignity
The decisions up to you.
I do not want my family
To suffer at my death
I want them to remember,
As I take my final breath,
The time we’ve spent together
And the joys that we have shared
And acknowledged my decision,
For a painful going, spared.
So when you come to cast your vote
Give a thought to those like me
And since death comes in many ways
Vote yes for V.A.D.

HON STEPHEN DAWSON (Mining and Pastoral — Minister for Environment) [9.42 pm] — in reply: I begin by thanking everybody who has made a contribution over the past week or so in this debate on the Voluntary Assisted Dying Bill 2019. I have been in this place for about six years and I think this is the first debate in which essentially every member of the chamber who could make a contribution has made a contribution, and it just shows how we are all treating this debate, how important it is to us and to the community. Thus far, it certainly has been conducted civilly and with great respect, and I congratulate members on that.

I acknowledge those members who shared difficult personal stories, like Hon Alanna Clohesy; Hon Peter Collier; Hon Robin Chapple; Hon Colin de Grussa, who talked about his own experience with cancer; and Hon Matthew Swinhourn, who today spoke to us about his loving son and the reasons for his support of the bill that is before us.
I also want to acknowledge Belinda Teh and Noreen Fynn who have been here during the debate. Their suffering has been 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 thank you for that.

The evidence is clear. Complete relief of suffering is not always possible, even with optimal palliative care. To argue that palliative care does achieve complete relief is to deny the reality of those who have shared with us their personal experiences. It is also clear from the evidence that compassionate assistance is already rendered to those for whom death is imminent, but that assistance is reliant on the decision-making of the medical practitioner, with no safeguards and sometimes without consent.

Debate adjourned, pursuant to standing orders.
Hon Jim Chown, rightly, reminded us of the 10 per cent of suicides related to chronic or terminal conditions. He reminded us of the terrible guilt and devastation for those left behind. These are the wrongful deaths that we should all be very deeply concerned about.

The issue of coercion has been raised by a number of members in this place. It is important to consider the facts. Repeated, independent and exhaustive reviews have shown no evidence of abuse of the vulnerable overseas. Facts in this debate are very important. Information presented as fact, not based on evidence, does this Parliament no credit and the Western Australian community a disservice. Evidence from overseas demonstrates that members of vulnerable groups are no more likely to receive assistance in dying. Those who access assisted dying have competent social, economic, educational and professional advantage. Under this bill, assessment to determine whether the decision was made voluntarily and to detect coercion will form an explicit component of the mandatory training. 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. This bill includes safeguards to ensure a person is acting freely. Clause 15(1)(e) provides that the eligibility criteria for voluntary assisted dying include the requirement that the person is acting voluntarily and without coercion. Clauses 23 and 34 provide that the person is required to be assessed against the 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 a determination.

Clause 54 requires that the medical practitioner must be satisfied that 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 practice administration. The bill provides that an application may be made to the State Administrative Tribunal for review of a decision that the person is acting voluntarily and without coercion. The process is suspended whilst the review application is determined. 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 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 cost and complexity by encouraging people down this path. Hon Nick Goiran worries that these laws will result in an increase of elder abuse. The McGowan government is committed to preventing and addressing elder abuse. The government has invested funding in 2019–20 for elder abuse prevention initiatives. This includes funding for Advocare to run the elder abuse helpline, the Northern Suburbs Community Legal Centre to provide the older people’s rights service and the age-friendly and dementia-friendly community grants program. Five-year service agreements for elder abuse prevention services, such as Advocare and the Northern Suburbs CLC, provide much-needed funding security to allow them to continue to provide vital on-the-ground services to older Western Australians. This bill does not address concerns relating 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, on the timing and manner of their death.

The bill includes safeguards through stringent eligibility criteria and strict procedural requirements for accessing voluntary assisted dying. Under the eligibility criteria, a person must have decision-making capacity and be diagnosed with a terminal illness or disease that is advanced and progressive, causing intolerable suffering and will, on the balance of probabilities, cause death within six months or 12 months for a neurodegenerative condition. The bill provides for a strict assessment process by two qualified doctors working to clear guidelines set down in law. Medical practitioners must have particular qualifications and must undergo approved training before they can assess a person. The coordinating and consulting practitioners must refer for specialist advice when they are unable to confirm the condition, the prognosis, or that the person has decision-making capacity. Under clauses 25 and 36 of the bill, if the assessing doctor is unable to determine that the person is acting voluntarily and without coercion, the doctor must refer the patient to a person who has appropriate skills and training to make a determination. This may include a social worker or a police officer.

The bill contains rigorous safeguards to guard against coercion, but it is important that we also acknowledge that older people are entitled to human rights. Hon Tjorn Sibma considered this issue closely as a member of the Select Committee into Elder Abuse. The honourable member told the house —

For me, the inherent dignity and autonomy of older people is essential, and it has been an essential consideration in my evaluation of this bill. I have not met an elderly person who has felt victimised by the prospect of this Voluntary Assisted Dying Bill.

...
These are people who want to maintain their own dignity, autonomy and sense of agency over the full length of their life, however long that might be. I want to do credit to those people. I want to treat adults like adults. I want to actually defer to people who have lived on this planet twice as long as I have done. I think they have earned the right to ask for assistance in the circumstances of a terminal diagnosis or an irreversible neurodegenerative disorder.

There has also been a question as to the level of coordinating and consulting commerciality that may exist with practitioners. Based on the overseas evidence, the rates of people accessing voluntary assisted dying ranges from about 0.4 per cent in Oregon to four per cent in the Netherlands. Given that the 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 rates of voluntary assisted dying will be closer to Oregon. Given those very low rates, voluntary assisted dying will not be a commercial prospect for any health practitioner.

Some members have contended that with the best quality palliative care all suffering can be treated. This is patently untrue. Australian data from the Palliative Care Outcomes Collaboration shows that a small percentage of people—even those being cared for in the best specialist palliative care services—experience pain at end of life. Hon Alannah MacTiernan relayed to us the words of retired gynaecological oncologist Professor Ian Hammond, who told of patients he could not help—patients with severe bone or nerve root pain whose only answer was terminal sedation, which was temporally inappropriate. It is also clear that people are motivated to request voluntary assisted dying for a range of complex reasons, which are not specific to pain management only. PCOC Professor Kathy Eagar has told the ABC that when it comes to choosing euthanasia, pain does not even make it into the top five reasons. The most common reason is the person not wanting to lose their independence and autonomy.

A number of members commented that we need to do more for palliative care, especially in the regions. This government is doing more than any government in recent history and providing record levels of funding. Across the forward estimates there will be a $224 million investment in palliative care. This level of funding stands in stark contrast to previous investments in palliative care services. Increased metropolitan palliative care services will see an additional 10 inpatient beds in the northern suburbs and expanded community services for care in the home. The McGowan government is also dedicated to expanding services in rural and regional WA to enable care closer to home with a boost to regional community-based services, provision of in-home palliative care support, and ensuring palliative care on-country visits are delivered. More than 61 full-time equivalent staff will be employed over a phased approach across regional Western Australia as part of the government’s $411 million end-of-life choices and palliative care services package, as included in the 2019–20 state budget. This will triple the staffing arrangements for palliative care support in regional Western Australia. This includes the establishment of new specialist district palliative care teams comprising medical, nursing, allied health and Aboriginal health workers across all regions. As part of the package, $3 million will enable 24-hour support via the WA Country Health Service Telehealth hub, which will ensure staff, patients and families have access to nursing care for patients who want to die at home. There will be an additional $2 million for the expansion of community palliative care services in regional Western Australia to better meet demand for domiciliary services, and a further $2.5 million for enhancing rural and regional palliative care services by improving governance, consistent with the recommendations of the report of the Joint Select Committee on End of Life Choices. In addition, a further $5 million has been allocated to progress a purpose-built 38-bed residential aged and palliative care facility in Carnarvon. This increases the total funding for that facility to $16.6 million. Over four years, the investment for regional palliative care services builds on current service arrangements.

Hon Adele Farina in her contribution asked what the government is doing about the joint select committee recommendations. The Department of Health is currently addressing the recommendations set out by the joint select committee. As part of the program of work, five distinct work streams have been established—one on current state activities; the second on service models, patient choice, benefits and risks; a third on health profession education and awareness; a fourth on consumer education and awareness; and a fifth on needs analysis and future commissioning priorities. The first work stream has been established to assess current state activity and funding of palliative care in Western Australia. With this, information gaps in recorded activity will be identified and future initiatives to improve services systems will be identified. A statewide palliative care services plan will also be produced.

The WA Country Health Service is also working carefully to ensure equity of access across the seven regions so people can benefit from receiving high-quality palliative care regardless of where they live. I also note that the Department of Health is working closely with Palliative Care Western Australia. For example, PCWA has representation on the end-of-life and palliative care advisory committee, which advises on the development, implementation and review of effective sustainable and high-quality end-of-life and palliative care health systems and services in WA. It also provides statewide strategic direction on implementation of this strategy. PCWA has received funding from the Department of Health to facilitate advance care planning workshops since 2015 and 76 workshops have been delivered across the state in the four-year period to date. The Department of Health has agreed to continue funding for PCWA to facilitate advance care planning workshops through a grant. This will involve the delivery by PCWA of 36 two-hour advance care planning workshops in metropolitan and rural

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communities. Other work is underway by the Departments of Health and Justice to address all the recommendations in relation to advance health directives. The Department of Health is finalising a statewide advance care planning policy, which will ensure that when an advance health directive is provided to a hospital, it will be easily accessible and stored prominently on the patient record. The government is considering all the recommendations of the expert panel on advance directives. The Attorney General has already indicated to the Parliament interim acceptance of all recommendations except one. The government will not support advance directives for voluntary assisted dying. The Department of Health will continue to work with the Department of Justice, Palliative Care WA, WA Country Health Service and other stakeholders in end-of-life and palliative care to progress all recommendations.

The premise of the bill is not, as one honourable member stated, self-interest, public expediency polls or government propaganda. The premise of this bill is choice—choice for an expected small number of people already nearing the end of their life on the timing and manner of their 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 their 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. As Hon Jacqui Boydell noted, this is not a choice between palliative care and voluntary assisted dying; this is about helping to support people throughout end of life.

A number of members on both sides of the argument told this place that they believe in the sanctity of life. But I think Hon Pierre Yang said it best when he said that his God wants us to have dignity, liberty and self-determination. Whatever your belief, individual freedom and choice is something that most of us can support.

I acknowledge the contribution of Hon Tjorn Sibma, who properly stated that the bill establishes a right for a very small number of people to ask for assistance to die when facing their inevitable, imminent and difficult death. He noted that the bill’s reach is modest and the safeguards are well balanced, well drafted and appropriate.

This bill will protect vulnerable people in ways that do not exist now. Parliaments are actually arguing for the substandard status quo to remain. Decision-making capacity 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 healthcare practice. Doctors routinely assess decision-making capacity now: decisions made by their patients to consent to, or refuse, dialysis; decisions to consent to, or refuse, chemotherapy; decisions to consent to, or refuse, surgical interventions; and decisions to forgo treatment that may result in the person’s death. Under this bill, the coordinating and consulting practitioners must refer to a relevant health practitioner, such as a psychiatrist, geriatrician or psychologist, if 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. It said—

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.

This bill does not overturn the fundamental legal principle that an adult is presumed to have decision-making capacity. But when there is a question, when there is doubt, the practitioner must refer to specialist assessment. The coordinating practitioner must also complete a final review that certifies, by way of a 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 purpose of mental healthcare plans. These are not undertaken during a short consultation but require a long appointment to enable GPs to properly assess the mental health needs of their patients.

I wanted to touch on the issue of conscientious objection. This bill provides for the ethical, moral and professional objection to voluntary assisted dying held by some medical practitioners but balances this with the need to facilitate timely and appropriate access for people who request voluntary assisted dying. Practitioners are not obliged to refer persons seeking voluntary assisted dying directly on, but it does require them to inform the patient of their refusal and give the person basic contact information about voluntary assisted dying. Faith-based hospitals and hospices 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 participating hospital, care facility or home. 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.

Hon Colin de Grussa raised the issue of equity of access across the state. All of us in this chamber are aware of the challenge of delivering world-class health care across the single largest jurisdiction in the world. As the Ministerial Expert Panel on Voluntary Assisted Dying noted, Western Australia covers 2.5 million square kilometres of the Australian mainland, being the largest state in the commonwealth. Although most of the Western Australian

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population resides in Perth and surrounds, a significant part of the population is vastly dispersed across the state. According to the Australian Bureau of Statistics, almost 40 per cent of Western Australia’s Aboriginal population lived in remote or very remote locations compared with just under five per cent for non-Indigenous populations. Apart from the challenges presented by its geographical size and location, Western Australia is also the most culturally and linguistically diverse state in Australia, with Aboriginal people, migrants and refugees accounting for nearly 30 per cent of its population.

People across the state sometimes have to travel. Albany has perhaps the best regional palliative care service, but some residents still have to travel to Perth for heart surgeries. Some Western Australians still have to travel interstate for certain surgical procedures. This is the reality we face given our vast state and the nature of health care. This 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 provisions for the appropriate use of technology for some communications. Although we acknowledge the challenge of service access equity across regional and remote WA, it is not the purpose of the Voluntary Assisted Dying Bill 2019 to address underlying issues related to access to healthcare services generally. During implementation, the government will work closely with regional stakeholders, such as the WA Country Health Service, 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 regional and remote Western Australians.

Hon Simon O’Brien raised the issue of prisoners accessing voluntary assisted dying. The bill contemplates that this may occur, but the death of a prisoner will remain a reportable death to the coroner, as will all deaths of persons in care. This will be managed on a case-by-case basis with the involvement of the relevant medical team and the prison authorities and subject to the Prisons Act. A prisoner can request voluntary assisted dying and may be assessed as being eligible under the bill if they meet all the necessary requirements. The bill requires the VAD board to advise the CEO, who has administration over the corrections portfolio—presently, the director general of the Department of Justice—in circumstances in which a prisoner has been given final approval for voluntary assisted dying. The enabling clause is clause 117(c)(v). A prisoner may be on a long-term sentence or a continuing detention order.

It should also be noted that the CEO of Justice is not included in the Victorian legislation as a referral agency; however, the government views this as a necessary referral as it will ensure that proper processes, such as transfer and management of the patient, can be followed. It would be unlikely for the administration of the substance to take place in a prison setting. The patient would most likely be transferred to a hospital, and it is important that there is capacity to refer and communicate. It should be noted that a patient who is a prisoner is a person held in care and this bill provides provision for a death of a person held in care to be automatically referred to the coroner as a reportable death.

If the bill passes, Western Australia will adopt a voluntary assisted dying care navigator program, similar to Victoria. Many people will be well supported as they go through the voluntary assisted dying process by their coordinating doctor or healthcare team; however, some people will need extra support during the process. For these people, WA Health will, during the implementation phase for VAD, establish the role of voluntary assisted dying care navigators. In Western Australia, the navigator role will provide culturally appropriate advice and also include Aboriginal health workers.

Aboriginal health services will link with local health and community services to facilitate the cultural and spiritual support that is needed at end of life for people, their families and communities. We have entered into a dialogue with these services about voluntary assisted dying and during the implementation we will continue to work with Aboriginal communities and healthcare services to ensure appropriate information and access in a manner that suits Aboriginal people. I know this was an issue that was raised by a number of members, including Hon Kyle McGinn, and I think Hon Robin Scott also had something to say in this space.

I want to briefly touch on telehealth.

Sitting suspended from 6.00 to 7.00 pm

Hon STEPHEN DAWSON: Concerns have been raised about the commonwealth Criminal Code Act provisions on counselling or inciting suicide over a carriage service such as telephone, internet or video, and that they may prevent the use of telehealth for the voluntary assisted dying process. Firstly, there is nothing in the Voluntary Assisted Dying Bill 2019 that is inconsistent with the commonwealth Criminal Code Act. In fact, the bill makes it clear that it does not authorise the use of a method of communication if or to the extent that that use would be contrary to or inconsistent with commonwealth law.

We acknowledge that there may be uncertainty about whether particular communications about voluntary assisted dying will contravene the commonwealth legislation. That is why the state has engaged, and will continue to engage, with the commonwealth about this issue. Discussions have taken place at the highest level and the commonwealth has kindly offered its assistance to the Department of Health in further considering this issue. If telehealth cannot be used as a method of communicating with people for the purposes of access to voluntary

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assisted dying in Western Australia, the WA health department will adopt alternative implementation strategies. There are other jurisdictions that have similar restrictions, such as Victoria, and similar geographic challenges, such as Canada. For example, in Victoria a direction has been issued that requires the provision of information to occur face to face.

Options currently being considered for this state include a central hub that would link with networked spokes in regional and remote WA, and transport assistance to support face-to-face interactions. The hub would be able to receive requests for information on access to voluntary assisted dying and then facilitate the provision of information either by hard copy or in person. Assessments may need to be undertaken in person, with either the patient travelling to the practitioner or the practitioner travelling to the patient. If the bill passes and this is required, WA Health will provide packages to support access for regional patients where needed.

If the bill becomes law, there will be an implementation period of at least 18 months before the Voluntary Assisted Dying Act becomes operational. This time period will enable the Department of Health, in consultation with the commonwealth, to develop appropriate administrative measures to ensure compliance with state and commonwealth laws. The training for health professionals will reflect the outcome of the ongoing consultations between the state and the commonwealth. We are confident that, as in Victoria, this issue will not compromise health professionals or prevent eligible Western Australians from accessing voluntary assisted dying.

Some members, including Hon Adele Farina, have also asked about training for health practitioners. Training will be comprehensive and will address the legislation. It will cover assessing capacity, detecting coercion, assessing patients against the eligibility criteria, best clinical practice and communication with patients about end-of-life care. Consultations will include the Department of Health; key medical, nursing and allied health stakeholders and experts; palliative care and end-of-life stakeholders and experts; cultural stakeholders and advisers; and consumer and community representatives.

The Royal Australian College of General Practitioners will be involved in the development and accreditation of the training to ensure that it is both effective and meets required standards. In addition, a submission to the Joint Select Committee on End of Life Choices, the Western Australian branch of the Royal Australian and New Zealand College of Psychiatrists noted that psychiatrists are well placed to support the upskilling of colleagues in relation to capacity assessment. The training will contain competency assessments, and a successful pass will be required for the training requirements to be met.

The bill does not require that one of the assessing doctors be a specialist in the disease. People who are terminally ill will have already consulted at least one specialist. If a GP is uncertain about the diagnosis or prognosis, they will seek further specialist input. In fact, the bill mandates that where there is uncertainty, the assessing doctors must seek a further opinion. Requiring a specialist in the disease to be an assessing doctor would be particularly onerous. That is particularly the case for regional Western Australians. This would make access very difficult if there is a limited number, if any, of such specialists in remote and regional areas, or if there is only a handful of specialists for rare diseases, for example. Of course, specialists would still provide an opinion where necessary, but would not be required to take on the role of an assessing doctor. This reflects contemporary medical practice, under which a multidisciplinary team is involved, and the care is coordinated by the GP. Further, in Australia, general practice is a medical speciality. Under the bill, assessing doctors must be either specialist doctors with at least one year’s experience as a specialist, generalist doctors with 10 years’ experience, or overseas-trained specialists who meet the requirements prescribed by the CEO of Health.

Another issue relates to the Victorian prohibition on health practitioners raising the topic of voluntary assisted dying. The bill does not prevent health practitioners from appropriately raising the issue of voluntary assisted dying. Victoria is the only jurisdiction in the world with this prohibition. The Joint Select Committee on End of Life Choices, and the Ministerial Expert Panel on Voluntary Assisted Dying, strongly recommended against prohibition. Conversations about all options at end of life is good clinical practice. That a patient is well informed is fundamental. There is no other law that imposes a restriction on a doctor discussing a lawful treatment option with a patient. It is an extraordinary measure, which is out of step with a patient’s fundamental right to know all options available to them. This is not about a medical practitioner suggesting voluntary assisted dying to a patient. It is about appropriately informing patients about their choices, consistent with professional standards. An academic review of the Victorian provisions concluded that open and honest communication between doctor and patient represents good clinical practice, and the prohibition may lead to less optimal patient outcomes.

It is anticipated that a hub-and-spoke model may work best for Western Australia as a way of balancing appropriate access with appropriate control. For example, there would be a central pharmacy service, potentially based at 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 a central ordering and storage point for approved voluntary assisted dying medications. It would also be responsible for the training and certification of authorised suppliers of voluntary assisted dying medications. The central pharmacy service would also receive prescriptions, dispense
medications and dispose of any unused medications for metropolitan patients. Regional pharmacy hubs with appropriately trained and certified pharmacists would obtain supplies of voluntary assisted dying medications from the central pharmacy service.

In relation to death certification, voluntary assisted dying will not be listed on the medical certificate, or on the public death certificate, as the cause of death. The intent of this provision is to prevent circumstances in which the information is released into the community by persons who may see the cause of death on the certificate that is provided by the medical practitioner to a person making funeral arrangements. It would not be appropriate for several communities, for cultural and faith-based reasons, for information about a patient accessing voluntary assisted dying to become more widely known. This strong sentiment was reflected through the consultation led by the ministerial expert panel and the Department of Health. Instead, when the medical practitioner reasonably believes or knows that the cause of the person’s death was the administration of a voluntary assisted dying substance in accordance with this bill, they must notify the Voluntary Assisted Dying Board of the patient’s death in writing on an approved form. The board will monitor that the correct process is being followed in each case of voluntary assisted dying and maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

In relation to the coroner, with the exception of the death of a person in care such as a prisoner or a person involuntarily detained under the Mental Health Act, a death pursuant to the voluntary assisted dying process is not automatically reportable to the coroner. The Voluntary Assisted Dying Board will provide the necessary oversight and monitoring of all deaths brought about by voluntary assisted dying. The board is able to refer any suspected contraventions of the bill to the appropriate investigative authorities, including the Western Australia Police Force and the coroner. An automatic investigation by the coroner is thus unnecessary and could cause significant distress to the person’s family. For an expected death brought about by voluntary assisted dying, it would not be appropriate to require coronial or police investigation and questioning of families for each of these deaths, unless there is a suspicion that the proper process for accessing voluntary assisted dying was not followed.

The Voluntary Assisted Dying Bill 2019 does not restrict who may refer a matter to the coroner. A death involving voluntary assisted dying may still be a reportable death if it is not in accordance with the act or suspected of not being in accordance with the act and, therefore, is reportable to the coroner for investigation. This may be reported by the medical practitioner examining the patient’s body or it may be a concern reported by a family member to the Western Australia Police Force.

Members, this is a watershed moment. It is within our power to be courageous, compassionate, decent and fair. This Voluntary Assisted Dying Bill offers a beacon of hope for those in our community who experience unnecessary suffering at end of life. It is an exemplar of safety, freedom and individual autonomy. 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. Let us have the courage and confidence to uphold freedom 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 80 per cent of Western Australians. Members, I commend the bill to the house.

The PRESIDENT: Members, before I put the vote, I am going to say that this debate has been conducted in a very calm and respectful manner and I want to acknowledge that. I hope that continues as we deal with the vote that we are about to have.

Division

Question put and a division taken with the following result —

Ayes (25)

Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Tim Clifford
Hon Alanna Clohesy
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Adele Farina
Hon Colin Holt
Hon Alannah MacTiernan
Hon Kyle McGinn
Hon Martin Peitchard
Hon Samantha Rowe
Hon Robin Scott
Hon Aaron Stonehouse
Hon Matthew Swinbourn
Hon Dr Sally Talbot
Hon Darren West
Hon Alison Xamon
Hon Pierre Yang (Teller)

Noes (10)

Hon Peter Collier
Hon Donna Faragher
Hon Nick Goiran
Hon Rick Mazza
Hon Michael Mischin
Hon Simon O’Brien
Hon Ken Baston (Teller)
Hon Charles Smith
Hon Dr Steve Thomas
Hon Colin Tincknell

Question thus passed.

Bill read a second time.

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Committee

The Chair of Committees (Hon Simon O’Brien) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 1: Short title —

The CHAIR: Order, members. We are considering the Voluntary Assisted Dying Bill 2019, 139–1. I draw your attention to supplementary notice paper 139, issue 2, of today’s date, Wednesday, 23 October 2019, which contains a number of proposed amendments that we will come to in due course. I also draw members’ attention to a Legislative Council procedural note for members, number 1 of 2011. Members may wish to peruse that procedural note to refresh their memory about what a clause 1 debate is and what it is not. In particular, I draw members’ attention to the remarks of a previous Chairman of Committees, Hon Barry House, on 16 October 1996 when he pointed out to the chamber—and I again point out to the chamber, for those of you who were not here in 1996—

The short title debate does no more than give members the opportunity to range over the clauses of the Bill, foreshadow amendments and indicate, consistent with the policy of the Bill, how its formal content may be improved. It is not a vehicle for continuing debate on policy; rather, if members do not wish the Bill to proceed, the action they should follow is to vote to defeat clause 1 of the Bill as it stands.

With all that in mind, members, my proposition is that it is the will of the Committee of the Whole that my purpose is to facilitate the proceedings of the chamber through this stage—no more, no less. I will be upholding the rulings of previous chairmen of committees, particularly in respect of a clause 1 debate, just so we can keep it focused and this chamber can function as it should—sentiments with which I am sure everyone will agree. With that in mind, I will not be allowing too much carte blanche in respect of the clause 1 debate. To give members an example of what I have seen from time to time, if someone gets up during the clause 1 debate and says, “Look, I’ve got some concerns about clause 127”, that is fine. What is not fine is for them to then say, “But while I’m on my feet, I may as well ask the minister now anyway.” I will sit you down and say, “We will come to clause 127 in due course.”

I say that up-front now, and these will be the standards that the deputy chairmen of committee will be following also. I make that clear now so that nobody thinks they are being limited improperly or anything like that, I would hope. With all that in mind, we come to clause 1, “Short title”.

Hon NICK GOIRAN: Minister, what is a “voluntary assisted substance”?

Hon STEPHEN DAWSON: Under the definitions on page 8, the bill states —

voluntary assisted dying substance has the meaning given in section 7(2);

Proposed section 7(2) states —

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

The CHAIR: Hon Nick Goiran, who is addressing clause 1, of course, not clause 7.

Hon NICK GOIRAN: Minister, that was not my question. I asked: what is a “voluntary assisted substance”?

Hon STEPHEN DAWSON: I am advised that that is a clerical error that has already been picked up by the Parliamentary Counsel’s Office and will be fixed up at a later stage.

Hon NICK GOIRAN: The minister is saying that there is an error. Is the government intending to move an amendment?

Hon STEPHEN DAWSON: I am advised that it is a technical amendment, so it does not require the government to move an amendment. It will be fixed up as part of the process once the bill has passed this place.

Hon NICK GOIRAN: Minister, on whose advice is that the case?

Hon STEPHEN DAWSON: I am advised that it is on the Parliamentary Counsel’s advice.

Hon NICK GOIRAN: With all due respect, minister, to the Parliamentary Counsel, it is not up to it to decide what the Clerk of the Parliament will or will not amend. Standing orders deal with clerical amendments. It is not for the Parliamentary Counsel to determine these things. Has advice been sought by the Clerk of the Parliament as to whether he is able to make the amendment that the government now recognises is an error in the bill?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: The minister has sought the advice of the Clerk of the Parliament and he has agreed that he can make an amendment to the bill for this phrase “voluntary assisted substance”. Can the minister confirm that that was the case and the date upon which that advice was obtained?

Hon STEPHEN DAWSON: Yes, I am advised that advice was sought by the PCO from the Clerk. It should say “voluntary assisted dying substance”, but the advice from the Clerk was that it could be fixed and an amendment was not needed. I do not have the information as to what date that advice was sought, but I am well aware that the clause 1 debate may well take us through this evening, so I will be able to provide the answer to that tomorrow.

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Hon NICK GOIRAN: We will most certainly take that up later. Minister, what other errors have been identified in the bill?

Hon STEPHEN DAWSON: My advisers tell me that we have not noticed any other errors in the bill.

Hon NICK GOIRAN: Minister, in the debate in the other place, the Premier on 5 September said —

I understand the sentiments behind the proposed amendment … 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 with doctors, the health department and the like. 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.

Minister, is the government intending to move any amendments in light of the Premier’s remarks on 5 September 2019?

Hon STEPHEN DAWSON: I am advised that the government will not be moving any amendments to the bill.

Hon NICK GOIRAN: That is interesting because during the second reading debate at least one member indicated that the government would be moving some amendments, so clearly there has been some communication. I understood that the Minister for Health indicated that some amendments would be moved. I certainly look forward to exploring that further. If it is the case that the minister has misled one of the members of this place, no doubt that member will want to take that up further. At least for the time being, I think it is clear that the government says that there is no need for any amendments. It has not identified any errors. It alleges that one error can be addressed by clerical amendment and, apparently, according to the minister, we will consider that tomorrow, once he has obtained the date of the advice that he obtained from the Clerk of the house.

I turn to the 20 amendments that were moved in the other place. The Premier indicated that there would be some consultation with doctors, the health department and the like on those amendments. I am not too sure what he meant by “the like”, but in any event, has there been consultation with doctors, the health department and the like on the 20 amendments that were moved in the other place?

Hon STEPHEN DAWSON: I am advised that all of those amendments have been the subject of consultation, certainly with the health department. I am also aware that conversations have taken place with the AMA in relation to amendments generally.

Hon NICK GOIRAN: I do not want to hear about consultation with people generally. We will only make good progress if we are specific. I am asking about the 20 amendments that were put in the other place. The government knows precisely what those 20 amendments were. I would like to know who the government has consulted in respect of those 20 amendments. I ask the minister to take a moment to work out when the consultation took place with respect to each and every one of those 20 amendments.

Hon STEPHEN DAWSON: It is preposterous to take a moment to go through information that I do not have before me. As I said, conversations have taken place with the health department in relation to the amendments that were proposed in the other place and numerous conversations have taken place.

Hon NICK GOIRAN: I do not want to hear about consultation with people generally. We will only make good progress if we are specific. I am asking about the 20 amendments that were put in the other place. The government knows precisely what those 20 amendments were. I would like to know who the government has consulted in respect of those 20 amendments. I ask the minister to take a moment to work out when the consultation took place with respect to each and every one of those 20 amendments.

Hon STEPHEN DAWSON: It is preposterous to take a moment to go through information that I do not have before me. As I said, conversations have taken place with the health department in relation to the amendments that were proposed in the other place and numerous conversations have taken place.

Hon MARTIN PRITCHARD: I am finding it very hard to hear the minister, and it is very important. I apologise for raising it but I cannot hear.

The CHAIR: Minister, perhaps if you could project a little more, that might accommodate Hon Martin Pritchard. It is a full chamber, and that restricts us a little. I thank members, too, for keeping their conversations down. Have another go, minister.

Hon STEPHEN DAWSON: Thank you for your guidance, Mr Chairman. Certainly I will speak as loudly as I can. Often in this place I am told that I speak too loudly, so it is interesting to be told that I am not speaking loudly enough this evening.

As I was saying, conversations have taken place with the health department and the WA branch of the Australian Medical Association about amendments moved in the other place. I note that the amendments that were moved in the other place were, indeed, moved in that place and it is for this place to decide whether members in this place should be moving amendments to the bill that is before us.

Hon MARTIN PRITCHARD: I want to follow on in a similar manner. I just supported the second reading of the bill, which I was happy to do. However, that does not mean that I am particularly enamoured of all the drafting within the bill. The question I would like to ask has been asked before, but I want to ask it in a slightly different way. I understand that the minister is not proposing to move any amendments, but it has been put to me during consultations outside this chamber that any amendment, no matter how small, would make the bill fundamentally unworkable. Could the minister confirm whether he holds that same view or whether amendments that may improve the bill or at least satisfy some of our concerns would be acceptable? I make that point with regard to the first amendment that I will move, which is quite minor. Would that amendment be unacceptable on the basis that it would make the bill unworkable?

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The CHAIR: Without debating the issue of the amendment, if the minister wants to provide a general response, that is consistent with the clause 1 debate.

Hon STEPHEN DAWSON: Thank you, Mr Chair. I am not aware of those statements having been made. Any amendment would have to be considered on the basis of that amendment, and we would make a decision at that stage, depending on what the amendment is, as to the effect it might have on the bill and its implementation in the future.

Hon MARTIN PRITCHARD: Just for clarification, it was not a member of the government who made that comment; it was someone outside the chamber who suggested that any amendment should be rejected on the basis that it would have unintended consequences. Is the government open to amendments so long as they are not directed at making the bill unworkable, even if they will not necessarily improve the bill but will satisfy some of the concerns that have been raised in this chamber?

Hon STEPHEN DAWSON: Honourable member, we are dealing with the clause 1 debate. At this stage, there are no amendments before us. I am not in a position to say yes or no to any amendment until any debate happens at a particular clause.

Hon JIM CHOWN: Obviously, medical practitioners are integral to the process of voluntary assisted dying, as stated in the bill. St John of God Health Care has six hospitals in this state. It is a well-known and well-respected institution that has hospitals in Bunbury, Geraldton, Midland, Mt Lawley, Murdoch and Subiaco. They are part of our health system. St John of God Health Care has medical practitioner by-laws on healthcare requirements that medical practitioners have to abide by. I am wondering how the Voluntary Assisted Dying Bill will be able to be upheld and complied with, certainly in regional areas, especially when we understand that St John of God Health Care employs 71 per cent of Western Australia’s doctors.

Hon STEPHEN DAWSON: Faith-based hospitals are obviously able to object to participating in the voluntary assisted dying process for any reason, including but not limited to conscientious objection. There are faith-based organisations in operation in Victoria, including in regional Victoria, and the scheme is able to operate in that state. These questions are for the implementation phase of the scheme, if I can call it that. I alluded to this in my second reading reply: if this bill passes Parliament, there will be an approximately 18-month implementation phase during which all these issues will be worked out. I cannot confirm or deny the figure the honourable member used; that is, that 71 per cent of doctors work for that organisation —

Hon Jim Chown: Either wholly or partially, yes.

Hon STEPHEN DAWSON: I am not aware of that, so I cannot comment on that. We are confident that regardless of faith-based organisations and their opposition to voluntary assisted dying, voluntary assisted dying can operate in Western Australia and in regional Western Australia, and there is a commitment to ensuring that regional Western Australians can access voluntary assisted dying.

Hon JIM CHOWN: Thank you for that, minister. Seventy-one per cent is a large percentage of doctors in this state who are partially or wholly employed by St John of God Health Care. According to its 2017–18 annual report, it employs about 2 500 doctors, and they have signed St John’s by-law arrangement and agreement that they will not participate in such things as sterilisation, termination of pregnancy, or physician-assisted suicide and euthanasia. If we take 71 per cent of this state’s qualified medical practitioners and specialists out of the equation, we are left with a very small number of doctors who are able to assist or give advice in regard to the bill before us today. Regional Western Australia, as I said during a motion earlier today, has a large number—almost 60 per cent of overseas-trained doctors, who actually do not understand the processes and are challenged culturally in the words of the English language. This concerns me greatly, minister, even though I supported the second reading of this bill. The minister’s response to date has not been adequate, in my opinion, in how the state is going to implement the Voluntary Assisted Dying Bill, when only about 30 per cent of doctors across the whole state of Western Australia are free to do so.

Hon STEPHEN DAWSON: The honourable member is, of course, entitled to his opinion and to express his views; obviously he has expressed those. This bill has been drafted in full awareness of the challenges faced by regional Western Australians. It seeks to enhance accessibility through the inclusion of nurse practitioners and provisions for the appropriate use of technology, when appropriate.

In my second reading reply, I also alluded to the fact that the voluntary assisted dying scheme in Western Australia will be similar to that in Oregon in terms of the numbers—0.4 per cent of deaths in Oregon relate to voluntary assisted dying. We anticipate a similar number in Western Australia. We are talking about, I guess, fewer than 150 people accessing voluntary assisted dying annually. Of course, there are thousands of doctors in Western Australia. I am well aware that not all doctors will participate in this, but during the implementation phase it is our intention to work closely with regional stakeholders such as the WA Country Health Service, 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.

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Hon JIM CHOWN: The minister is still not answering the question to my satisfaction. I am a supporter of this bill. My concern is that if we take out 70 per cent of trained doctors, especially in regional Western Australia, we will be left with a very small cohort that people can access.

I will read to the minister part of St John of God Health Care’s by-laws, which very clearly state —

the Medical Practitioner has provided Health Care Services (whether at SJGHC or elsewhere) in a manner that demonstrates a lack of commitment to SJGHC’s Mission …

I have already outlined that mission statement. In effect, these doctors, 70 per cent of whom are actually working at St John’s, would put their employment in jeopardy under the provisions of the by-laws that they sign up to if they addressed voluntary assisted dying or helped somebody to accomplish that outcome. The minister has already stated that the government will not put through any amendments on this bill, which I find most disturbing. The Legislative Council can put through amendments that would override St John’s by-laws and put it in black-letter law.

Hon KYLE McGINN: In respect to the implementation stage, I raised Indigenous navigators in my contribution to the second reading debate and I notice that the minister touched on that in his second reading response. I want to understand further what that will look like with respect to each area. Who will be guiding that conversation? Will all Indigenous stakeholders be invited?

Hon STEPHEN DAWSON: Honourable member, it is intended that during the 18-month implementation period there will be extensive and detailed work done with Aboriginal communities and health services. The implementation phase will enable the development of appropriate models of cultural, spiritual and practical support for Aboriginal people and their families who choose to seek information about or access to voluntary assisted dying. The Department of Health will build on the consultation already undertaken by the ministerial expert panel and work closely with a range of stakeholders, including the Aboriginal Health Council of Western Australia, Aboriginal health services, the WA Country Health Service, other health services and the WA Primary Health Alliance. As recommended by the Aboriginal Health Council of WA in its submission to the ministerial expert panel, the navigator program will be planned, designed and implemented in a culturally appropriate way, and suitable training and ongoing support will be provided to care navigators. Community awareness and communication programs about voluntary assisted dying will also be developed to ensure that everyone in the community, including Aboriginal people, has accurate and appropriate information about this choice. That is our intention and, certainly, the detail of that will be fleshed out during that 18-month implementation phase. The commitment is to work in partnership with Aboriginal organisations to make this work culturally for those people.

Hon KYLE McGINN: I appreciate that, minister. I suppose there has been some commentary outside of these walls on the navigator role pushing people through the process, which is not the intent of what I have said and I believe not the intent of the government’s response. Correct me if I am wrong, but the navigator role is there to ensure that people understand the process they are going through, as the minister said, culturally as well. It is simply to ensure that people do not misunderstand the process and fall through a gap. I want to clarify that the intent is to assist people who want to go through the process, not to coerce people into the process.

Hon STEPHEN DAWSON: That is certainly the intent, honourable member. As was alluded to in the second reading phase of the bill, Aboriginal people are not a homogenous group. We will certainly ensure that several different approaches are developed to ensure that needs are met across different Aboriginal communities, because what may work in one community may not work in another. Indeed, what may work with one family group may not work with another. For some people, care navigation may be provided by Aboriginal health services or health workers in their community. In other circumstances, dependent on the patient’s preference, or when services or workers in the community are not able to provide a care navigator service, other options will be made available. Those options need to be developed in collaboration and consultation with Aboriginal communities to ensure that the patient and the family receive culturally appropriate support. It is about providing an option. It is certainly not about pushing people.

The CHAIR: A number of members are seeking the call and, one way or another, everyone will get a go. We can stay here for as long as you like. Members are deferring to Hon Kyle McGinn.

Hon KYLE McGINN: That gives me some peace of mind. One of the key things that seems could happen is that people will come from another area, having completed cultural competency courses—someone from Perth, for example—and that is deemed to be appropriate culturally out in areas such as communities, of which there are plenty in my electorate. I want to know that these discussions will be based around ensuring that they are as local and close to culturally appropriate as possible, rather than just saying that someone who is culturally competent will be brought from Perth to fill a gap. If there is a gap in people being able to fill the navigator role locally, will the government ensure training is done to ensure that the most appropriate and culturally respectful person in that area will be able to perform that role?

Hon STEPHEN DAWSON: We are certainly committed to ensuring that culturally appropriate services are available to people who want to access this scheme. Some people, including Aboriginal people, may not want to access services locally and indeed may not want to have local people providing assistance or helping them navigate...
the process. It is a difficult area. We cannot say we absolutely will give people a local person to help them get through the process because some people might not want that. Our commitment is to make sure that during that implementation phase we work through all options to ensure that the service provided is appropriate for the people in that community who want to access the service.

Hon PETER COLLIER: I did not intend to talk at this early stage of the proceedings, but I picked up on something the minister said about amendments. Can I clarify something? I did not support the second reading, but I respect the will of the house in that regard. I said in my contribution to the second reading debate that should the bill pass the second reading stage, I would like to do whatever I could to improve what I felt were areas of deficiency in the legislation. In the other place, the Minister for Health made it quite clear he was not going to countenance any amendments whatsoever. Some very legitimate amendments were moved in the other place. Again, that was the will of the house and I respect that. However, we have now got to this point and we are at this stage. Probably every person in this chamber has gone out and done an enormous amount of research on this legislation. As I said earlier today, this bill essentially changes the fundamental fabric and a tenet of our society, so I would like to think we can ensure that we get it right. With that in mind, I note that I have personally accessed the views of a vast array of groups in the community that are directly involved in this area and will be impacted by this legislation, as have probably most other people in this room. Can the minister clarify—I guess it is a simple yes or no answer; it is up to the minister of course—that the government will not countenance any amendments whatsoever to this legislation in its transition, potentially, to the third reading?

Hon STEPHEN DAWSON: I did not say that. What I said was that there are no amendments before us at clause 1, and there are no amendments lodged in my name on any supplementary notice paper.

Hon PETER COLLIER: I am conscious of that. My question was not whether the minister is going to move any amendments. I am asking whether the government will countenance or consider any amendments, or is this pretty much a fruitless exercise, as far as the government is concerned?

Hon STEPHEN DAWSON: I think we will take each clause as it comes and we will consider whatever is put before us at each clause.

Hon PETER COLLIER: Without divulging too much here, I have been led to believe that some considerations have been put to the Minister for Health and he has been quite receptive to that. With all due respect to the minister, I will take him at his word, and of course the minister in his representative capacity will do likewise. Is the minister aware of whether the Minister for Health is considering any amendments to the legislation at this stage?

Hon STEPHEN DAWSON: I understand that conversations are taking place between, I think, members of this place and the minister’s office, and indeed outside organisations and the minister’s office, but I say again that there are no amendments at clause 1, and if amendments are moved by honourable members in this place as we progress through the bill, they will be considered at that time.

Hon PETER COLLIER: I am mildly comforted by that. I know that the minister cannot say too much at this stage. Suffice to say, I was a little perturbed at what I thought I heard, which I obviously heard incorrectly, which was that no amendments would be countenanced, because, as I said, that is certainly contrary to what I have been informed and what I would like to think will occur.

Hon Stephen Dawson: That was not what I said.

Hon PETER COLLIER: That is great. I cannot go out there now and say that the government is not going to countenance any amendments, because what will happen, as I understand it, as with any piece of legislation, is that if amendments are put on the supplementary notice paper, the government will consider those amendments and will not flatly reject them.

Hon Stephen Dawson: Amendments will be considered on their merit.

Hon PETER COLLIER: And not flatly rejected?

Hon Stephen Dawson: No.

Hon MARTIN ALDRIDGE: Clause 9 of the bill refers to the conscientious objection of a health practitioner. I do not want to ask this specifically about clause 9, but do any provisions in the bill relate to institutional objection? While the minister is considering that, I want to put to the minister my concern about the way in which the private sector has become more involved in the delivery of health care in our country. We have a number of public hospitals that are run by private entities; namely Peel Health Campus, Joondalup Health Campus and Midland Public Hospital, as well as, for example, the palliative care unit run by St John of God Health Care in Geraldton. Are there any provisions within the bill that provide for institutions to object to their participation in the regime? I understand, for example, that public–private hospitals have a contractual protection that prevents them from being forced to provide services such as termination services, but when those contracts were executed it was not anticipated that a regime like this would come into play; therefore, they are not specifically protected by their contract with the state from being obliged to provide these services.
Hon STEPHEN DAWSON: No, there are no clauses in the bill that relate to institutional objection, if I can call it that, as the bill is directed towards practitioners and not institutions.

Hon MARTIN ALDRIDGE: A situation could arise, then, in which a practitioner working for a private operator is willing to participate in the voluntary assisted dying regime, but the institution objects to such participation, or a circumstance in which the state requires an institution, by enforcing a contract, to participate in the regime. Are those two scenarios possible, as the bill stands, and how does the government intend to deal with those situations?

Hon STEPHEN DAWSON: Clause 113 gives legal protection for a person acting in accordance with the legislation.

Hon MARTIN PRITCHARD: The minister said in his second reading response that, if this bill were to pass, he believed that it would be best practice for the doctor to be able to discuss a range of treatment options, including voluntary assisted dying. I want to confirm that there is nothing in the bill that requires a doctor to raise this with their patient.

Hon STEPHEN DAWSON: There is no obligation in the bill for a doctor to raise this with their patient, but I am advised, bearing in mind that I am not a doctor, that good clinical practice would be that a doctor would discuss a range of options in relation to a person’s health with the patient.

Hon MARTIN PRITCHARD: Given the issue raised by Hon Jim Chown, and adding to that doctors with their own conscientious objection, or doctors who just do not wish to be involved, it would seem to me, on the surface, that there may be many doctors who will not raise voluntary assisted dying with their patients, even if the bill is passed. Does the department have some plan to make people aware of their entitlement to access voluntary assisted dying?

Hon STEPHEN DAWSON: Although there is no obligation, for the successful implementation of this bill there will need to be a high level of community awareness. The department is adept at advising the community and communicating with the community about any such changes, as it does with other services or changes to its policy. Should this bill pass, we anticipate that we will work with the various professional organisations, whether they be the Australian Medical Association or the royal colleges, to advise people of the legislation. Obviously, there is no obligation, and the member is correct—there may well be hundreds, if not thousands, of doctors in Western Australia who may not want to participate in voluntary assisted dying; that is their right, and they are entitled to have a conscientious objection. There will also be hundreds, if not thousands, of doctors in Western Australia who will want to provide this option to their patients, or at least have conversations with their patients that this option is available, bearing in mind that we anticipate the number of people who may well access such a scheme would be around 150. We are confident that even though many doctors may object, there will be others who will participate, and we are confident that the Department of Health will be able to alert the community and ensure that there is a high level of awareness of voluntary assisted dying, should the bill pass.

Hon MARTIN PRITCHARD: I raised that matter because when I had discussions with people from the department about an amendment, which I will not go into, regarding doctors not being restricted from raising voluntary assisted dying, the argument that was put to me was that people may not be aware of it—for instance, people in faith-based hostels and such. I would be quite interested to know what sort of public awareness campaign the department will run now and into the future. I would have thought that this topic would be well known to most people in the community at the moment, but it might not be so well known in the future. I would be interested to know about the plans the department has for such awareness programs.

Hon STEPHEN DAWSON: We have not considered this issue in detail. The same processes would be followed as are followed with any other policy that Health is involved in. We will also learn from the work that has been undertaken in places like Victoria on how they have advised the community in that state. The member is correct: I suspect that there is a heightened level of awareness of this issue in the community at the moment based on this debate. However, it is certainly the government’s intention that the Department of Health ensures that there is a high level of awareness of the policy if the bill passes.

Hon MARTIN PRITCHARD: I will not labour the point, but it does seem that if the department is confident that there will be an ongoing program of awareness, opposition to my amendment concerning doctors being restricted from raising the issue should not be so heightened. If there is a general awareness of voluntary assisted dying, one would imagine that a patient would be aware of it and could raise the issue. Of course, nothing in my amendment would restrict a doctor from having a discussion with their patient; it is just a restriction on them raising it in the first instance. I am not asking for a comment. We can deal with that when we get to my amendment.

Hon NICK GOIRAN: The minister has not responded to my earlier questions; we will get back to that in a minute. However, in the interim, there has been some interesting discussion between the minister and members. In particular, I note that in response to Hon Jim Chown, the minister mentioned, I think, in accordance with my notes, that the government anticipates 0.4 per cent of deaths will be due to voluntary assisted dying, and it says so on the basis of data from Oregon. Can the minister confirm that is the case?

Hon STEPHEN DAWSON: I certainly did allude to Oregon, where a similar scheme is in operation and where the figure for those accessing voluntary assisted dying is approximately 0.4 per cent. But we have to be careful,
because the scheme in Oregon is different from the scheme in Western Australia, and the landscape is different too. However, we anticipate the figure to be around that same number. It would be very inaccurate to say at this stage that we could arrive at an evidence-based estimation of the number of deaths in this state that will be attributable to voluntary assisted dying. When we use an international jurisdiction on a comparative basis, there will be many varying factors, such as differences in eligibility criteria, cultural and geographic characteristics and healthcare systems. That makes it very difficult to make an accurate prediction. Certainly, the statistics from Oregon could be used to widely infer that number, given that its eligibility criteria are most similar to those proposed for WA.

**Hon NICK GOIRAN:** The minister has said that the Oregon scheme is similar but different. What are the differences?

**Hon STEPHEN DAWSON:** Oregon is different from Western Australia; the culture is different, the geography is different and the health system is different. Certainly, the 0.4 per cent rate is from Oregon. In my second reading reply, I mentioned the rate of four per cent in the Netherlands, which has a very different voluntary dying process from the one outlined in this bill. We believe that our scheme is closer to that in Oregon than it is to the one in the Netherlands. The rate of 0.4 per cent is the one that we are using as a comparative basis.

**Hon NICK GOIRAN:** The minister has indicated that the differences are in culture, geography and health, but how is the scheme in Oregon different from the scheme that the government proposes for Western Australia?

**Hon STEPHEN DAWSON:** I draw the member’s attention to the final report of the Ministerial Expert Panel on Voluntary Assisted Dying. Appendix 5 relates to voluntary assisted dying in other jurisdictions. Pages 132 to 135 list the differences between the schemes in Victoria, Canada, Oregon, Washington State, Vermont, California, Belgium and the Netherlands. The differences are listed there.

**Hon NICK GOIRAN:** No, minister; that is unacceptable. My question was: what are the differences between the Oregon scheme and the Western Australian scheme? There is no point in referring me to the ministerial expert panel’s report when we both know that the ministerial expert panel did not have a copy of the bill when it prepared the final report. I go back to my original question: what are the differences between the Oregon scheme and the Western Australian scheme?

**Hon STEPHEN DAWSON:** I am advised that the key difference is with self-administration. The Oregon laws require self-administration. There would be other minor differences, but the key one would be the self-administration issue.

**Hon NICK GOIRAN:** What period of time is required in Oregon for the prognosis of death?

**Hon STEPHEN DAWSON:** It is six months.

**Hon NICK GOIRAN:** What is the period of time under the Western Australian scheme?

**Hon STEPHEN DAWSON:** It is six months, or 12 months for a neurodegenerative disease.

**Hon NICK GOIRAN:** Is 12 months for a neurodegenerative disease a minor difference?

**Hon STEPHEN DAWSON:** With the greatest of respect, we are talking about the Western Australian legislation that is before us now. I indicated that the main difference relates to self-administration. I also suggested that there were other differences between the two bills. We are dealing with the Western Australian legislation, not the Oregon legislation. The member may point out a range of differences in that legislation or, indeed, legislation in other states or jurisdictions around the world. There are differences, of course, but the legislation that we are dealing with this evening is the Western Australian legislation. I would urge us all to focus on the legislation before us.

**Hon NICK GOIRAN:** The minister introduced the Oregon scheme this evening—not me. In response to Hon Jim Chown, the minister indicated that the WA government anticipates that 0.4 per cent of deaths in our state would result from the bill that is before the chamber that the government has introduced and that the minister has responsibility for in this place, and he based that on the Oregon data. I did not introduce that concept; the minister introduced it under clause 1 in response to a question from Hon Jim Chown. I am testing the veracity of the minister’s statement that the government anticipates that 0.4 per cent of deaths would result from this bill. So far, the minister has indicated to me that there are some differences in the scheme. The minister has indicated that self-administration is one, and I will get to that in a moment. The second thing he said is that there are other minor differences. It is interesting that the criteria being extended from a six to 12-month terminal prognosis is something that the minister and his government would describe as minor, or merely a matter of categorisation. I would have thought that was a major difference between the Oregon scheme and the Western Australian scheme, because, quite plainly, we are going to have an extra cohort of individuals who would not qualify under the Oregon scheme because they have a prognosis of more than six months to death. Nevertheless, the minister indicated that self-administration is one of the key differences. I take that to mean that practitioner administration is not permissible under the Oregon scheme. Can the minister clarify that?

**Hon STEPHEN DAWSON:** It is permissible when the patient is unable to physically administer.

**Hon NICK GOIRAN:** How many deaths occur annually in Oregon as a result of practitioner administration?
Hon STEPHEN DAWSON: I beg the member’s pardon; I have misled the chamber there. In Oregon, a doctor cannot administer. The only option is for people to self-administer.

Hon NICK GOIRAN: I thank the minister for the correction. Practitioner administration is not permitted under the Oregon scheme. Would it be permissible under the Western Australian scheme; and, if so, under which clause?

Hon STEPHEN DAWSON: It is under clause 58.

Hon NICK GOIRAN: What number of deaths does the government anticipate would arise under clause 58?

Hon STEPHEN DAWSON: What number of deaths does the government anticipate under clause 58?

Hon NICK GOIRAN: What number of deaths does the government anticipate would arise under clause 58?

Hon STEPHEN DAWSON: We do not have a figure, and it would be inaccurate at this stage to say that we could arrive at an evidence-based estimation of deaths attributable to this category of voluntary assisted dying in this state. Again, I make the point that it is difficult to use international jurisdictions as a comparative basis, because there is a great number of varying factors such as differences in eligibility criteria, cultural and geographic characteristics and healthcare systems. Therefore, it is very difficult to make an accurate prediction. What I suggested is that the scheme in Oregon is most similar, or certainly the eligibility criteria in Oregon are certainly most similar, to the scheme that is proposed for Western Australia, but obviously there are differences. Some widely inferred numbers have been given for Western Australia, but I am not aware; I cannot give this chamber a number. It would be very difficult for anybody to accurately suggest or project the number of people who may access voluntary assisted dying in this state.

Hon NICK GOIRAN: What is the government’s anticipated additional number of deaths as a result of its decision to extend, in certain circumstances, the period of time for death from six months to 12 months?

Hon STEPHEN DAWSON: We cannot anticipate that.

Hon MARTIN PRITCHARD: I did not wish to interrupt the honourable member, but I thought some other members might want some answers. I am interested in the skills required in order for a general practitioner to be a coordinating practitioner. Clause 25(1) provides that the coordinating practitioner is able to refer. It states —

Subsection (2) applies if the coordinating practitioner is unable to determine whether …

It then lists a number of things for which the coordinating practitioner is able to refer to another practitioner. Is there anything other than skill or training —when it says “unable”—that the minister would contemplate?

The DEPUTY CHAIR (Hon Dr Steve Thomas): Honourable member, I just bring your attention to the comments that were made by Hon Simon O’Brien a little earlier that debate on specific clauses must for the most part be restricted to those specific clauses. I will allow you a little bit of leeway at the start, but if you are going to delve into specific clauses in detail, I will ask you to hold that debate until we get to those specific clauses, unless you are looking at a more general debate early on.

Hon MARTIN PRITCHARD: I am. I have a concern about what skills general practitioners will bring to this. It affects a number of areas within the bill. I am just trying to determine whether I can be satisfied that for referring it, I will not necessarily need to move my proposed amendments.

The DEPUTY CHAIR: I am going to cut you a little slack at the beginning of the process.

Hon MARTIN PRITCHARD: Thank you very much.

The DEPUTY CHAIR: The minister is yet to reply.

Hon STEPHEN DAWSON: Sorry, member. I am not clear on the question.

Hon MARTIN PRITCHARD: I believe that the reason a general practitioner would refer to somebody else— I would say a specialist, but it may be another person equally as able—is that they do not have the appropriate skill or training. I want to confirm whether that is the only reason for which a referral would be made.

Hon STEPHEN DAWSON: Another reason would be if they were unable to do it—if they would be unavailable, essentially, at that time and place; so, in that case, they could refer.

Hon MARTIN PRITCHARD: Would it not invalidate them from being a coordinating practitioner if they could not fulfil those requirements?

Hon STEPHEN DAWSON: I will answer that question in this way, honourable member, bearing in mind clause 25: general practice is a speciality in which the person is considered as a whole—body, mind and spirit—in the context of their family and community. Specialists in a particular disease may prognosticate about the disease, but it is the GP who considers this information in the context of the whole person and the likely comorbidities that impact on their prognosis, and is better placed to be an assessor in the context of VAD. The referral clauses in the bill, clauses 25 and 36, enshrine good clinical practice into legislation. This requirement ensures that the quality of the assessment is not compromised. It is well within a medical practitioner’s current scope and practice to make a referral when they feel there is a need to do so in a particular case.

Extracted from finalised Hansard
Hon MARTIN PRITCHARD: Clause 25(4) states —

> if the coordinating practitioner makes a referral under subsection (2) or (3), the coordinating practitioner may adopt the determination …

I want to know why it is “may” and not “will”.

Hon STEPHEN DAWSON: With the greatest respect, I am happy to answer the honourable member’s questions at clause 25. This essentially refers to amendments that he has on the notice paper at clause 25. Given the detail he is requesting about clause 25, I prefer that the issue be dealt with then.

The DEPUTY CHAIR: Hon Martin Pritchard, taking that on board, if you have a more general question, I will accept it.

Hon MARTIN PRITCHARD: As a correction, I think my amendment is at clause 16, which comes before clause 25. If I were satisfied at clause 25, I would not necessarily need to move my amendment at clause 16. That is the reason I raised it. I am happy if the minister is happy for me to raise the amendments, even if they are not required.

Hon STEPHEN DAWSON: I am advised that it is not appropriate to require that the coordinating practitioner must adopt the determination of the assessing practitioner. It is the assessing practitioner who must make the final determination on consideration of all materials before him or her, and to require otherwise would be to set aside good clinical practice.

Hon MARTIN PRITCHARD: I understand that. Clause 28(3)(i) states —

> if the patient was referred under section 25(2) or (3), the outcome of the referral;

Would it not be more accurate to say “outcome of all referrals”?

Hon STEPHEN DAWSON: I am sorry; we are still discussing the last point. Can the honourable member ask that again?

Hon MARTIN PRITCHARD: Keeping in mind that I think the minister’s response is that the general practitioner is best placed to take in all the information—a number of referrals possibly—it is my understanding that they have to report those to the board. Would it be more appropriate if clause 28(3)(i) said, “if the patient was referred under section 25(2) or (3), the outcome of all referrals;”? Would that be more accurate?

Hon STEPHEN DAWSON: I am told that the “outcome of the referral” encompasses everything because it refers to sections 25(2) and (3).

Hon RICK MAZZA: I have a few questions about the safety aspects of this bill. It has been much heralded that this will be a very safe procedure. My understanding is that there will be a coordinating medical practitioner and a consulting medical practitioner, and a contact person can be appointed by the patient, who can acquire the prescribed substance from an authorised supplier. From what I can understand, the contact person can then take that home to the patient. Can the minister explain how that will be monitored? I would imagine that the substance will be sitting around the patient’s home. If the patient changes their mind, what is there to prevent coercion by the contact person? Will the contact person be able to be a family member or somebody who may benefit financially from the person’s passing? I would like to get a general sense of how this bill will provide safety around those matters.

Hon STEPHEN DAWSON: Clause 64 sets out how the patient is to appoint a contact person. A patient who is the subject of a self-administration decision must appoint a person as their contact person. The appointment of a contact person only places a new responsibility on a person who consents to undertaking the role. The role of the contact person is set out under clause 66. The intent of appointing a contact person is to ensure that once supplied, a voluntary assisted dying substance can be monitored and safely retrieved and disposed of if unused or there is any remaining. Clearly identifying who will be responsible for returning the unused substance to the authorised disposer will be another safeguard in the process of accessing VAD in this state. In agreeing to take on the role, the contact person agrees to take on the responsibility for any voluntary assisted dying substance that is unused when the person dies. The contact person must return any unused or remaining substance within 14 days after the day of the patient’s death. The contact person must also inform the coordinating practitioner if the person dies, and provides a clear contact point for the VAD board.

I refer to eligibility requirements of the contact person. The bill sets out that the contact person must be at least 18 years of age and may be the patient’s coordinating or consulting practitioner or another registered health practitioner. The patient is able to choose a family member or another person to be their contact person as long as they are 18 years old. In practice, the contact person will need to be a person who maintains close involvement with the patient to enable them to effectively undertake the role. It is likely that the contact person will be a close and trusted carer, family member or friend of the patient and will have been involved in discussions with the coordinating practitioner and the pharmacist, including instructions about storing the voluntary assisted dying substance in a safe manner. The coordinating practitioner has an important role to play in guiding the patient through the process. From that perspective, it is reasonable to expect that they would want to make sure that the

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participate in this process, so I will answer it that way. Organisations may, on various grounds, object to. I do not think that provides any protection for those organisations.

Hon MARTIN ALDRIDGE: We do not believe it is in the patient’s best interests to force any faith-based organisation, hospital or otherwise, to do anything under the legislation. The state’s best interests are in ensuring that the individual gets the best care. It may not be in that person’s best interests to force anyone to do anything. I am not sure if this is where the member is going, but in terms of future contracts, when a contract with St John of God Health Care or another institution expires, would the state seek to renegotiate or not sign again, based on voluntary assisted dying? I cannot answer that question. Certainly, under this legislation, individuals can conscientiously object. Faith-based hospitals are able to object to participating in the processes for any reason, including, but not limited to, conscientious objection. Faith-based hospitals are able to object to participation in voluntary assisted dying. I cited examples such as a public–private hospital and the potential for the state government to enforce an existing contract; or, indeed, what happens when it comes to the renewal or execution of an option under a new contract. As I understand it, there are no protections in the bill for an institution to object; it is centred around the health practitioner. I want to understand the view of the state government on private organisations or companies providing public services.

Hon STEPHEN DAWSON: There is no reference to institutions in the bill because institutions are not obliged to do anything under the legislation. The state’s best interests are in ensuring that the individual gets the best care. It may not be in that person’s best interests to force anyone to do anything. I am not sure if this is where the member is going, but in terms of future contracts, when a contract with St John of God Health Care or another institution expires, would the state seek to renegotiate or not sign again, based on voluntary assisted dying? I cannot answer that question. Certainly, under this legislation, individuals can conscientiously object. Faith-based hospitals are able to object to participating in the processes for any reason, including, but not limited to, conscientious objection. But the bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of individuals and organisations that do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility. That may be the case, for example, for a person who is living in a nursing home that is run by a faith-based institution. There may well be a requirement for that patient to be transferred to a hospital, a home or somewhere else to enable them to access voluntary assisted dying. But in relation to future contracts, I am not in a position to answer yes or no, contracts will be negotiated, renegotiated or not signed again. We anticipate that people in faith-based hospitals may want to access voluntary assisted dying upon passage of the bill, and the likelihood is that they will need to be transferred elsewhere, whether it is to a house or another facility, to enable that access to take place.

Hon MARTIN ALDRIDGE: I want to confirm what the minister has said to me. Let me use St John of God Midland Public Hospital as an example, because that is the most recent one that has been done in my time. At the time, its contract specifically excluded termination services. I recall it quite well because I remember at the time, the Labor opposition made quite some noise about it in this very chamber. The hospital is not excluded from providing voluntary assisted dying services specifically under its contract. Can I take it from what the minister just told me that the state will not seek to enforce St John of God Midland from providing a voluntary assisted dying service, despite the fact that its contract does not specifically exclude it from such a provision?

Hon STEPHEN DAWSON: If I can answer it this way: it is not in the state’s interest to force any faith-based adviser or indeed anybody to participate in this process. We have allowed for the conscientious objection of doctors, and we do not believe it is in the patient’s best interests to force any faith-based organisation, hospital or otherwise, to participate in this process, so I will answer it that way.

Hon MARTIN ALDRIDGE: That reassurance is welcome, minister; that the government will not seek to exploit aspects of contracts with private organisations and may not protect them from providing services that the organisations may, on various grounds, object to. I do not think that provides any protection for those organisations.
in terms of future contractual negotiations, because from what I have heard there is certainly no guarantee that they may be discriminated against in a future contractual process by being excluded if they were to object to providing such services.

If an aged-care provider objects to having any interaction with voluntary assisted dying, would it be liable for prosecution under any civil or criminal code with respect to, say, discrimination? Is there any protection, or is there any possibility that it could be pursued if it were to object to having one of its patients participate in voluntary assisted dying?

Hon STEPHEN DAWSON: An institution cannot object to a patient participating in the voluntary assisted dying process. The likelihood is that it would not happen at that facility. It is likely that the patient would be moved to their home or to another care facility where the voluntary assisted dying process would be undertaken.

Hon NICK GOIRAN: I wish to follow up on this line of questioning by Hon Martin Aldridge. I know that another member wants to ask some questions. Eventually, I will take the minister back to those anticipated death counts.

With respect to what Hon Martin Aldridge is pursuing at the moment, I want to clarify what the minister has said. When the minister responded to Hon Jim Chown, he said that faith-based organisations can object. In response to Hon Martin Aldridge, the minister indicated that there is no need to have an institutional conscientious objection as no obligations have been imposed. Further, he indicated that, in essence, a patient wanting to access voluntary assisted dying would need to be transferred from the institution. Obviously, that transfer process requires individuals to do something, as the minister quite rightly pointed out. It is not like the institution or the organisation itself can uplift the person and transfer them; it requires individuals within the institutions to do things. I will give the minister a practical example. What happens if the individuals within the institution have grave concerns that the person is being coerced, which I know this government does not want to occur and is why it is one of the principles in the bill? What capacity does the institution have to address those concerns or is it simply obliged to transfer the patient?

Hon STEPHEN DAWSON: The facility could tell the coordinating doctor of its concerns. It could approach the VAD board with its concerns. If it reasonably suspects that coercion is taking place, it could also report that to the police.

In relation to the transfer, I am advised that the transfer is a necessity of good clinical practice.

Hon NICK GOIRAN: The minister says that the individuals within the institution can approach the VAD board or the police, and, of course, that relates to my example of a patient requesting a transfer but the individuals within the institution are concerned that there has been coercion. What can the VAD board do in those circumstances?

Hon STEPHEN DAWSON: I am told the board can alert the coordinating doctor. The board can look into the case, it can alert the CEO of the department and it can also advise the police. Those options are all available.

Hon JIM CHOWN: I would like to go back to the statement I made some time ago on faith-based institutions employing by far the majority of doctors in this state—almost three-quarters of them—and their protection from liability under the bill. Hon Martin Aldridge addressed the issue, but I do not think the minister has actually responded to the question to my satisfaction.

Hon Stephen Dawson: Honourable member, I do not have the figures in front of me in relation to that.

Hon JIM CHOWN: My figures are derived from the Australian Medical Association, so I assume they are correct.

Hon Stephen Dawson: Is the member suggesting 71 per cent of doctors in Western Australia are employed by —

Hon JIM CHOWN: They are employed either wholly or partially.

Hon Stephen Dawson: I actually think you are wrong.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Minister, take your seat for a minute. I am going to give the call to one person at a time. Hold on, Hon Jim Chown. Unless the interjection is taken, I am going to let Hon Jim Chown finish what he is saying. Minister, I will give you a chance after that.

Hon JIM CHOWN: Let us settle on something like a majority or a large proportion of doctors in this state are employed by faith-based organisations.

Hon Stephen Dawson: Ask the question. I can’t even agree to that.

Hon JIM CHOWN: What protection is available in this bill for the future contractual arrangements of these doctors if they implement a VAD consultation or VAD itself? How will they be protected from not being re-employed under future contracts? I refer the minister to a press release of 2012, some time ago, about a doctor at St John of God Health Care who became unemployed when he breached the contractual arrangements under its by-laws by carrying out a vasectomy, which is a lawful operation. What protection is there in this bill for medical practitioners who are employed by faith-based organisations when their contractual arrangements come up for renewal?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: That issue really is outside the scope of this bill. Clause 113, “Protections for persons acting in accordance with the Act”, states —

(1) This section applies if a person, in good faith, does a thing —

(a) in accordance with this Act; or
(b) believing on reasonable grounds that the thing is done in accordance with this Act.

(2) The person does not incur any civil liability, or any criminal liability under this Act, for doing the thing.

(3) The doing of the thing is not to be regarded as —

(a) a breach of professional ethics or standards or any principles of conduct applicable to the person’s employment; or
(b) professional misconduct or unprofessional conduct.

That relates to someone in a contract. Nothing in the bill precludes an organisation from not renewing an expired contract based on their actions, but that is really outside the bill. I cannot give the member industrial relations advice on whether that person may have a case to go to the Western Australian Industrial Relations Commission or the Fair Work Commission, depending on what area they are working in, but certainly for someone who is employed, clause 113 answers that question.

Hon JIM CHOWN: Surely, this is a deficit in this bill, because in reality, this bill will not work unless we have medical practitioners who are able to carry out the recommendations and the process in the bill. The minister was in the house earlier today when we had a motion on health in regional Western Australia, and we understand that this state is likely to have a decline in the number of general practitioners especially. The minister is saying the government has not addressed in the bill contractual arrangements with faith-based organisations when they come up for renewal. These are doctors with families and mortgages et cetera. Does the minister really think that in order to exercise the voluntary assisted dying process, they will jeopardise their future, their profession and their income without some protection in regard to their contractual arrangements at some stage in the future? If my figure from the Australian Medical Association is correct and these faith-based institutions employ 71 per cent of the state’s doctors, we have a serious issue in that the bill is deficient on this matter. Whether it is 71 per cent or 40 per cent, it is still an issue that needs to be addressed.

Hon Alannah MacTiernan: How would you address it, member?

Hon JIM CHOWN: I am not talking to you.

Several members interjected.

The DEPUTY CHAIR: Order, members!

Hon Peter Collier interjected.

The DEPUTY CHAIR: Order! The minister has the call.

Hon STEPHEN DAWSON: Members, the debate has been civil thus far, so it is probably good to keep it at that level.

Hon Jim Chown: I did not interject.

Hon STEPHEN DAWSON: I am just generally suggesting that we should keep it civil. I am happy to answer the member’s question. This is an important debate, as we would all agree. In response to the member’s question about the 71 per cent, my advice is that I am not able to get a guaranteed number of how many doctors work for St John of God hospitals in Western Australia, but certainly the annual report states that there are 2839 accredited doctors. We do not know whether this is FTE or headcount or whether doctors are registered at more than one hospital.

Hon Jim Chown: It is a large number.

Hon STEPHEN DAWSON: I am aware from the medical board that there are approximately 11 000 doctors registered in WA and about 6 500 are generalists or specialists. The figure would be much less than that 71 per cent.

Hon Jim Chown: I am happy to accept that, but 2 800 is a large cohort.

Hon STEPHEN DAWSON: I am happy, for the purposes of debate, to seek that information and provide it at a later stage so that it is on the record. In relation to doctors who have a contract, I have read from clause 113, which refers to protections for persons acting in accordance with the act.

Hon Jim Chown: Is that clause 113?

Hon STEPHEN DAWSON: Yes. My reading of that is that it is for people who have a contract. There is nothing in this legislation to make that organisation employ people who have a different ethos from that institution. Nothing in the legislation provides that upon the cessation of a contract, there is a protection to ensure that that person needs to be re-employed or given a new contract. Obviously, from time to time, contracts expire and organisations do not renew them. Certainly for those who are employed, there is a protection in there and clause 113(3) alludes to that.

Extracted from finalised Hansard
As I said, I am happy to get those numbers for the member and provide them at a later stage. I do not believe that the bill warrants an amendment to do what the member is suggesting. Hundreds and probably thousands of doctors will not want to participate in voluntary assisted dying in Western Australia, and many will conscientiously object. Others will participate and, upon the passage of this bill, the Department of Health is committed to working with those professional organisations in the implementation phase to talk to doctors, to train doctors and to encourage more doctors to participate in this bill. Certainly, others can object, if they so want to.

Hon STEPHEN DAWSON: I have no amendments, and any government amendments would be in my name.

Hon NICK GOIRAN: Further to this line of questioning from Hon Peter Collier, does the government have in its possession drafts of any amendments?

Hon PETER COLLIER: I am following on from the point that I raised earlier about potential amendments—I am speculating, I guess, to a degree—and following on from Hon Jim Chown. If I can play the devil’s advocate, let me say that the bill goes through the committee stage and some amendments get the approval of the chamber. We come out of committee, the report is adopted, and the third reading is then approved. At this stage, thinking pragmatically, if we go full hog at this—it will take a fair amount of time in the committee stage, I would imagine—the Legislative Council will sit beyond the Legislative Assembly. Will the Legislative Assembly return and accept any amendments that are approved by this chamber?

Hon STEPHEN DAWSON: Honourable member, I cannot answer that question. If there is a need for the Legislative Assembly to return following the passage of this bill, I am sure the Legislative Assembly will, but I am not in a position to countenance or second-guess what amendments may pass this place. If the Assembly needed to sit again post the passage of the bill, I am sure the Assembly would sit.

Hon PETER COLLIER: I will just finish on this, and the minister does not need to respond. I raise that point because based upon the comments of Hon Jim Chown, there will be a considerable amount of appraisal of this legislation, and so there should be; that is what I said in my second reading contribution. It is very important that we give this legislation the scrutiny and respect that it deserves.

With that in mind, as I said earlier, I am at pains to point out that I am disappointed that the government did not countenance any amendments in the other place. I think it would have been in the better interests of not only the legislation, but also the government having a more seamless process for this piece of legislation had it considered some very legitimate amendments in the other place. Having said that, we cannot unscramble an egg, so we are here now on the assumption that potentially there will be amendments. We heard ad infinitum from the Premier, along with some other somewhat intemperate comments, that he wants this legislation passed by Christmas. I will accept the will of this chamber, as I have done with the second reading, and that of the other place, but I will be very disappointed if we go to all that trouble and the bill comes out at the other end with amendments based upon the will of this chamber only to find that the Premier then says, “Sorry, but we’re not coming back until February”, because that would put paid to the sincerity of getting this piece of legislation through. That is fine; I take the minister at his word.

Hon PETER COLLIER: That is correct—to consider the amendments. If it does not accept them, of course, it is game on again.

Hon NICK GOIRAN: Further to this line of questioning from Hon Peter Collier, does the government have in its possession drafts of any amendments?

Hon STEPHEN DAWSON: I have no amendments, and any government amendments would be in my name. I have no amendments to this bill. There are not any at this stage. Could there be? As I said earlier, we will deal with the bill on a clause-by-clause basis and we will deal with each amendment at that time as well.

Extracted from finalised Hansard
Hon NICK GOIRAN: Minister, let us be clear: the government does not have in its possession any draft amendments. I am not asking whether the minister has amendments on the supplementary notice paper. I can read; I can see that there are none in his name. I am asking whether there are any draft amendments in the possession of anybody in government. I am not asking whether there are any in the name of this minister; I am asking whether there are any in the possession of government. The minister must know whether parliamentary counsel has been briefed on any amendments.

Several members interjected.

Hon NICK GOIRAN: With all due respect, Leader of the House, you do not have carriage of this bill, so I suggest you stay out of it!

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, please direct your comments to the Chair, not to other members in the chamber.

Hon STEPHEN DAWSON: I have the same answer: I do not have any amendments to this bill.

Hon Nick Goiran: That was not my question.

Hon STEPHEN DAWSON: That is the answer I am giving the member. I do not have any amendments to this bill. Any amendments to this bill that would be moved by the government would be in my name. No amendments have been provided to me, if they do exist.

Hon NICK GOIRAN: The minister has advisers at his disposal. He can also defer and ask for a recess to get this information. It is important for the chamber; if we are to range over possible amendments on clause 1, we need to know what the government is up to. I do not know whether any of the minister’s advisers have any role within the Parliamentary Counsel’s Office. I am simply making the observation that it is impossible for the government not to know whether it has briefed parliamentary counsel on amendments. I know that the minister does not have any in his name. I am simply asking him a very basic question. Has the government briefed parliamentary counsel on any amendments to this bill?

Hon STEPHEN DAWSON: The government has had conversations with parliamentary counsel about amendments that have been foreshadowed by the Australian Medical Association and others. Conversations have happened, but I am not at liberty to suggest what those amendments are and I do not have any amendments.

Hon NICK GOIRAN: The minister said that there have been conversations with Parliamentary Counsel. Does the government have any draft amendments in its possession as a result of those conversations?

The DEPUTY CHAIR: Member, you have asked that question four times, to my recollection. The standing orders of this chamber refer to tedious repetition. It is tedious repetition to ask the same question four times, with the minister answering the question but not giving you the answer that you want. Perhaps you might rephrase the question and not ask it in that manner. Of course, the minister is entitled to answer if he chooses.

Hon NICK GOIRAN: Mr Deputy Chair, I am happy for Hansard to be checked. The question that I have just asked the minister I have never asked before this evening. I simply asked if the government has in its possession any draft amendments as a result of the conversations that we have just learnt for the first time that the government has had with Parliamentary Counsel. I am asking whether any draft amendments have been provided to government as a result of those conversations.

Hon STEPHEN DAWSON: I am advised that the government has some draft amendments in its possession. It is beginning to discuss those draft amendments with interested members.

Hon NICK GOIRAN: Will the minister table those draft amendments?

Hon STEPHEN DAWSON: No. I do not have the draft amendments, but, no, I will not table them. I have been told that they are being discussed with interested members.

Hon AARON STONEHOUSE: I have a couple of questions on the interaction with the Medicines and Poisons Act. Before I get to that, I would like to reflect on the conversation that seemed to lead towards discussion around compelling organisations to continue their contracts with medical practitioners who offer voluntary assisted dying, and a concern raised by Hon Jim Chown about the accessibility of voluntary assisted dying, if there are no protections for practitioners who offer such a thing to have their contracts renewed. I might just express my concern. I raised in my second reading contribution the importance of protecting conscientious objectors, which I think this bill does somewhat well, although it is deficient in other areas. I have an amendment to address that, but we can discuss that at a later time when we get to that clause. On protections for conscientious objectors, I bring to members’ attention clause 4(1)(j) under division 2. This principle of this legislation is stated as —

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

I feel that applies not only to frontline practitioners who may be conscientious objectors to voluntary assisted dying, but also to the organisations that employ those practitioners, such as faith-based private hospitals.

Extracted from finalised Hansard
I think it is important that we do not lose sight of that. As I said in my second reading contribution, we cannot extend freedom to one class of people at the expense of another. Freedom should be applied broadly to all people. We should not be in the business of compelling people with strongly held moral objections to voluntary assisted dying to participate in a scheme that is counter to their own moral values. With that said, I wonder whether the minister could advise about the interaction with the Medicines and Poisons Act. Earlier, Hon Rick Mazza gave a scenario in which a patient who had been given a voluntary assisted dying substance did not use all of that substance. What measures are in place to recover that substance? How would recovery of that substance be done? Will the bill grant any powers to the Voluntary Assisted Dying Board to recover such a substance?

Hon STEPHEN DAWSON: I thank the member. Disposal of unused medication will be controlled and reported back to the board; that is in clauses 75 and 77. For self-administered voluntary assisted dying medications, the proposed electronic approval and notification system will show when any unused medication is disposed of by the authorised disposer when it is received from the contact person. The board will receive the authorised disposal form from the authorised disposer. For any unused practitioner-administered voluntary assisted dying medications, the proposed electronic approval and notification system will identify any unused voluntary assisted dying medications that have been disposed of by the administering practitioner, and the board will receive the practitioner disposal form.

In relation to the return of medication, I want to make the point that it should be noted that no evidence of misuse associated with voluntary assisted dying medication has been found elsewhere in the world. A person undertakes to adhere to certain obligations when they consent to taking on the role of contact person. If the contact person were to retain the prescribed substance or mislead authorities about how much was used, they would be in breach of the requirements of clause 104 of the bill. Both the contact person and the patient’s agent will also be subject to very strict laws, including under the Medicines and Poisons Act 2014 and the Misuse of Drugs Act 1981, that relate to unauthorised possession of drugs and poison.

In relation to the return of medication by others, under the bill, the contact person, not the patient or agent, will be legally required to give the authorised disposer any prescribed substance that is unused or remains. There will be nothing to stop the patient from returning it to an authorised disposer, but the contact person will be the person responsible under the act and will bear the responsibility.

Hon AARON STONEHOUSE: Can the minister point me to the offences in the bill—if they exist—for refusing to dispose of either a practitioner-administered or self-administered voluntary assisted dying substance?

Hon STEPHEN DAWSON: It is in clause 104, “Contact person to give unused or remaining substance to authorised disposer”. The penalty for an offence under subclause (1) is imprisonment for 12 months.

Hon MARTIN PRITCHARD: I want to turn the minister’s mind to clause 6 and the concept of decision-making capacity. I must say that I have a different view with regard to decision-making capacity. It seems that this clause talks more about understanding. I can imagine a doctor saying, “Do you understand that if you take this poison, you are going to die?”; and the person says that yes, they understand.

I note also that at clause 9(2), a person is not excised from the use of voluntary assisted dying just for the sake of having a mental illness. With regard to a patient having a mental illness that impacts on their decision to access VAD, how is it coped with in the bill?

Hon STEPHEN DAWSON: A person who has a disability or a mental health condition would still be eligible for voluntary assisted dying as long as they met all the eligibility criteria, including decision-making capacity. Having a disability or mental health condition does not exclude someone from accessing voluntary assisted dying, but they are not able to access voluntary assisted dying only on the basis of disability or mental illness, and that is in clause 15(2).

Hon MARTIN PRITCHARD: I understand the two concepts, but I am saying that a person may end up with clinical depression, obviously because they have just been told they have six months to live. I am concerned because the bill seems to suggest that decision-making capacity is understanding, and I understand that. What part of the bill would require the two medical practitioners to determine whether a decision is impacted upon by a mental illness or depression, for instance?

Hon STEPHEN DAWSON: When the coordinating practitioner cannot determine whether the patient’s disease, illness or medical condition meets the eligibility criteria or whether the patient has decision-making capacity in relation to voluntary assisted dying under the eligibility criteria, the coordinating practitioner must refer the patient to a registered health practitioner with the appropriate skills and training to make that determination. The appropriate registered health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate.

The DEPUTY CHAIR: Minister, sorry to interrupt you, but I think the member might be struggling to hear a little bit. Perhaps a bit more audibly would be helpful.

Hon STEPHEN DAWSON: Let us do that again.

Hon Martin Pritchard: No; I — Extracted from finalised Hansard
Hon STEPHEN DAWSON: I would be grateful if perhaps someone in the chamber could make sure the microphones are turned up.

If the coordinating practitioner cannot determine whether the patient’s disease, illness or medical condition meets the eligibility criteria or whether the patient has decision-making capacity in relation to voluntary assisted dying under the eligibility criteria, the coordinating practitioner must refer the patient to a registered health practitioner with the appropriate skills and training to make that determination. The appropriate registered health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate. If the concern is decline due to ageing, a geriatrician may be preferable. The ability to refer the patient to a specialist is consistent with the joint select committee’s legislation framework.

Hon MARTIN PRITCHARD: If I understand the minister correctly, there will be two main bases for referral—I am not trying to limit it. One is whether the practitioner can determine whether the underlying illness meets the criteria. The other is whether the patient has decision-making capacity. I am inferring that decision-making capacity is about understanding. A person may have decision-making capacity as referred to in the bill, but still have a mental illness that can impact on the decision. What the minister suggested—that is, sending the patient to a psychiatrist if there is a mental illness—may not be a bad thing, but I cannot see that under the two prescribed reasons the minister indicated. One is about the illness and the other is about decision-making capacity. I do not think the decision-making capacity, as stated in the bill, has anything to do with mental illness. I would be happy if I were wrong.

Hon STEPHEN DAWSON: Clause 6 of the bill refers to decision-making capacity. It states—

(1) In this section—

voluntary assisted dying decision means—

(a) a request for access to voluntary assisted dying; or
(b) a decision to access voluntary assisted dying.

(2) 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—

(a) understand any information or advice about a voluntary assisted dying decision that is required under this Act to be provided to the patient; and
(b) understand the matters involved in a voluntary assisted dying decision; and
(c) understand the effect of a voluntary assisted dying decision; and
(d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purposes of making a voluntary assisted dying decision; …

Hon MARTIN PRITCHARD: Is the minister indicating that paragraph (d) is the one?

Hon Stephen Dawson: Paragraph (d) is the one.

Hon JIM CHOWN: I have just been checking some figures in my previous statement about employment and faith-based institutions. The St John of God Health Care annual report 2017–18 states that it fully or partially employs 2,500 doctors. That includes general practitioners and specialists. The Department of Health’s “General practice workforce supply and training in Western Australia” report from 2018 states that our general practitioner ratio in this state is 81.5 per 100,000 people. We have a population of 2.72 million people in the state, so 2,216 GPs are employed in Western Australia, excluding specialists. I believe my statement about the 71 per cent is pretty close to the number of doctors employed by faith-based health institutions. I would be happy to have this figure corrected by the volume of people in the health department. If that is the case, there is a massive fault in this bill with having VAD exercised by medical professionals across the breadth and width of this state. The minister cannot tell me that a professional doctor employed by a faith-based institution, regardless of those who object to voluntary assisted dying, would jeopardise their future employment without some indemnity in this field to allow them to do so—to exercise VAD. My question is: how is the government going to address this?

Hon STEPHEN DAWSON: As I said, honourable member, I do not propose to move an amendment on this issue. In relation to the member’s earlier comments about the numbers, as I have indicated to the member, I still have a difference of opinion in relation to the numbers and that 71 per cent figure. As I indicated to the member previously—I again make this commitment—I have committed to seeking advice on the numbers and placing them on the record, but I still believe the member’s figure of 71 per cent is inaccurate. Nonetheless, that is a moot point. There will be a significant number of doctors in Western Australia who are employed by faith-based institutions. I have already pointed to clause 113 of the bill, which talks about protection for those who are employed and who have contracts. I do not propose to move an amendment in relation to those whose contracts cease and the agency, for whatever reason, does not employ them again.

Extracted from finalised Hansard
Hon AARON STONEHOUSE: I have some more questions around the interaction with the Medicines and Poisons Act, if it is not unruly to ask them now, as I am not sure where they appear in the bill, or whether they appear in the bill at all, but it seems to be relevant. What is the normal penalty for someone in possession of a schedule 8 poison without otherwise having some exemption?

Hon STEPHEN DAWSON: I am advised that the penalty is a fine of $45 000 and imprisonment for three years. Those penalties are under the general penalties in section 115 of the Medicines and Poisons Act 2014. The offence falls under section 14(4) of the Medicines and Poisons Act 2014, but the penalties are a fine of $45 000 and imprisonment for three years.

Hon AARON STONEHOUSE: Can the minister clarify whether someone who fails to return a voluntary assisted dying substance within the 14-day window, as is outlined in proposed section 104 of the Voluntary Assisted Dying Bill, would be liable for prosecution by the CEO for 12 months’ imprisonment? Would they also be liable to penalties under the Medicines and Poisons Act? Is that correct?

Hon STEPHEN DAWSON: For possession, the penalty of a fine of $45 000 and three years’ imprisonment is the same.

Hon AARON STONEHOUSE: All right. What I am getting at is a scenario in which someone is in possession of a VAD substance and they exceed the standard 14-day window to return the substance to an authorised disposer. They would be in breach of the penalty in proposed section 104 of the VAD bill and also in breach of the Medicines and Poisons Act; therefore, they would be liable to both penalties. Is that correct?

Hon STEPHEN DAWSON: It can be both.

Hon AARON STONEHOUSE: It can be both, assuming there is not some defence or other circumstance that might exempt them from the penalties of the MPA. Under the VAD bill, the CEO can commence prosecution. The CEO is responsible for the enforcement of the penalties under proposed section 104. Who is responsible for the enforcement of the MPA? That would be the Department of Health, but would it be the CEO, or is there some other delegated sub-agent or authority that would be responsible for enforcing the provisions of the MPA?

Hon STEPHEN DAWSON: It is the CEO and any person he authorises.

Hon AARON STONEHOUSE: It is the same person, at least, and they can apply those penalties when they think appropriate. Are there powers in either the VAD bill or the Medicines and Poisons Act that facilitate the recovery of a schedule 8 poison such as the VAD substance? There are penalties for being in possession, but what powers exist to allow the CEO to investigate someone in possession of a VAD substance? For instance, someone has a substance and they fail to return it. It turns out that, maybe, they sold it or gave it away or lost it—who knows? Is it now a matter for the police, or does that still rest with the CEO of the Department of Health?

Hon STEPHEN DAWSON: Part 7 of the Voluntary Assisted Dying Bill relates to enforcement. It sets out the application of the Medicines and Poisons Act 2014 and factors relating to the enforcement of this issue. I am told that the MP act enables police or investigators appointed by the CEO to investigate, and they also have powers of seizure.

Hon AARON STONEHOUSE: I might have some more detailed questions around how that will work at a later stage. If there is a concern that someone lawfully in possession of a VAD substance, with their prescription and exemption, may be misusing that substance—giving it away, selling it, cutting it or whatever—will the board be empowered to notify the CEO to recover that substance, assuming that it is within that 14-day period and there is no obligation on them to dispose of the substance but concerns are raised that they have acquired a substance, they do not intend to use it, they may be misusing it or they may intend to use it for some nefarious purpose or who knows what?

Hon STEPHEN DAWSON: The board has the power to advise the CEO and the police. The likelihood is that the board would refer the issue to the police.

Hon RICK MAZZA: I want to pick up on a couple of questions asked by Hon Martin Pritchard around mental capacity and the eligibility criteria. I gathered from the minister’s answer earlier that three parts of the clause on decision-making capacity had to be met—paragraphs (a), (b) and (c)—but the patient also had to be able to weigh up those factors. There is a whole list of things under the eligibility criteria—the patient has to be over 18 years of age and a permanent resident of Australia et cetera. One of those criterion is that they have to have decision-making capacity. Am I right in saying that if, for argument’s sake, somebody has advanced dementia and then develops another illness or disease, which means they will die in, say, six months, but the coordinating medical practitioner and consulting medical practitioner cannot establish decision-making capacity, that person will be ineligible to access VAD?

Hon STEPHEN DAWSON: The short answer is yes. Advanced dementia means that a person would likely not have capacity.

Hon RICK MAZZA: If the coordinating and consulting medical practitioners cannot establish decision-making capacity and they are concerned about the condition of this person, are they able to access a consulting psychiatric assessment to try to establish that?
Hon STEPHEN DAWSON: In that instance, they must refer a person. I want to place on the record—this probably goes back to Hon Martin Pritchard’s comment—that decision-making capacity is a different concept from mental illness. Doctors are skilled at ascertaining whether a person has decision-making capacity. It is standard clinical practice when they are ascertaining whether a person consents to treatment, and they must refer if they are uncertain. Decision-making capacity is not just about understanding; it is also about properly weighing all the options and factors to reach a decision.

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

Legislative Council

Thursday, 24 October 2019

[page 8276]

VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 23 October. The Deputy Chair of Committees (Hon Dr Steve Thomas) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 1: Short title —

Progress was reported after the clause had been partly considered.

Hon STEPHEN DAWSON: I want to follow up on the issue raised by Hon Jim Chown last night about the number of doctors employed by the St John of God group. I am advised that according to the St John of God Health Care annual report 2017–18, there are 2,839 accredited doctors attributed to Western Australian St John of God Health Care hospital sites. The report does not identify whether this figure is a headcount or the number of full-time equivalent positions; nor does it identify whether it includes double-counting doctors who work across multiple sites. Registrant data from the Medical Board of Australia reports that there are 11,829 registered medical practitioners in Western Australia, of which 1,571 hold specialist registration and a further 4,914 hold both general and specialist registration, which totals 6,485 doctors of this type. If the St John of God Health Care medical workforce figures are taken at face value, this would represent a maximum of 44 per cent, so 2,839 out of 6,485, but that may be less if the headcount is less than 2,839. That is the information on that.

Last night when we were talking about faith-based hospitals, I made the point that clause 113 protects doctors from being found of having breached principles of conduct applicable to the person’s employment. I want to state, though, the government would be deeply disappointed if health organisations discriminated against employees or contractors for undertaking what will be a lawful end-of-life treatment.

Hon NICK GOIRAN: Last night when we were considering clause 1, we had the revelation that the government has draft amendments in its possession prepared by Parliamentary Counsel. The minister indicated that he would not be willing to table them. In the absence of any information that he has provided so far today, I take it that the position remains that the government will not be tabling those amendments that it has had drafted. Can the minister indicate to the house how many of those amendments are new clauses and how many are amendments to clauses in the bill?

Hon STEPHEN DAWSON: The member is correct: it is not my intention today to table anything about possible amendments. I was further advised overnight that conversations have taken place over the past few weeks with members in this place and indeed with outside organisations about some issues that they have raised. I understand that the Australian Medical Association, for example, has prepared a document on amendments, and, of course, amendments were moved formally and informally in the other place. I understand that the Minister for Health is considering those issues and has sought advice from Parliamentary Counsel on some of them. No policy decision has been made by government on any of those amendments, so I am not at liberty to disclose what those issues are or how many there are, other than to say that conversations are taking place. We will deal with each clause and each amendment as they appear in the bill. If the amendments are to clauses 2 or 4, for example, they will be dealt with at that time.

Hon NICK GOIRAN: How many draft amendments are in the government’s possession?

Hon STEPHEN DAWSON: As I have said, I am not at liberty to disclose any amendments. I say again that I do not have any amendments, but any amendments that are brought forward will be brought forward in my name. However, I am not saying what draft amendments are around because they are draft amendments and no policy decision has been made by government on any possible amendments; therefore, I will leave that point there.

Hon NICK GOIRAN: The government has had conversations with Parliamentary Counsel. Which clauses were those conversations about?
Hon STEPHEN DAWSON: I am not disclosing, and the member would not expect disclosure of, conversations between Parliamentary Counsel —

Hon Nick Goiran: I would expect disclosure—gold-standard transparency.

Hon STEPHEN DAWSON: The transparency issue in this place relates to the supplementary notice paper. When the government has made decisions on possible amendments, they will appear on the supplementary notice paper. That is as transparent as this Parliament requires. That is normal practice. If per chance the government decides to move forward with any amendment, it will appear on the supplementary notice paper at that time, and every member of this place can get a copy of that, as indeed can outside organisations.

Hon NICK GOIRAN: The problem I have with the minister’s response is twofold. Firstly, I am trying to get amendments drafted by Parliamentary Counsel at the moment and I have not had all my amendments drafted. It is no wonder that I cannot get all my work done if the government is hogging the time of Parliamentary Counsel; and even though it has done that, it will not let us know which clauses it has a problem with. This is supposed to be a respectful debate. It needs to be an honest debate. It should be a transparent debate. If the government has decided to hog the time of Parliamentary Counsel and invest the time of those legal practitioners in drafting amendments for government, that is fine—it is quite at liberty to do that; that is quite normal. The minister is quite right; that is normal practice. But as there is a conscience vote on this bill, and members are expected to cast their vote in accordance with their conscience, with no party position, I do not think it is appropriate for some members to have an advantage over others.

I will quote from yesterday’s uncorrected proof. My question was: will the minister table those draft amendments? The minister can tell me whether this is wrong, but according to the uncorrected proof, he said —

No. I do not have the draft amendments, but, no, I will not table them. I have been told that they are being discussed with interested members.

I am an interested member. I want to know what these amendments are. I suspect that more members in this place are interested members. There certainly has been no discussion with me. The minister says that that is being transparent. I give him a score of zero out of 10 on transparency on this issue.

I have a range of other questions, obviously, as the minister can imagine, but I am asking him to take this issue on board. Now is not the time to discuss it, because he will not be able to get instructions from the Minister for Health, but I ask him to have a conversation with the health minister certainly during the next adjournment and see whether he is willing to release these draft amendments. If he is not willing to table them, that is fine. I am asking for an indication of which clauses the government is sufficiently concerned about that it has invested the time of Parliamentary Counsel. If there are some new clauses, we need to know about them now. If the amendments are to particular clauses, we need to know now before we can proceed properly.

Hon STEPHEN DAWSON: I say again for the record that when a policy decision is made on amendments to this bill, those amendments will appear on the supplementary notice paper. Generally, at that stage, members in this house will be advised of them. There is no intention to make any amendments, draft or otherwise, available to anybody other than through that process. The member can keep asking all he wants, but that is the decision; that is the policy.

Hon Donna Faragher: Who are the members?

Hon STEPHEN DAWSON: People in the other place have raised ideas about amendments. It is inappropriate.

Hon Donna Faragher: It is appropriate.

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and again he indicated that he did not know what the quantum of those deaths was anticipated to be. If the rate is 0.4 per cent in Oregon without the extended prognosis period and without practitioner administration, is it reasonable for us to infer at this point that the number of deaths will be higher in Western Australia than it is in Oregon?

**Hon STEPHEN DAWSON:** I will say this again and I did say it last night: it would be inaccurate at this stage to say that WA could arrive at an evidence-based estimation of deaths attributable to voluntary assisted dying in this state. We simply do not know.

**Hon NICK GOIRAN:** If the minister simply does not know, why did he say to Hon Jim Chown last night that it was 0.4 per cent?

**Hon STEPHEN DAWSON:** Last night I gave a number of qualifications in relation to that figure. We used international jurisdictions as a comparative basis, but, quite simply, we cannot give an accurate estimation and I will not give an estimation.

**Hon NICK GOIRAN:** The minister says that he has used international jurisdictions as a comparator. I recall that last night he referred to the rate of four per cent in the Netherlands. Why has the government ruled out four per cent as a rate and is more comfortable referring to the 0.4 per cent rate in Oregon?

**Hon STEPHEN DAWSON:** I did in fact suggest last night that the rate could well be between 0.4 per cent and four per cent, but it would be likely to be closer to that 0.4 per cent rate based on the similarities between the schemes.

**Hon NICK GOIRAN:** What are the differences between the Western Australian scheme and the Netherlands scheme that suggest that it will not be more like the four per cent but will be more like the 0.4 per cent?

**Hon STEPHEN DAWSON:** Obviously, I will not go through every element of the Netherlands scheme, because that is not the bill that is before this chamber for consideration. Certainly the system in the Netherlands is different from the one proposed for Western Australia. That is because access to voluntary assisted dying in that country has never been limited to people at the end of their lives. A person only needs to be suffering. The Netherlands is an example of a jurisdiction with far broader eligibility criteria. Thus it is incorrect to describe the availability of euthanasia in the Netherlands for mentally unwell persons—again, this is the slippery slope issue—as eventuating as an expansion of a type of slippery slope. The Netherlands scheme is very different, because it has never been limited to people at the end of their lives. A person only needs to be suffering.

**Hon NICK GOIRAN:** That is a good explanation of the difference between the Netherlands scheme and the WA scheme with regard to the eligibility criteria. When the minister explained the difference between Oregon and Western Australia, he said originally that Oregon allows for practitioner administration. He then corrected the record and confirmed that that was not correct; it is only self-administration. What is the situation in the Netherlands? Does it allow for both self-administration and practitioner administration, or only one type?

**Hon STEPHEN DAWSON:** In the Netherlands, a physician may administer or assist in self-administration. Again, I draw this information to the attention of the honourable member, who for some reason seemed to not like the report of the Ministerial Expert Panel on Voluntary Assisted Dying. As I mentioned last night, page 137 of that report helpfully lists medical administration and suggests that a physician may administer or assist in self-administration.

**Hon NICK GOIRAN:** The only reason I was unimpressed last night was that my question at the time was around the difference between the Oregon and the Western Australian schemes. As I pointed out last night, it was pointless the minister referring me to the report of the ministerial expert panel when the panel had not even had access to the WA scheme at the time, because it had not been drafted. That raises an interesting question: when was this bill drafted by government?

**Hon STEPHEN DAWSON:** I am advised that cabinet approval to draft the bill was given at the end of November 2018. Drafting instructions gave consideration to the framework set out by the joint select committee and the Victorian bill, noting that changes would be made following consultation by the Department of Health, and through consultation led by the ministerial expert panel. Subsequent drafting instructions were given throughout the consultation process, consistent with the proper drafting processes.

**Hon NICK GOIRAN:** The minister has just revealed to the chamber that instructions to commence drafting this bill were given in November 2018. When was the ministerial expert panel formed and when was its final report released?

**Hon STEPHEN DAWSON:** Development of the bill occurred through three consultative means: the recommendations made by the Joint Select Committee on End of Life Choices in its report “My Life, My Choice” of August 2018; the Ministerial Expert Panel on Voluntary Assisted Dying in its final report of June 2019; and the Department of Health, based on comprehensive consideration of key matters outside the scope of the panel, and in consultation with key agency stakeholders. While the panel was conducting the public consultation on issues within its scope of appointment, namely matters contained within parts 1 to 3 of the bill, and concepts underpinning part 4, the Department of Health was concurrently consulting with key stakeholders and instructing on a number

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of matters outside the panel’s scope; that is, the remainder of the bill. Consultation led by Health commenced in January 2019, with agency stakeholders given the opportunity to consider a number of key policy positions throughout the process. The panel’s public consultation commenced on 19 March 2019 and ran for two months. Drafting instructions on matters reflecting the panel’s public consultation were given after the panel chair presented the panel’s final report to the Minister for Health, and following consideration by government. At this stage, six drafts of the bill setting out the other matters had already been developed. I want to note that although the panel’s recommendations informed some policy positions for the bill, the panel was not involved in providing drafting instructions for the bill. The intricacies of providing drafting instructions, and drafting, were a matter for the Department of Health’s instructing officer and the parliamentary drafter.

Hon NICK GOIRAN: Did the minister indicate when the ministerial expert panel was formed? The minister may have done, because he provided quite a lot of information just then. The minister indicated that the report was released in June 2019. When was the expert panel formed?

Hon STEPHEN DAWSON: It was around 12 November 2018.

Hon NICK GOIRAN: The minister said at one point in his response that six drafts had been prepared by that stage. I understood that to mean that by the time the ministerial expert panel released its report in June 2019, six drafts of the bill had already been prepared. Can the minister clarify whether that is the case?

Hon STEPHEN DAWSON: I understand there were six drafts of elements of the bill. I will provide some further information. Consultation draft 10 of the bill was circulated to agency stakeholders for consideration and comment. The bill was tabled in the other place on 7 August 2019, and that was draft 14.

Hon NICK GOIRAN: As I understand it, there were 14 drafts of the bill. Six drafts of parts of the bill had already been done prior to the ministerial expert panel releasing its report in June 2019. I find that very curious. Nevertheless, the minister indicated that draft 10 was a consultation draft that was circulated to people. Who are the Western Australians who were in the luxurious position of seeing a consultation draft, and when did they receive that?

Hon STEPHEN DAWSON: I am advised that they are the WA Police Force; Justice, including the State Solicitor’s Office and the Attorney General; the Director of Public Prosecutions; the State Administrative Tribunal; Health and Disability Services Complaints Office and the Office of the State Coroner.

Hon MARTIN ALDRIDGE: I would like to ask the minister about some comments made in response to my question yesterday about institutional objection. In his second reading reply, according to the uncorrected proof, he said —

Faith-based hospitals and hospices are able to object to participating in the voluntary assisted dying process for any reason, including, but not limited to, conscientious objection.

When I asked the minister questions in the Committee of the Whole, he confirmed that nothing in the bill provided for such an objection to be made. With that in mind, why was it necessary to include an objection provision for a health practitioner but not for an institution?

Hon STEPHEN DAWSON: We included the option of conscientious objection for individuals in here because we wanted to enshrine the ability of practitioners to conscientiously object.

The DEPUTY CHAIR: Members, there is some really audible conversation, and I know people are having trouble hearing the minister, so can we keep conversation down to a minimum.

Hon STEPHEN DAWSON: It is the practitioner who chooses to participate or not participate in this process; it is not the organisation they work for that chooses. It is the individual who must decide whether to participate. The hospital does not play a role in that sense. Also, it is consistent with international jurisdictions.

Hon MARTIN ALDRIDGE: The minister mentioned that it is consistent with international jurisdictions. Is it consistent with the Victorian legislation?

Hon STEPHEN DAWSON: Yes.

Hon MARTIN ALDRIDGE: Have any organisations or institutions in Western Australia expressed any concern to the government about the provisions in the bill and their right to object not being explicit within the bill?

Hon STEPHEN DAWSON: I am advised no, not to our knowledge.

Hon MARTIN ALDRIDGE: In the minister’s second reading reply yesterday, he talked about the delivery of packages. I think it was in response to overcoming telehealth or using a carriage service issue. Can he explain to me what he meant by the “delivery of packages”?

Hon STEPHEN DAWSON: This issue will be dealt with during the implementation phase but, essentially, it will likely be financial assistance for an individual to travel to a medical practitioner or it could be the opposite: financial assistance for a medical practitioner to travel to an individual.
Hon MARTIN ALDRIDGE: The minister will be aware that on four occasions thus far I have sought from the Minister for Health during question time, via the parliamentary secretary in this place, correspondence between the commonwealth and the state about concerns relating to the application of the federal Criminal Code Act to the Voluntary Assisted Dying Bill 2019. Is the minister in a position now to table that correspondence?

Hon STEPHEN DAWSON: I am not in a position to table any correspondence in relation to that issue.

Hon MARTIN ALDRIDGE: Why is the minister not in a position to table the correspondence?

Hon STEPHEN DAWSON: I understand that it was confidential communication between the commonwealth and the state and public interest immunity is attached to it.

Hon MARTIN ALDRIDGE: Can the minister tell me on what date the commonwealth first initiated—if, indeed, it did initiate it—the date on which it first expressed its concern or raised the issue with the state?

Hon STEPHEN DAWSON: I am advised that the WA Attorney General wrote to the commonwealth Attorney on 28 August 2019 in response to an email that was received by the WA health department.

Hon MARTIN ALDRIDGE: That correspondence is known to me because I think it was tabled in the other place. It was in response to a communication from the commonwealth. What was the date of that communication; was it 21 August 2019?

Hon STEPHEN DAWSON: I will have to check the date of the communication. I do not have it with me. I will provide an answer later today.

Hon MARTIN ALDRIDGE: I thank the minister for that commitment. I understand that the state has sought legal advice from the State Solicitor’s Office about using a carriage service and how that related to the Voluntary Assisted Dying Bill. Can the minister confirm whether the government has received that advice and whether it is prepared to table that advice?

Hon STEPHEN DAWSON: Yes, honourable member, advice was sought. I am not in a position to table the advice because I am advised that it is subject to legal professional privilege.

Hon MARTIN ALDRIDGE: I am certain that it is subject to legal professional privilege, minister, but is the government prepared to waive legal professional privilege to facilitate the chamber’s understanding of the application of the federal Criminal Code Act to this bill?

Hon STEPHEN DAWSON: I am not in a position to waive that.

Hon MARTIN ALDRIDGE: Can the minister provide advice to the chamber, based on the advice he has received, about the way in which the Voluntary Assisted Dying Bill 2019 will be limited by the application of the federal Criminal Code Act?

Hon STEPHEN DAWSON: Should telehealth not be able to be used as a method of communicating with people for the purposes of access to voluntary assisted dying in Western Australia, the WA Department of Health would need to adopt alternative implementation strategies. In my second reading reply, I mentioned other jurisdictions, such as Victoria, that have similar restrictions. I also made the point about Canada having geographic challenges similar to those in Western Australia.

Hon MARTIN ALDRIDGE: As I understand it, the Victorians have basically said that it all needs to be done face to face. Is there a nuance to that? For instance, if one of the two practitioners referred a patient to another physician to assist with the assessment of capacity, diagnosis or prognosis, would that necessarily be considered as being for the purposes of accessing the Voluntary Assisted Dying Bill and therefore would the prohibition that applies to a carriage service also apply to that referral?

Hon STEPHEN DAWSON: I am told that the commonwealth legislation prohibits a person from using a carriage service for suicide-related materials, including material capable of constituting a communication that directly or indirectly counsels or incites someone to commit or attempt to commit suicide, and prohibits a person from possessing, controlling, producing, supplying or obtaining suicide-related material for use on a carriage service. I am told that it will not affect the circumstance to which Hon Martin Aldridge referred.

Hon NICK GOIRAN: Following up on Hon Martin Aldridge’s line of questioning, I heard the minister say in response to Hon Martin Aldridge, “Should telehealth not be able to be used”. My ears pricked up when I heard him say that, because the language he used is very similar to what was used by the health minister in the other place two days ago. On Tuesday, 22 October, the Minister for Health made a statement in the other place. Incidentally, for reasons unknown to me, no statement was made by the parliamentary secretary representing the Minister for Health in this place.

Hon Stephen Dawson: By way of interjection, I suspect we have the same advisers, honourable member.
Hon Nick Goiran: Yes. On 22 October, the Minister for Health said —

If telehealth cannot be used as a method of communicating with people for the purposes of access to voluntary assisted dying in Western Australia, the WA Department of Health will adopt alternative implementation strategies.

The question that needs to be answered by the government is: will telehealth be able to be used?

Hon Stephen Dawson: I am advised that that matter is yet to be determined or concluded, with ongoing conversations taking place with the commonwealth about this issue.

Hon Martin Aldridge: I welcome hearing that referrals to specialist services will not be captured, in the state’s view, by the limitations of the federal Criminal Code Act, because that would certainly be a further limitation on regional and remote access. If Harry in Halls Creek is dying of cancer and rocks up at Halls Creek health campus and makes a request, would the hospital be able to use a carriage service—for example, a telephone—to call a navigator to seek assistance in navigating this process or would that be a breach of the federal Criminal Code Act?

Hon Stephen Dawson: I am advised that the patient can call the navigator themselves, but from that point on, conversations have to take place in person.

Hon Martin Aldridge: Is the minister saying that the initial contact with a navigator would not necessarily be captured by the federal Criminal Code Act but further communication thereafter has the potential to be captured? Is that what I heard the minister say?

Hon Stephen Dawson: That is exactly what I am saying.

Hon Martin Aldridge: A later clause deals with audiovisual communication, but this goes beyond audiovisual communication so I cannot defer specifically to a later clause. There is really that one phone call and after that it has to be face to face. That is a significant limitation on the state’s ability to implement an appropriate regime in Western Australia. I know that matter will be thrashed out during the implementation phase, which is why understanding the government’s advice on this matter would be very helpful. I do not understand why the minister is not prepared to waive legal professional privilege on this issue. If he did, it would really help facilitate the progress of this debate. Certainly, having read the letter from the Attorney General of this state to the Attorney-General of the commonwealth, the primary defence of the state being that this bill would not be captured by the commonwealth Criminal Code Act because the Voluntary Assisted Dying Bill states that it is not suicide; this is ill-informed and will give nobody confidence that practitioners nor patients will not find themselves falling foul of the criminal code. I would really like the minister to consider seeking some advice from the Minister for Health and the Attorney General about the extent to which he can waive privilege and table that legal advice to give us and the rest of the community some confidence on this matter.

Hon Stephen Dawson: This is an issue under consideration and is being consulted on with the commonwealth at the moment. I make the point that the state will not rely on a provision in the bill that suggests that because the legislation does not mention suicide that it will not be captured by the commonwealth act.

Hon Martin Aldridge: Maybe the minister should mention that to the Attorney General.

Hon Aaron Stonehouse: Thank you, minister, for clarifying that for us. I was very confused up until this point because not only has it been the view of the Attorney General that specifying that voluntary assisted dying is not suicide will provide some protection to practitioners, as the member mentioned just a moment ago through interjection, but also it was communicated to me during one of the briefings that I received that that is the case. It was very confusing right up until this point when the minister clarified that that is not the basis upon which we are reliant for indemnity for medical practitioners in Western Australia. I am glad to hear that it is an issue that we continue to look into. I met with representatives from the Australian Medical Association just this morning who are very concerned that practitioners who are looking to be involved in the voluntary assisted dying regime are concerned about falling foul of criminal law. I pity the poor doctor who is the first one to test this case in a federal court if the commonwealth takes a hard line on its interpretation of the Criminal Code Act and how it relates to the communication of suicide through a carrier service. Thank you for looking into that, minister. I hope that some legal advice can be revealed to us soon on how that might be addressed and dealt with.

The Chair: Hon Aaron Stonehouse, when you jump to your feet, I would like you to wait until I give you the call.

Hon Aaron Stonehouse: Sorry, Chair—my apologies.

Hon Nick Goiran: The minister has indicated in response to my question of whether telehealth will be able to be used that it is not yet determined. How is that possible? The Joint Select Committee on End of Life Choices held a 12-month inquiry into this matter and I draw to the attention of the minister term of reference 2(c) that was given to the committee by this chamber and the other place. It states —

consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation; …

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What guidance did the government take from the report of the Joint Select Committee on End of Life Choices, “My Life, My Choice”, on this issue?

Hon STEPHEN DAWSON: I am advised that we did not take advice from the report because it is not contained in the report.

Hon NICK GOIRAN: I thank the minister for his honesty and confirmation that the Joint Select Committee of End of Life Choices did not fulfil its role. The house asked it to examine any federal laws that may impact such legislation. But everyone was in such a hurry to sign off on this piece of work—“Forget about term of reference 2(c). It is only the houses of Parliament that have asked the Joint Select Committee on End of Life Choices, those eight members and the staff who were paid by the taxpayers to be on the committee, to examine any federal laws that may impact such legislation.” We have now been told by the minister who has carriage of this bill that this report is worthless on this point. People talked to me yesterday on another matter with regard to the waste of taxpayers’ money. That report was tabled in August 2018. In November 2018, the minister told us that cabinet gave instructions to draft the bill, notwithstanding the fact that the joint select committee had not done its job. But that is okay, minister, because, of course, the backstop was the Ministerial Expert Panel on Voluntary Assisted Dying. What advice did the ministerial expert panel give the minister on this point?

Hon STEPHEN DAWSON: Firstly, I want to make the point that I was certainly not suggesting that the joint select committee did not undertake its role; I place that on the record. Secondly, in relation to the member’s specific question, the ministerial expert panel was not asked to provide advice on this issue.

Hon NICK GOIRAN: That is peculiar. It is supposed to be an expert panel. Why would the government not ask it about this issue, knowing full well, as the minister has already acknowledged, that the joint select committee did not cover it. The government could not take any advice from that committee report because there was nothing in it; that is what the minister indicated earlier in his answer. Knowing that, and once it was decided to get the ministerial expert panel involved—a panel of experts—why was it not asked about it?

Hon STEPHEN DAWSON: Quite simply, it was not in the panel’s terms of reference.

Hon NICK GOIRAN: What was the job of the ministerial expert panel? If that panel of experts was not asked to look into the intersection with federal law and to address the types of problems and concerns that Hon Martin Aldridge has been prosecuting for an extensive period over many weeks and months, what was the ministerial expert panel asked to do?

Hon STEPHEN DAWSON: I draw to the honourable member’s attention appendix 2 of the final report of the Ministerial Expert Panel on Voluntary Assisted Dying. Page 113 of that document lists the panel’s terms of reference. It states —

1. **Purpose**
   The Voluntary Assisted Dying Ministerial Expert Panel … will provide advice to the WA Government to assist in the development, consultation and implementation of new legislation for Voluntary Assisted Dying in Western Australia.

2. **Background**
   As a result of the inquiry into the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices, the report of the Parliamentary Joint Select Committee … on End of Life Choices ‘My Life, My Choice’ was released in August 2018.
   The Committee made 24 recommendations. 12 of the recommendations relate to the provision of palliative care; 6 relate to advance care planning and the need for statutory recognition of Advance Health Directives; and 6 relate to voluntary assisted dying.
   Recommendations 19–24 relate to the introduction, by Government, of a legal framework for voluntary assisted dying in Western Australia. Recommendation 21 specifically recommends the establishment of a Ministerial Expert Panel … to undertake consultation and develop legislation for voluntary assisted dying in Western Australia.
   Importantly, the development and introduction of the voluntary assisted dying legislation is being progressed in parallel to the End-of-Life Care program which is designed to improve access to end-of-life and palliative care services, as well as improved policy and practice, governance, and education for health professionals and the wider community on advance care planning and Advance Health Directives.

3. **Role**
   The MEP will provide advice to government to assist in the development, consultation and implementation of new legislation for voluntary assisted dying.
   The MEP will take the findings and recommendations of the JSC report ‘My Life, My Choice’ including consideration of the recommended voluntary assisted dying framework, and consider the detail of how voluntary assisted dying legislation could be implemented safely and compassionately in Western Australia.

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As such, the MEP’s remit is to consider the ‘how’ of voluntary assisted dying, using the context of the Victorian Legislation as a starting point and proposing amendments that reflect the Joint Select Committee’s findings and recommendations and to meet the needs of the Western Australian community.

It goes on, honourable member, but the terms of reference are there and available.

**Hon Nick Goiran**: I understand the minister indicated earlier that the ministerial expert panel was in existence from 12 November 2018, and released its report in June 2019. I assume it ceased to exist after its final report. During that period, was this issue, this problem with the intersection with federal law, ever raised with the ministerial expert panel?

**Hon Stephen Dawson**: I am advised no. In relation to the member’s comment that he presumes that the expert panel finished at that time, he is correct.

**Hon Nick Goiran**: I want it to be clear: nobody, during the entire life of the ministerial expert panel, ever raised this issue about the intersection with federal law. It was never raised at a community forum, verbally by any person, with the ministerial expert panel, and it was never raised in writing in any submission—under no circumstances was it ever raised with the expert panel.

**Hon Stephen Dawson**: I am advised no, honourable member. I am also told that the commonwealth laws were enacted in relation to cyberbullying. A highly technical legal provision would require a subject matter expert to draw the relevant conclusions. The provision was not highlighted during the Victorian parliamentary inquiry or during the drafting of the Victorian bill or, indeed, in its passage through Parliament. It is fortunate that we have had the benefit of drafting the bill in the full knowledge of that highly technical commonwealth provision, though.

**Hon Nick Goiran**: We have identified that the government knew nothing about this after the “My Life, My Choice” report, and that the government, according to the minister, knew nothing about this after the ministerial expert panel report. At what point in time did the government become aware that this was a problem?

**Hon Stephen Dawson**: The issue was first brought to our attention on 26 June 2019.

**Hon Nick Goiran**: Who brought that to the government’s attention?

**Hon Stephen Dawson**: I cannot tell the member who brought it to our attention, but it was certainly brought to our attention following the publication of that information in a newspaper article.

**Hon Nick Goiran**: To be clear —

**Hon Stephen Dawson**: I suspect it was a person reading the paper and they saw it in the paper. I’m not being tricky.

**Hon Nick Goiran**: Because the minister does not know.

**Hon Stephen Dawson**: I cannot tell the member whether it was Joe Bloggs, for example.

**Hon Nick Goiran**: On 26 June 2019, someone has alerted the government to this problem and then action has been taken. It is a real shame that that Joint Select Committee on End of Life Choices did not do its job properly. It had 12 months, and the chamber asked it to look into the intersection with federal law. Would it not be interesting to see the minutes of that particular committee inquiry. Nevertheless, we are not able to do that.

**Hon Stephen Dawson**: By way of interjection —

**Hon Nick Goiran**: I do not want an interjection; I want to ask my question. I would like to make progress.

Several members interjected.

**The Deputy Chair**: Members, can we keep the noise down a little bit.

**Hon Nick Goiran**: Thank you, Mr Deputy Chairman. Through you, my question to the minister is: we know that we cannot see the secret minutes of the Joint Select Committee on End of Life Choices and we know that we cannot see the secret draft amendments that the government has, which were prepared by parliamentary counsel, but will the government release the minutes of the ministerial expert panel?

**Hon Stephen Dawson**: I am advised that there were no formal minutes of the ministerial expert panel and, therefore, there is nothing to table.

**Hon Nick Goiran**: Let us be clear about this, minister. The government assembled a group of—I am going to say it—so-called experts. I received an email recently that was seeking to correct me on my use this week of the term “so-called expert panel”. I want to clarify that. It is an expert panel as described by the government. That does not necessarily mean that it is a panel of experts. I concede that there are some experts on the panel, but to describe everybody on that panel as an expert is something that I will not do. That is the context of my earlier remarks. I know that, potentially, some people have taken offence to that and no offence was intended. I respect every individual in Western Australia, most particularly those people who provide service to the state, including the people on the Ministerial Expert Panel on Voluntary Assisted Dying. But my question in respect of this issue is that apparently there are no formal minutes. I find that very peculiar because the government has entrusted the ministerial expert

*Extracted from finalised Hansard*
Hon STEPHEN DAWSON: I am advised there was a secretariat. The panel operated under its terms of reference. There was a meeting schedule. An attendance register was kept and there was an action register. The panel ran consultations and then the outcomes were developed based on the consideration of all submissions that were received. Of course, the submissions are published on the Department of Health website.

Hon NICK GOIRAN: I make the observation that that is a rather remarkable process for a very, very important panel that has been put together by government to formulate for the first time in Western Australian history ready access to lethal injection. This is no small matter and, quite understandably, a ministerial expert panel has been put together, not the least of which is because the “My Life, My Choice” report recommended that that happen. But I find it quite remarkable that that process did not even involve the formal structure of minute taking. What was the cost to the taxpayer of the ministerial expert panel?

Hon STEPHEN DAWSON: I will have to take that question on notice. I will provide it at a later stage.

Hon NICK GOIRAN: I return to the minister’s responses to Hon Martin Aldridge. He asked whether the minister would be willing to table the correspondence, and the minister indicated that he would not, explaining that it was confidential. Later, in some exchange, it became apparent from something that Hon Martin Aldridge said that some correspondence had been tabled in the other place. Why does the government take the attitude that it is okay to table some correspondence in the other place and not in this place? Can this chamber not be treated in the same fashion as the other place? Can the minister indicate to the house what correspondence has been tabled in the other place? Can he also undertake to table that here?

Hon STEPHEN DAWSON: I think the honourable member is getting two things mixed up there. I am not in a position to table what Hon Martin Aldridge asked me to table. He referred to a letter from the Attorney General to the commonwealth that was tabled in the other place, and no-one has asked me to table that in this place. If the member is asking me whether that letter could be tabled here, I am sure it could be. In fact, I can go further. I have that letter here, and I am very happy to table it in the interests of helping the debate. I will ask that if the attendant takes this letter from me, it comes back to me before it is given to anybody else who may want to ask a question on it.

[See paper 3318.]

Hon NICK GOIRAN: I thank the minister for that. That is one piece of correspondence. Obviously, we will get a copy of that in a moment. Can the minister indicate to the house on how many occasions the government has corresponded with the commonwealth on this issue and on how many occasions the commonwealth has corresponded back to the government? I know that we are about to see one document. I am interested to know how many other documents exist.

Hon STEPHEN DAWSON: I am aware of only one letter between the Attorney General and the commonwealth. I will have to seek further advice from the Attorney General, so I cannot give that to the member now. I am happy to do that later in the day. There would certainly have been conversations between the state and the commonwealth but I am aware of only one physical letter. I will certainly take that question away and provide an answer later.

Hon NICK GOIRAN: Just to clarify something, what is the document that the minister is not willing to provide to Hon Martin Aldridge? I know that the minister has indicated that he is not prepared to table legal advice, and he explained why. I also have a view about that, which is probably similar to Hon Martin Aldridge’s view, but that is not what I am asking. He was asking for some correspondence to be tabled. It is obviously not the document that has just been tabled. What is the document that he is not willing to table?

Hon STEPHEN DAWSON: I think the honourable member was asking about any correspondence from the commonwealth and the state, and I am not in a position to table any correspondence from the commonwealth to the state.

Hon NICK GOIRAN: The minister is getting himself into difficult territory here. Let me explain. Hon Martin Aldridge asked the minister to table correspondence. The minister said no and he gave an explanation why, not because no document exists but because it is confidential. That indicates that a document exists and the minister cannot table it; he needs to keep it in his pocket because it is confidential. He is entitled to hold that view and we are entitled to hold a different view, but it indicates that a document exists. When I asked him how many documents exist,
because I know there is at least one, he said that there are no more that he is aware of. He must be aware of at least one other because there is at least this confidential document that he is not willing to table. In my mind, there has to be at least two documents.

**Hon Stephen Dawson:** It is one and the same.

**Hon NICK GOIRAN:** I will ask the minister to clarify that in a minute because it is quite confusing at the moment. There is the document that the minister just tabled. Clearly, that is not the confidential one that he was not willing to table earlier. There must be a second document in existence, which is the confidential one. I am simply asking for the minister to confirm what that document is, notwithstanding the fact that he is not willing to table it.

**Hon STEPHEN DAWSON:** The document that I understand Hon Martin Aldridge has asked to be tabled in this place is a letter from the commonwealth to the state in response to the letter I have just tabled.

**Hon MARTIN ALDRIDGE:** If I can assist, the response to the letter that the minister just tabled is already a tabled paper in this place. It is tabled paper 3272. I draw the attention of members to the second paragraph of this letter, which states —

> The Western Australian Department of Health has recently received a communication from the Attorney-General’s Department asking whether …

I have been seeking the communications between the commonwealth Attorney-General’s Department and the state Department of Health. That is the communication that has been referred to today.

**Hon STEPHEN DAWSON:** I thank the honourable member for clarifying that. I am still not in a position to table what he has asked for.

**Hon NICK GOIRAN:** Now that we have clarity on what documents are being sought, can the minister confirm that there is at least one letter from the Attorney General of Western Australia to the commonwealth Attorney-General, which is dated 28 August this year? That was tabled by the minister today. There is also a letter in response from the commonwealth Attorney-General to the state Attorney General, and that was tabled on a previous occasion. It is the tabled paper that was identified by Hon Martin Aldridge. They are the two documents that the government is aware are in existence. The government is unaware of any other document in existence at this point. Clearly, when the minister was responding earlier about a confidential document that he was not willing to table, he was thinking it was the one that was tabled. I think that Hon Martin Aldridge is entitled to an explanation of why the government will not now table communication between the Western Australian Department of Health and the Attorney-General’s Department. It cannot be because this letter is confidential because he was not talking about that at that time. He was talking about the document that he now has in front of him. Why will the government not release this information to Hon Martin Aldridge when plainly it has been happy to release information between the respective Attorneys General?

**Hon STEPHEN DAWSON:** This question relates to matters within the Attorney General’s portfolio, so I will have to seek further advice and provide an answer later today.

**Hon NICK GOIRAN:** I take the minister to the document that he tabled today, dated 28 August 2019. As Hon Martin Aldridge has just identified, it states —

> The Western Australian Department of Health has recently received a communication from the Attorney-General’s Department …

That has nothing to do with the state Attorney General’s department. It has to do with the Department of Health. At the moment, the minister is representing the health minister. It is not satisfactory to then palm this off and handball it to Hon John Quigley, who has nothing to do with this situation. Hon Martin Aldridge is asking about the Western Australian Department of Health and its interactions with the Attorney-General’s Department, and asking for that information to be provided. It seems to me very appropriate of the honourable member and it seems incumbent upon the government to provide a response.

**Hon STEPHEN DAWSON:** My answer remains the same: I have given an undertaking to seek further advice that I am not in a position to give now.

**Hon NICK GOIRAN:** Earlier the minister indicated that the first time the government was made aware of this problem with the intersection of commonwealth laws was on 26 June 2019. What steps were taken by government after 26 June 2019 to have this matter determined? I acknowledge that earlier the minister indicated that the matter has not yet been determined, a situation that I find totally unacceptable. I do not blame him for that; that is the situation that we find ourselves in. It is clear from the government that this matter has not yet been determined, but clearly steps have been taken between 26 June 2019 and today, 24 October 2019. What steps were taken by the government to determine the matter?

**Hon STEPHEN DAWSON:** I am advised that upon finding out this information, general counsel at the Department of Health liaised with the State Solicitor’s Office and the Solicitor-General on the issues. That is the action that took place once the issue was brought to our attention.

*Extracted from finalised Hansard*
Hon NICK GOIRAN: There has been some interaction with the Solicitor-General and the State Solicitor’s Office. Is that why in the fourth paragraph of the letter from the state Attorney General dated 28 August 2019, which the minister tabled earlier, the Attorney General says, “I have taken advice at the highest level”?

Hon STEPHEN DAWSON: The answer to that is yes.

Hon NICK GOIRAN: According to the letter, that advice indicates a view that communications about voluntary assisted dying via a carriage service do not contravene the commonwealth Criminal Code Act. Is that still the view of the government or is that yet to be determined?

Hon STEPHEN DAWSON: This remains the state’s view, but we are not going to rely on that. Certainly, my advisers tell me that this remains the state’s view.

Hon NICK GOIRAN: But earlier the minister said to Hon Martin Aldridge that the state is not going to rely on clause 11 of the bill, which makes it clear that voluntary assisted dying —

Hon Stephen Dawson: And that’s what I have said again. Although it remains the state’s view, we are not going to rely on that. That is because of a perception of a risk and we are not going to rely on that; hence, we had that discussion with Hon Martin Aldridge about other options.

Hon NICK GOIRAN: Perhaps this will be clearer to other members than it is to me. The position that has just been expressed by the minister is that the view of the state of Western Australia, certainly under the stewardship of the current state Attorney General, is that clause 11 of the bill makes it clear that voluntary assisted dying is not suicide and that communications about voluntary assisted dying via a carriage service do not contravene the commonwealth Criminal Code Act, but the government is not going to rely on that. What is it going to rely on?

Hon STEPHEN DAWSON: It is the view of the government, but we are engaging with the commonwealth to put the issue beyond doubt. I am advised that the issue will be settled as part of the implementation, and health practitioners will be given clear guidelines. The view is that voluntary assisted dying is not suicide. This does not mean that others will have that view. I make the point again that, as we know, commonwealth legislation always trumps state legislation, so the conversations continue with the commonwealth to put the issue beyond doubt.

Hon RICK MAZZA: I am trying to navigate my way through this. The patient can arrange through their administering practitioner or through a contact person for the lethal substance to be provided to them. If the patient has decision-making capacity, they can make the decision to either have the lethal substance administered by the administering practitioner or self-administer it. If they make the decision to end their life, is that not suicide?

Hon STEPHEN DAWSON: We do not believe it is suicide. The member has a view on suicide and he obviously has a view about this bill. We certainly believe that a person taking actions that are allowed for under this bill equals voluntary assisted dying. We do not believe that it equals suicide.

Hon RICK MAZZA: I find that a little perplexing, because my understanding has always been that if someone ends their own life, regardless of how that may occur, that is suicide. The mere fact that clause 11 says that voluntary assisted dying is not suicide is an interpretation within the bill, but it does not take away from the fact that, quite clearly, if someone ends their own life, it is suicide. That is why I find the correspondence between the Attorney General and Hon Christian Porter, MP, to be somewhat perplexing. I can understand why the state sees some risk around this and therefore is not recommending it. Would it not be better if the bill reflected what is going on; that is, if someone ends their own life, it is in fact suicide?

Hon STEPHEN DAWSON: Certainly, it is our view that suicide is completely separate to and distinct from voluntary assisted dying. Suicide generally connotes loss of life of a person who is typically not dying, 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 when they are already dying. It is a process that is requested and led entirely by the person and they are given the support and care they require at the end-of-life stage. Concern was raised in the 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; that is, it is based on personal views, including political and religious beliefs, about the ethics, morality and psychology behind the choice to take one’s life.

Hon MICHAEL MISCHIN: There seem to be a number of views about what suicide may or ought to mean, but what is the dictionary definition of “suicide”? Never mind what the government would like us to believe or how it is redefining the term for the purposes of Western Australian law, what is the common or garden meaning of “suicide”?

Hon STEPHEN DAWSON: Of course, the honourable member would very well know that there are multiple dictionaries in operation. Although one dictionary might say something, it may not be the commonly held or understood view of suicide by the general community.

I want to go back to a previous point. Despite the state having the view that VAD is not suicide, it will not put practitioners at risk, so we will not authorise the use of telecommunications until the question is resolved.

Hon MICHAEL MISCHIN: I would like to pursue this line.
The DEPUTY CHAIR (Hon Martin Aldridge): Members, we are dealing with the Voluntary Assisted Dying Bill 2019 in Committee of the Whole. I draw members’ attention to supplementary notice paper 139, issue 3, dated Thursday, 24 October 2019. We are dealing with clause 1 and the question is that clause 1 stand as printed.

Hon MICHAEL MISCHIN: Before the luncheon adjournment, I was going to ask a few questions about the concept of suicide. I entirely accept that there is a clause in the bill that will redefine or at least limit the commonly understood meaning of the word “suicide” for the purposes of the law of the state. That is proposed section 11 of the bill, which states —

For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not commit suicide.

That is rather different from the concept of suicide that has been mentioned by the minister. I did say that it is a commonly understood word or phrase. Essentially, it is taking one’s own life voluntarily and intentionally—a deliberate act resulting in the voluntary death of the person who does it. Whether it is defined in a particular fashion in this bill for the purposes of the law of the state, and notwithstanding the comments about what might generally constitute a suicide, those are very different concepts from the meaning of the word. Surely, part of the problem that we are exploring—the potential interaction with commonwealth law—is what is commonly understood by the term “suicide”. That is what needs to be addressed. If the minister has something to suggest that the commonwealth would be looking at it in a totally different way from the commonly understood meaning of the word or the dictionary definition of it, then I would appreciate knowing about it. But from where has the government drawn the understanding of “suicide” that it is promoting?

Hon STEPHEN DAWSON: The bill reflects the views of a significant proportion of Western Australians and addresses a genuine choice for someone nearing the end of their life. It draws a meaningful distinction between the public understanding of suicide and the type of death that is permitted under this bill.

Hon MICHAEL MISCHIN: The minister is telling us that the word “suicide” does not mean taking one’s own life intentionally as a result of a deliberate act, that it means something else, and the public understands the concept differently. What evidence does the minister have of that?

Hon STEPHEN DAWSON: During the public consultations of the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying, it was raised a number of times that, generally, people in the community see a distinction between voluntary assisted dying and suicide.

Hon RICK MAZZA: As part of that consultation, did the coroner provide any feedback or commentary on how he or she viewed voluntary assisted dying and whether it was suicide?

Hon STEPHEN DAWSON: The answer is no, the coroner did not raise an issue about the use of that word. I have had further advice. The term “voluntary assisted dying” is not new. It has been used in Victoria, New South Wales and Tasmania in the introduction of similar bills, albeit the bills did not pass in some of those jurisdictions. Certainly, the term “voluntary assisted dying” has been used previously in Victoria. The Tasmanian bill was introduced in 2013 and the New South Wales bill in 2017. The Victorian bill was passed in 2017. The terminology has been around for a little while and has been used elsewhere.

Hon MICHAEL MISCHIN: I appreciate that, and I understand that we can use various terms to describe what is proposed by this bill and by government policy. Just getting back for a moment to the public consultation, I make one point: it was made quite clear that, during the public consultation that took place with the expert panel, the expert panel was not revisiting the arguments for or against what was then described as euthanasia. Apparently, euthanasia has nothing to do with this bill, according to the second reading speech. Therefore, as a rule, the people going along to these consultations were interested in how the scheme was to operate rather than whether there would be one at all. We are looking at a fairly narrower demographic than the majority of the Western Australian population. Is the minister saying that the people there saw a distinction, or that they wanted to draw a distinction that natural progression would be in a minute or in a year, is my ending my life, voluntarily and by a deliberate act, necessarily suicide? That, presumably, is what the commonwealth is looking at. It is not what might generally be thought to be a suicide, involving tragedy and the rest of the experiences and the circumstances associated with it. It is a simple fact. The government may be redefining that for the purposes of this legislation and the purposes of the law of Western Australia, but that does not change the concept, nor does it change the meaning of the word. Indeed, the way in which the legislation is framed reinforces that general meaning. It is stating that if it is done in these prescribed circumstances, a person does not commit suicide. It is interesting that “commit” is used in that context. I thought that the idea of suicide being an offence had been removed from the WA Criminal Code. The reason we tend to associate suicide with “committing” suicide is the longstanding view that it is an offence. It is no longer an offence, so it is interesting that we are still using that terminology in proposed section 11 of the bill. I would have thought that if the government really wants to be politically correct, it would...
remove “commit” and have it read “does not suicide”, but I am not going to argue about that. Surely, to try to reframe it because that is what the government wants people to distinguish is a very different thing from the meaning of the word. Is it not that problem that the commonwealth is presenting the state government? Although we might redefine it for our purposes, as far as the commonwealth is concerned, it still means what everyone understands it to mean—not what the state government wants it to mean or be limited to.

**Hon STEPHEN DAWSON:** I think that in quite a lot of that, the member was making a point rather than asking me a question. I want to make mention that the purpose of the ministerial expert panel was to consider a number of specific issues related to voluntary assisted dying and to assist in the development of robust policy and legislation in Western Australia. It was not the purpose of the panel to review or debate the arguments for or against voluntary assisted dying. That was the subject of the inquiry and recommendations of the Joint Select Committee on End of Life Choices. I want to place that on the record. I am further advised that attendees at the consultations did not conflate the terms “suicide” and “voluntary assisted dying”. They saw the difference in those concepts. It was not only people who were pro–voluntary assisted dying who were involved in those consultations. People with a range of views attended those meetings. I also make the point that if a person in hospital now refuses their medication and dies as a result, would we suggest that that is suicide? No, we would not.

**Hon Nick Goiran:** It’s hardly the same.

**Hon STEPHEN DAWSON:** We would not suggest that it is suicide. Coming back to the earlier point, the term “voluntary assisted dying” is not new. It has been used before and that is the terminology used in this bill.

**Hon MICHAEL MISCHIN:** All right. I do not think there is much purpose in pursuing this much further. I point out that section 288 of the WA Criminal Code makes it an offence for any person who procures another to kill himself, counsels another to kill himself and thereby induces him to do so, or aids another in killing themselves is guilty of a crime and liable to imprisonment for life. That, surely, is one of the reasons why this bill states that it is not suicide and the person is not killing himself in the common meaning of the term if they follow precisely the procedures available under the bill. The government reminds me of Humpty Dumpy in *Through the Looking Glass*, who said, “When I use a word, it means exactly what I choose it to mean—neither more nor less.” If the government wants to change the terminology for common parlance, it will, but it does not avoid the fact that the bill recognises that ordinarily this may mean suicide. Otherwise, there is no point to clause 11, is there?

Getting onto other terminology, the government keeps talking about “voluntary assisted dying”. Why is this not “euthanasia”? What is the difference?

**Hon STEPHEN DAWSON:** The bill makes clear that the prerequisite for the decision to be voluntary is absolutely essential. That is why we use the term “voluntary assisted dying” and not “euthanasia” or “suicide”. Euthanasia refers to a situation in which death is induced to relieve suffering. However, this term has significant and mixed connotations. Historically, it has reflected abuse in involuntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value. More recently, people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient. Even when the term “voluntary euthanasia” is used, it does not entirely capture the intent that a person is being assisted in taking their final steps with the choice ultimately residing with the patient. Furthermore, the term “voluntary euthanasia” still evokes a sense of patient passivity in the process. By contrast, the term “voluntary assisted dying” reflects that the death is the result of a process that has been requested and led entirely by the patient. The term “voluntary assisted dying” is used because it best reflects the intent of this legislation and the principles behind accessing the process set out under the legislation. Modern acts tend not to rely on the term “euthanasia” because it has a range of meanings in a range of different jurisdictions. To summarise, only two jurisdictions refer to euthanasia—Belgium and Luxembourg. I have given the example previously of Victoria. The Victorian Voluntary Assisted Dying Act 2017 uses the term “voluntary assisted dying”, as did the bill that failed to pass the Tasmanian Parliament in 2013 or 2014 and the New South Wales bill.

**Hon MARTIN PRITCHARD:** I did not want to break in on the line of questioning there, but I have a quick question that I want to put on the record. If it is passed, the bill will allow for people to access voluntary assisted dying in a period shorter than nine days in certain circumstances, and my question is about what may lead to that. It is slightly outside the realm of the bill, but I wonder whether I can put a question to the minister to be answered later on. My question is about the schedule 8 prescribing code. This provides that medical practitioners can apply to the CEO for authorisation to increase dosages of things such as opioids above the allowable levels within the code. I am happy for the minister to get back to me on this, but I just want to ask: how long would it take to get an authorisation from the CEO, given that often people are in pain while waiting for that authorisation, and will that be looked at in the future? It is not a question for the minister to answer now, but maybe to take on notice and come back to me at some point.

**Hon STEPHEN DAWSON:** I am very happy to take that question on notice and I will most likely provide an answer at that clause, but certainly later.

*Extracted from finalised Hansard*
Hon MICHAEL MISCHIN: I can understand why the government wants to call this voluntary assisted dying, but from what the minister has described about euthanasia, it sounds like euthanasia to me. It also sounds like the government wants to have its cake and eat it. The second reading speech refers to many years of people advocating for what is proposed under this bill, but they have been doing so under the title of “euthanasia”. Indeed, Hon Robin Chapple’s bill back in 2010 was the Voluntary Euthanasia Bill 2010. I would have thought that the “voluntary” element of it would serve the same purpose as “voluntary” does in the Voluntary Assisted Dying Bill 2019. There is voluntary euthanasia—that is, the voluntary easing of death—and voluntary assisted dying, the voluntary assistance to death. What are the negative connotations that the expert panel said would make it unpalatable to use a commonly understood term for this legislation? Why do we have to resort to euphemisms and the reframing of language if this is meant to be a robust, honest debate about matters of life and death? Why do we have to engage in sugar-coated language to deal with this issue and make it more palatable? Is it more saleable that way, to avoid people having to consider the consequences of what this involves?

Hon STEPHEN DAWSON: It is not about it being more palatable, honourable member; we believe it is more precise. Certainly, the terms have evolved over time. Euthanasia can be involuntary, which is why we do not use that term, but in relation to —

Hon Michael Mischin interjected.

Hon STEPHEN DAWSON: Sorry, I am answering —

Hon Michael Mischin interjected.

The DEPUTY CHAIR (Hon Martin Aldridge): Order!

Hon Michael Mischin interjected.

The DEPUTY CHAIR: Order, member. The minister has the call.

Hon STEPHEN DAWSON: The honourable member asked me some questions, and I was trying to provide an answer to them.

Language is an important issue and Western Australians obviously had many important conversations about voluntary assisted dying during the deliberations of the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying’s consultation period, and those conversations will be ongoing. It is critical that these conversations continue to take place respectfully and with clarity about what is being said. Having a common, easy-to-understand approach to the meanings of key words and phrases can help ensure clarity and avoid the misunderstandings that can sometimes derail helpful discussion. The term “voluntary assisted dying” is used by the joint select committee and the panel. It emphasises the voluntary nature of the choice of the person to make this decision. Throughout the process of voluntary assisted dying, the person must have the capacity to make a voluntary choice. To be eligible, the person must already be suffering and dying as a result of an illness, disease or medical condition. It reflects a person-centred approach, focused on those who are eligible to access assisted dying. Voluntary assisted dying involves a process to access medication and to enable a person to legally have choice about the matter and timing of their death.

Hon NICK GOIRAN: I think the minister said that only two jurisdictions use the term “voluntary euthanasia”. How many jurisdictions have what the minister would describe as a voluntary assisted dying scheme? By definition, I mean those jurisdictions that have either a voluntary euthanasia scheme, an assisted suicide scheme, or one of the types of schemes that we are referring to here. How many of those jurisdictions exist?

Hon STEPHEN DAWSON: I do not have a number in front of me at the moment, but my advisers might very well provide one to me. Similar schemes operate—I use the word “similar” lightly, because, obviously, they are very different—in Belgium, Luxembourg and Quebec. In the United States, California has an end-of-life option act, as do Colorado, the District of Columbia, Hawaii and Maine. In Montana there is no act; it is done on the basis of common law. New Jersey has an act, as do Oregon, Vermont and Washington. I am of the understanding that there about 19 jurisdictions; however, not all jurisdictions have legislation. In some places, the ability to access such a scheme comes under common law.

Hon NICK GOIRAN: I turn to page 17 of the “My Life, My Choice” report of the Joint Select Committee on End of Life Choices, and one of the definitions in the “Glossary of terms” table. The definition of “Assisted suicide” states, in part —

This term is used in some jurisdictions to describe interventions which assist individuals to end their lives. It places emphasis on the person’s active decision-making and involvement …

Is that not what this bill is doing?

Hon STEPHEN DAWSON: That may be the case, but this government has chosen to use the words “voluntary assisted dying”.

Extracted from finalised Hansard
Hon NICK GOIRAN: I accept that; that is the choice of the government. I just want to make sure that we are all on the same page. Notwithstanding the government’s choice of language, this bill allows for assisted suicide as defined at page 17 of the “My Life, My Choice” report.

Hon STEPHEN DAWSON: The term “voluntary assisted dying” encapsulates the range of methodologies that are able to be used, so it is broader than the term “assisted suicide”. Certainly, in the jurisdictions that I read out earlier, different terminologies are used in different places. “Voluntary assisted dying” is used in the Victorian act, as I have previously mentioned. The other jurisdictions use a range of different terminologies. In this case, in Western Australia, the government has decided to use the term “voluntary assisted dying”.

Hon NICK GOIRAN: I agree with the minister that assisted suicide is part of a voluntary assisted dying scheme here in Western Australia. Obviously, that means that there are other parts. Would it be correct to say that a voluntary assisted dying scheme in Western Australia would consist of two parts: one would be assisted suicide, as we have just discussed, and the other part would be voluntary euthanasia?

Hon STEPHEN DAWSON: No. It includes self-administration and practitioner administration.

Hon NICK GOIRAN: A moment ago, the minister said that it included assisted suicide, so it does not just include those two things —

Hon Stephen Dawson: I did not say that.

Hon NICK GOIRAN: We will check Hansard and come back on that. The minister says it involves self-administration and practitioner administration. To what extent is the definition of assisted suicide at page 17 self-administration or practitioner administration?

Hon STEPHEN DAWSON: I am told that what is on page 17 is a glossary of terms; they are not definitions as such.

Hon NICK GOIRAN: The words on page 17 read —

This term is used in some jurisdictions to describe interventions which assist individuals to end their lives. It places emphasis on the person’s active decision-making and involvement.

Is that self-administration or is that practitioner administration under the proposed WA scheme?

Hon STEPHEN DAWSON: Both of the methods proposed in the Western Australian bill are assisted. Even with self-administration, assistance is given by a practitioner or by others as part of a process. Sorry, let me say that again. In terms of self-administration, assistance is still given by somebody as part of a process — on the journey to receive approval. With practitioner-assisted suicide, obviously assistance is given there too. Both are assisted — one by the practitioner through a process, and one by self through a process.

Hon NICK GOIRAN: So both self-administration and practitioner administration are assisted suicide?

Hon STEPHEN DAWSON: No, I do not agree. It is voluntary assisted dying.

Hon NICK GOIRAN: If a person in Western Australia under this scheme were to elect self-administration, would that be an intervention to assist an individual to end their life, with emphasis on the person’s active decision-making and involvement?

Hon STEPHEN DAWSON: I am advised that this issue of an administration decision is dealt with in clause 55. Clause 55 provides that the patient, in consultation with the coordinating practitioner, may make a decision that the administration of the voluntary assisted dying substance is to occur either via self-administration or by practitioner administration. The clause makes it clear that the administration decision must be made in consultation with, and on the advice of, the patient’s coordinating practitioner, obviously, and the patient must provide consent to the method of administration being advised by the coordinating practitioner before the VAD process can progress.

Hon NICK GOIRAN: I was not asking about that clause in the bill. The minister has indicated that this scheme will consist of two parts: self-administration and practitioner administration. I am parking practitioner administration for the moment and I am just asking the minister about self-administration. If a Western Australian resident were to die under this scheme as a result of self-administration, would that be an intervention that has assisted the individual to end their life, with emphasis on the person’s active decision-making?

Hon STEPHEN DAWSON: If the person has participated in the voluntary assisted dying process, they have been assisted to end their life.

Hon NICK GOIRAN: Again, I take the minister to the words on page 17 of the “My Life, My Choice” report, the glossary of terms and the term “assisted suicide”, which says that it is an intervention that assists individuals to end their lives. I hear from the minister, in the answer he is giving, that self-administration under the Western Australian scheme is an intervention that assists an individual to end their life. I hear that from the minister; he will clarify whether that is wrong. If it is not an intervention that assists an individual to end their life, perhaps the minister could explain how it is not an intervention that assists an individual to end their life. Clearly, it is an intervention; clearly, it assists an individual; and clearly, the outcome is the end of a life. In addition, the glossary entry for that term refers

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“emphasis on the person’s active decision-making and involvement”, and the minister has indicated to me that self-administration would involve the person and it would involve the person’s active decision-making, so it seems to have all the elements set out at page 17. If I am wrong about that, can the minister indicate which elements are missing?

**Hon STEPHEN DAWSON:** The terminology used on page 17 in the glossary of terms makes the point, “This term is used in some jurisdictions.” In fact, I think it is used in two jurisdictions. This is the committee’s glossary. The end-of-life choices report informed the WA bill via the framework, but it is not the sole consideration for the bill.

**Hon NICK GOIRAN:** I understand that. I am not asking the minister whether he agrees it is assisted suicide or not; I am simply asking him whether self-administration is an intervention that assists an individual to end their life and places emphasis on the person’s active decision-making and involvement. It is either that or it is not that. I might, and the committee might, describe that as assisted suicide, and the minister might describe it as something entirely different. That is fine. I am simply making sure that we are talking about the same thing here. Are we both talking about an intervention that assists an individual to end their life and places emphasis on the person’s active decision-making and involvement? They are the elements that I am seeking confirmation of. If those elements are present in self-administration, I am asking for the minister’s confirmation of that. If there are other elements, the minister should let us know what they are.

**Hon STEPHEN DAWSON:** I again make the point that we have chosen to use the words and terminology “voluntary assisted dying” in Western Australia. If a person has participated in the voluntary assisted dying process, they have been assisted to end their life.

**Hon NICK GOIRAN:** Self-administration and practitioner administration are the two forms that have been indicated. Are both of those things interventions?

**Hon STEPHEN DAWSON:** We are of the view that they are an assistance. They are the words that we are using. I do not know what the member is trying to get me to say.

**Hon Nick Goiran:** I am just asking whether it is an intervention or not.

**Hon STEPHEN DAWSON:** The advisers are telling me that it is not.

**Hon NICK GOIRAN:** Why is it not an intervention?

**Hon STEPHEN DAWSON:** It is a question of definition, because “intervention” means coming between someone.

**Hon NICK GOIRAN:** Tempting as it is to ask the minister which dictionary definition he has just decided to use for “intervention”, can I ask him about voluntary euthanasia, and draw to his attention page 20 of the same report that we have been referring to, where it states —

> Euthanasia means the intentional termination of the life of a person, by another person …

> Euthanasia can be voluntary, non-voluntary or involuntary. Voluntary euthanasia means euthanasia performed in accordance with the wishes of a competent individual …

Under this scheme in Western Australia, would the wishes of a competent individual for the intentional termination of their life take place?

**Hon STEPHEN DAWSON:** I have made this point earlier on, but it is important that I do so again. Even when the term “voluntary euthanasia” is used, it does not entirely capture the intent that a person is being assisted in taking their final steps, with the choice ultimately residing with the patient. Furthermore, the term “voluntary euthanasia” still evokes a sense of patient passivity in the process. There is an element of ambiguity, and we are trying to be precise in using the term “voluntary assisted dying”.

**Hon NICK GOIRAN:** It seems to me that the government has rejected the committee’s glossary of terms, particularly around “assisted suicide” and “euthanasia”. What other elements of the “My Life, My Choice” report has the government rejected?

**Hon STEPHEN DAWSON:** I think it is fair to say that the first report, “My Life, My Choice”, of the Joint Select Committee on End of Life Choices has been considered by the government, and the outcome of that consideration is the bill before us today.

**Hon NICK GOIRAN:** I do not know whether the minister heard my question, but my question was: what parts of the “My Life, My Choice” report has the government rejected?

**Hon STEPHEN DAWSON:** The government has provided a response to the report, but the government has not provided a response to the minority report of that committee.

**Hon NICK GOIRAN:** For the third time, I will ask my question, and I ask the minister to listen to it carefully, because it is not all that complicated. What parts of the “My Life, My Choice” report have been rejected by the government?

**Hon STEPHEN DAWSON:** That is a very broad question, and I am not sure what the honourable member is getting at, because the “My Life, My Choice” report deals with issues that are broader than just voluntary assisted dying. I am not sure what the honourable member is getting at. He said he has asked this question three times, and he has
asked me to listen. Believe me, I am listening and I am trying to provide an answer to the honourable member. I just do not know what he is getting at. Certainly, the report is not just about voluntary assisted dying.

**Hon PETER COLLIER**: I do not mean to be pedantic here, but just getting back to the title of the bill, who made the decision to call it the Voluntary Assisted Dying Bill?

**Hon STEPHEN DAWSON**: The government—it is a government bill, so we did.

**Hon PETER COLLIER**: Did anyone recommend to the government that it be referred to as the Voluntary Assisted Dying Bill as opposed to the voluntary assisted euthanasia bill?

**Hon STEPHEN DAWSON**: No advice was given to us by any external organisation about the title.

**Hon PETER COLLIER**: The reason I bring this up—I want to just make this point, and I will ask a question in a moment—is, as I keep on saying, that we are making a seismic shift here in where we are going, so we have to make sure that we are doing it for the right reasons. The optics of voluntary assisted dying, in my opinion, are probably less confronting than voluntary assisted euthanasia. That is just a personal opinion; it is how I feel. If that was the motivation behind the terminology—that the optics are softer for the public than voluntary assisted euthanasia—it is very similar to “dying with dignity”, which is a term that has been used constantly and consistently throughout this debate by the government, members and groups that are supportive of the bill. This bill is meant to assist people with a terminal illness to die with dignity. My only concern is that there is almost an implied assumption that a person cannot die with dignity if they do not access voluntary assisted dying. That may not be the case, but it is there.

I am not saying that it is in the bill; I am saying that “dying with dignity” is terminology that has been used. I have mentioned two people who were important to me in my life who died, and I recounted their stories. One died with a terminal illness that would have been captured by this legislation; the other death would not have, even though his illness ultimately took his life. But both of those individuals died with dignity because they had significant support mechanisms around them. I hope we are not getting to the point at which the culture is that the best option to die with dignity is through voluntary assisted dying, as opposed to voluntary assisted euthanasia. I hope we are not going down that path. Let us be up-front about where we are going with this legislation. I know that I am being pilloried as a Philistine because I do not understand and I am not progressive like so many people. A lot of people are not like that, but some are like that. I know that most people in this chamber are not, but some are. I am sorry—you can shake your head, honourable member, but you want to see some of the emails that I have received, so do not shake your head at me.

**Hon Sue Ellery**: Who are you talking about?

**Hon PETER COLLIER**: To Hon Darren West. That is who I am talking to.

**Hon Darren West**: Settle down.

**Hon PETER COLLIER**: No, I will not settle down, thank you. This is a very sensitive issue, and for some reason for him to question what I have just said insults me. I have been pilloried throughout this community because I have the audacity to oppose this legislation, and I resent that. I really resent that. The point being, as I said, I am not doing it for some bland, bigoted reason; I am doing it because it is genuinely what I feel.

With regard to voluntary assisted dying, no-one wants their loved ones or anyone to die in pain; I understand that. But a significant number of people in our community with a terminal illness do die with dignity. That is the point that I want to make and that is the point that I tried to make in my second reading contribution. All I am saying to members with regard to the actual —

**Hon Stephen Dawson**: By way of interjection, that point is accepted.

**Hon PETER COLLIER**: Thank you; I appreciate that. I am not casting aspersions on anyone in this chamber, but I would just like to think that alternate viewpoints are respected as much as we respect the viewpoints of those who voted for the legislation. I have to say that that respect has not been forthcoming from the chief member of Parliament in the other chamber. Having said that —

**Hon Donna Faragher**: The Premier.

**Hon PETER COLLIER**: Yes, I am referring to the Premier.

I just want to understand this. The minister went through this, but I am still not totally clear on the difference between voluntary assisted dying and voluntary assisted euthanasia. The minister identified a bit of differentiation, but, quite frankly, I am not convinced. This is not repetitive. I am not being repetitive here, minister. For my personal understanding, would the minister mind again going through the distinction between voluntary assisted dying and voluntary assisted euthanasia—for the same reasons that I said about “dying with dignity”, one can die with dignity without euthanasia. I would like to know why the title of the bill is what it is.

**Hon STEPHEN DAWSON**: Honourable member, I respect your view as I respect the views of other members in this place. Certainly, this is an issue of great importance to the community and there are a great number of views on the issue. It is absolutely the right of each and every member in this place to have a view on this bill that is before us, so I just wanted to place that on the record.

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The member alluded to that we do not talk about dying with dignity in this bill. In fact, I think it may well have been the Joint Select Committee on End of Life Choices that chose not to use that terminology and, indeed, the Ministerial Expert Panel on Voluntary Assisted Dying also chose not to use the terminology “dying with dignity”.

The bill makes clear that the prerequisite for the decision to be voluntary is absolutely essential and this is why we use the term “voluntary assisted dying” and not “euthanasia” or “suicide”. Euthanasia refers to the situation in which death is induced to relieve suffering; however, this term has significant and mixed connotations. Historically, it has reflected abuse in “involuntary euthanasia”, which raises the prospect of the medical practitioners of a society killing people whose lives were thought to have little value; for example, the word “euthanasia” has been used in the context of the Holocaust. More recently, people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient. Even when the term “voluntary euthanasia” is used, it does not entirely capture the intent that a person is being assisted in taking their final steps, with the choice ultimately residing with the patient. Furthermore, the term “voluntary euthanasia” still evokes a sense of patient passivity in the process. By contrast, the term “voluntary assisted dying” reflects that the death is requested and the process is led entirely by the patient.

Hon ROBIN SCOTT: Regarding the prescribed substance, I have all the information I need regarding the unused substance and any remaining substance and how it has to be disposed of by an authorised disposer. I would like to ask the minister: if someone wanted to access voluntary assisted dying and they chose the oral prescribed substance, who decides the quantity and how much has to be taken to effect the death of that person?

Hon STEPHEN DAWSON: The answer is it could be either, honourable member. It depends on the individual’s circumstances and the illness that they have. Some people may not be able to swallow, for example, so it could be either of those two things that the member raised.

Hon ROBIN SCOTT: Assuming that the person decides that they would like to take the liquid form of the prescribed substance, who decides the quantity and how much has to be taken to effect the death of that person?

The DEPUTY CHAIR (Hon Martin Aldridge): Member, I remind you that we are dealing with clause 1. I am not quite sure where you are going with this line of questioning, but some very specific clauses in the bill relate to prescribed substances. I will allow the minister to respond, but I just ask you to keep that in mind with your further questions.

Hon STEPHEN DAWSON: I appreciate your guidance, Deputy Chair.

The choice of legal medication for a patient will be a clinical decision; the patient will not decide. That decision will be made by the coordinating practitioner, and that will be from only an approved list of schedule 4 or 8 poisons. That is in clause 7, so the member may well have further questions at clause 7.

It is a matter for the patient’s coordinating practitioner, a fully qualified medical practitioner with additional training on voluntary assisted dying, to determine what dosage and formulation they consider appropriate to make up the voluntary assisted dying substance. What is prescribed will depend on each patient and their condition, their weight and 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. This is important because some diseases or previous medications may restrict the absorption or counter the effectiveness of other medications. The coordinating practitioner is authorised to prescribe a voluntary assisted dying substance for the patient that is of a sufficient dose to cause death.

Hon JIM CHOWN: My question is of a similar nature and is about the cocktail that is personalised for the patient, as the minister described. Who in this state has the sort of expertise to create either a tablet or a solution that would be effective on a case-by-case basis?

Hon STEPHEN DAWSON: There will not be a new substance created. What will be used —

Hon Jim Chown: It’ll be a cocktail of various poisons.

Hon STEPHEN DAWSON: It could be. Let me read this. 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 supply, dispensing and ensuring 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. The clinical panel’s recommendations will inform the CEO’s approval under clause 7 of the bill.

The DEPUTY CHAIR: Hon Jim Chown, before I give you the call, I want to bring your attention to page 45 of the bill where an entire division is for the prescribing, supplying and disposing of a voluntary assisted dying substance. I bring that to your attention because if you have specific questions around prescribed substances and their prescribing, that is a matter best left to division 4.

Hon JIM CHOWN: I will happily leave it until we get to that clause, Deputy Chair.

I will go on a different tack, minister. As brought up by Hon Martin Aldridge earlier today in Committee of the Whole House, the government’s lack of response or inability to address the issue of using a carriage service under
the commonwealth Criminal Code Act, section 11, is of great concern. It concerns me, as a member for regional Western Australia, on the grounds that at least 59 towns out there have a single doctor operating in the vicinity. A large proportion are overseas-trained doctors from different cultures and could possibly have a conscientious objection to being involved in VAD—and that is their right. If there is no ability to use a carriage service, this legislation, if it gets through this house, will discriminate against regional Western Australia. My question to the minister is: until this issue is resolved to the satisfaction of this chamber, how can the government pursue this legislation through this place when legislation that is carried and approved by Parliament is legislation for all Western Australians?

**Hon STEPHEN DAWSON:** If the bill becomes law, there will be an implementation period of at least 18 months before the Voluntary Assisted Dying Act would become operational. This time will enable the health department to develop, in consultation with the commonwealth, appropriate administrative measures to ensure compliance with state and commonwealth laws. Assessments may need to be undertaken in person, with either the patient travelling to the practitioner or the practitioner travelling to the patient. If the bill passes and this is required, WA Health will provide packages to support access for regional patients when needed. The training for health professionals will reflect the outcome of the ongoing consultation between the state and commonwealth, so regardless of where the doctor has been trained, all doctors who participate will need to go through a training process, and that training process will be worked out over the next 18 months. It is certainly the government’s intention that if this bill passes, people across Western Australia will be able to access VAD. Those details will be worked out during that implementation phase.

**Hon JIM CHOWN:** I thank the minister for his response, but I find it unsatisfactory. I am very concerned that this groundbreaking legislation for Western Australians is now being pursued, or bullied, through this place without the government providing an appropriate answer to a question that has been raised by a number of regional members. I think it is inappropriate, quite frankly, that this sort of legislation is reliant on a government process some months after it has been approved by Parliament. The government has had more than adequate time to address this issue. How the commonwealth Criminal Code Act, section 11, affects carriage services in regional Western Australia is not a secret. I am not asking the minister a question; I am making a statement. We will see where we go in regard to this issue as we progress through the bill.

**Hon STEPHEN DAWSON:** Although the honourable member finished by saying he was not asking a question, I appreciate that he gave his view on this bill. As Hon Kyle McGinn, I think it was, and Hon Robin Chapple mentioned in their contributions to the second reading debate, a number of issues and processes will be worked out after the passage of the bill, in that implementation phase, including ensuring access and information for Aboriginal people and people in remote Western Australia, but I appreciate member’s comments.

**Hon ADELE FARINA:** On that point, the minister indicated that when telehealth cannot be used—I think it is pretty self-evident from the way clause 156 is written that the state government understands very clearly that there are issues with that—alternative implementing strategies would be used. I understand that the minister’s advice today is that that would be by way of hard copy information brochures and the like. My experience with those sorts of fact sheets or information brochures is they usually do not answer all my questions. If I am living in regional WA and I have questions that that fact sheet does not answer, how do I go about getting that information?

Several members interjected.

**The DEPUTY CHAIR:** Order, members.

**Hon STEPHEN DAWSON:** The patient will be able to phone a number on the bottom of that fact sheet to make an appointment to sit down with someone face to face to have their questions answered.

**Hon ADELE FARINA:** That is fine. Will the person who will sit down face to face with the patient travel to where the patient lives to have that conversation, because, let us remember, the patient has a terminal illness and we should not be placing any additional burden on them to have to travel to Perth to have that face-to-face discussion?

**Hon STEPHEN DAWSON:** Options currently being considered—I apologise that my back is turned to the member.

**Hon Adele Farina:** I completely understand that you need to talk to the microphone; that is fine.

**Hon STEPHEN DAWSON:** I feel very bad about that. So excuse, not my rudeness, but the situation I find myself in. Options currently being considered for WA include a central hub that would link with network spokes in regional and remote WA and transport assistance to support face-to-face interactions. The hub would be able to receive requests for information on access to voluntary assisted dying and facilitate the provision of information by either hard copy or in person. I previously said that assessments may need to be undertaken in person, with either the patient travelling to the practitioner or the practitioner travelling to the patient. If this bill does pass, as I said, WA Health will work to provide packages to support access for regional patients when needed, and of course the training for health professionals will reflect the passage of the bill—the bill that passes this place is what the training of the health professionals will be based on.

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I take the member’s point. I will certainly bring it to the Minister for Health’s attention that the member always has outstanding questions when she reads some fact sheets. Also, the Department of Health is considering the development of a care navigator model, with a focus on enabling access to voluntary assisted dying, including for people living in rural and remote areas. The primary role of care navigators will be to assist patients who need support in obtaining information about or access to voluntary assisted dying. For example, care navigators will help a person find a coordinating or consulting practitioner. Care navigators will work closely with patients, their carers, family and friends, medical practitioners and healthcare teams to tailor support that meets the specific needs of patients. These are key points throughout the voluntary assisted dying process. The care navigators may also assist health practitioners with accessing support services. It is likely that a model similar to that used in Victoria will be developed for use in Western Australia.

Hon MARTIN PRITCHARD: I thank the minister for making some comments about the implementation process. I am very interested in the comments he just made. It reminds me of some contact I have had from a number of associations, probably the largest being the Asbestos Diseases Society of Australia, which was quite interested in that concept. Although many of its members are not ill enough at the present time to consider voluntary assisted dying or other things such as palliative care during the inevitable travel to their passing away, they certainly would want information about a range of services, including palliative care and maybe voluntary assisted dying, pain management and such. The minister has talked about navigators in cultural and regional contexts, but I would also urge him to consider reaching out to associations that could provide services, hopefully in a convenient way, to people on their books who will eventually pass away. That might mean that they are prepared as they move closer towards their demise. That was just a comment that I wanted to make.

Hon STEPHEN DAWSON: I appreciate the comment. It is not the intention that a care navigator service will operate solely in rural and remote Western Australia; it would be across the state. I take on board the member’s suggestion. I will use as an example the statewide voluntary assisted dying care navigator service that was established in Victoria. The care navigators employed as part of that service act as a point of contact for members of the public, health practitioners and health services seeking information about, or assistance with, voluntary assisted dying. In the case of Victoria, I understand that care navigators are based at the Peter MacCallum Cancer Centre while the statewide care navigator service is being established. There has been an overall government commitment to end-of-life choices, so it is certainly our intention to ensure that people around the state can access the information that they require.

Hon ADELE FARINA: If a care navigator deals with someone who does not have English as their first language and perhaps does not speak any English at all, they will need to use an interpreter service. Normally, people phone through to access an interpreter service. How will that work, given the complications with the commonwealth legislation?

Hon STEPHEN DAWSON: In terms of accessing the care navigator service, the bill provides for the use of interpreters when required. Furthermore, Western Australia adheres to the state government’s Western Australian language services policy 2014. An interpreter service can be provided for that care navigation service. Of course, it may not just be culturally and linguistically diverse communities that may need to access interpreter services. Obviously, there are Aboriginal people around the state who might have English as a third or fourth language, or indeed there may well be vision-impaired people who may need to access interpreter services too. It is intended that extensive and detailed work will be undertaken with Aboriginal communities and health services during the 18-month implementation period, but also more broadly with CALD community services to make sure that we are addressing the issues that may be raised or faced by people from those communities.

Hon ADELE FARINA: I think the minister missed my point. The problem is that if people will be using the telephone—a communication service—to have those discussions, we will run into the same problem as we will with telehealth, in that people will be discussing suicide options over a carriage service. The issue I am concerned about is how we will manage that when we need to access interpreters through a call process.

Hon STEPHEN DAWSON: I thought that the member was still asking about the care navigator service. I answered the question in the context of that. More broadly, the member was talking about people from CALD communities more broadly accessing the bill, in relation to the commonwealth act.

Hon ADELE FARINA: Sorry, minister; maybe I need to make myself clearer. The care navigators are not likely to speak every language under the sun. They may encounter a situation in which they have to give advice to a person and they cannot communicate.

Hon Stephen Dawson: That service can be provided with the assistance of interpreters.

Hon ADELE FARINA: Via telephone, or will the interpreter go to the regional area where the patient who is seeking the advice is living?

Hon STEPHEN DAWSON: Yes, they can. The care navigator service will be able to access interpreters. The commonwealth provisions that were introduced to deal with the phenomenon of cybersuicide prohibit a person from using a carriage service for suicide-related material, including material capable of constituting a communication
that directly or indirectly counsels or incites someone to commit or attempt to commit suicide. The care navigator service will not deal with those issues. They will give information, but when questions are broader or information is sought by people who want to access the service and that impinges on the commonwealth provisions, certainly the state will look at providing face-to-face access to interpreter services for those people. It is certainly something that is under active consideration by the state. It is the intention of the state to ensure that people who want to access voluntary assisted dying can access it. When appropriate, that may include using interpreter services over the phone to seek limited information. It could also include face-to-face interpreter services depending on the information that is sought.

Hon ADELE FARINA: I am having difficulty with the statements that the minister is making. I thought the care navigators were there to assist a person to access voluntary assisted dying, in which case they would be providing the same sort of information that would be provided through telehealth; therefore, I think this will fall foul of the commonwealth law in exactly the same way. If the minister is saying that a person who can speak the patient’s language and has full knowledge of how to access voluntary assisted dying will be sent to the patient’s home and will provide that information to them, I accept that answer, but I am not clear that that is the answer the minister is providing.

Hon STEPHEN DAWSON: The care navigators will provide that information face to face. If needed, a translator would be flown or transported with the care navigator or doctor, if required. Obviously, it is a hypothetical situation. We anticipate the numbers will be low; notwithstanding that, it is a very important issue to raise. Certainly, the advice from the advisers is that, if needed, a translator would be transported with the care navigator or doctor to enable that person from a culturally and linguistically diverse or Aboriginal community to understand what was being said. People will be trained in the care navigator model. What professional standards must they maintain? Will there be any professional standards in their training at all?

Hon STEPHEN DAWSON: On the contrary, the government has considered this issue. As I have said, we have been monitoring the care navigation service in Victoria and the likelihood is that we will have a similar care navigation service to the one in Victoria. I have also said that the detail will be worked out through the implementation phase. I say again: it is our intention to make this legislation work for Western Australians, rural and city or metropolitan. It is not a biased bill. I totally disagree with the member on that.

With the training, what was the word the member used?

Hon JIM CHOWN: Professional standards.

Hon STEPHEN DAWSON: The training and professional standards will all be worked out during the implementation phase. We will work with relevant stakeholders to develop the model and we will make sure that it works for Western Australia. Victoria has a care navigation model in place already. Although Victoria is nowhere near as big as Western Australia, it does have regional areas, and we will certainly learn from that and work with stakeholders to make sure that our model in Western Australia works.

Hon JIM CHOWN: Who would be the stakeholders in the training of the care navigator model, and what sort of people would the government be looking at to become part of that model for regional Western Australia?
Hon STEPHEN DAWSON: I am told the likelihood is that the care navigator role will be undertaken by nurses or social workers. The model would be designed with relevant bodies such as the Australian Nursing and Midwifery Federation, the Australian College of Nursing, the Royal Australian College of General Practitioners and the Royal Australasian College of Physicians. The Department of Health would also be involved in those conversations. We would talk to relevant professional bodies. It is also important to have consumer representation, so we would involve consumer groups to make sure that we have all bases covered. Professionals will certainly be there; not only medical professionals, but also professional bodies will be involved in this process.

Hon KYLE McGINN: Just briefly touching on the training, I picked up that a navigator care model is operating in Victoria and has a regional aspect to it. Does Victoria have a template of minimum standards of qualifications required to be a navigator?

Hon STEPHEN DAWSON: I will have to take that question on notice and provide the information at a later stage. A group that I forgot to include in the stakeholder design process was, of course, Aboriginal health workers and Aboriginal health organisations. They, too, would be consulted as part of the design of the care navigator system. I will have to see whether I can provide the detail the member has just asked about at a later stage.

Hon KYLE McGINN: I appreciate that. I definitely understand that there are lots of multifaceted approaches to the care navigator model—different angles and different groups. The minister commented earlier that the care navigator could be a nurse or a social worker. Is the minister aware of any requirement to hold a medical qualification?

Hon STEPHEN DAWSON: Sorry, can the member ask that question again?

Hon KYLE McGINN: If the care navigator is, for example, a social worker, not a nurse, would there be a requirement for that social worker to hold any medical qualifications?

Hon STEPHEN DAWSON: No, they would have their own professional qualifications as a social worker. I am told that it is more likely that the position will be undertaken by nurses, but in some circumstances it could be a social worker. Certainly, they would already have qualifications to be a social worker. Regardless of who undertakes that role, under the legislation, they would be trained in voluntary assisted dying, to make sure that, regardless of their background, they would be able to operate under this model.

Hon KYLE McGINN: Okay. I understand that. Previously, I asked questions about training. I understand there will be an extensive 18-month implementation process, which will involve all different groups, particularly in the Indigenous space for navigators. If we are required to upskill and train people, will there be the ability to ensure that we get skills locally rather than outsourcing the work to skilled workers in Perth? Where will the funding come from?

Hon STEPHEN DAWSON: I will give the member some information about training generally and then be more specific. The bill requires that the assessing medical practitioners, coordinating and consulting practitioners, and the administrating practitioners, medical or nurse practitioners, must have successfully completed the approved training for voluntary assisted dying before they can perform the functions required of them under the bill. The CEO will approve training for the roles of practitioners and their obligations under the bill. A clause in the bill relates to that. Other health practitioners also will be able to register interest in receiving training. Appropriate training packages will be created to support any role they may have under the bill or in supporting patients who are assessing VAD—for example, pharmacists, allied health professionals, interpreters, healthcare support workers and, indeed, navigators. The training package will be developed in consultation with the Department of Health, and key medical, nursing and allied health stakeholders and experts. That will include clinical, education and regulatory experts; palliative care and end-of-life stakeholders and experts; cultural stakeholders and advisers; and community representatives.

Training will be informed by the mandatory training program in place in Victoria—noting, of course, that there will be very different and additional requirements that will be unique to Western Australia. The Royal Australian College of General Practitioners has given an undertaking to help in the development of the training program to ensure that it is both effective and meets the required standards. In its submission to the Joint Select Committee on End of Life Choices, the Western Australia branch of the Royal Australian and New Zealand College of Psychiatrists noted that psychiatrists are well placed to support upskilling colleagues in capacity assessment.

I think the member also asked who will pay. The Department of Health will pay for the training.

Hon KYLE McGINN: That is excellent. That makes a lot of sense for training on the voluntary assisted dying process. I suppose I am not articulating my question right. Once we have an understanding of the nurses, social workers and people with the appropriate skills to train in VAD in small regional towns and regional areas, if there is a shortage of people with those skills or those who can service the broader electorate, will there be the capability to train people in those skills so that they can provide those services? If there is a shortage of nurses and we are unable to provide navigators because of the shortage, will we provide extra training to fulfil frontline services prior to people receiving VAD training?

Hon STEPHEN DAWSON: It is a difficult question. In the early days of the model, this will be a fairly labour-intensive process—certainly for care navigators, who will likely have to traverse the length and breadth of the state. Over

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time, as the hub-and-spoke model evolves, we will be in a position to re-evaluate. When possible, if there is an opportunity to have people on the ground in communities, that can be looked at during the rollout. In the early days, the likelihood is that the care navigators will be centrally based, albeit from different backgrounds to make sure the cultural sensitivities of dealing with Aboriginal people are addressed. Over time, there may well be the opportunity to broaden that and make sure that care navigation services are spread throughout the community. Hopefully, I have answered it in that way.

Hon KYLE McGINN: Yes. I understand that there will be a process in the implementation stage to decide how broad it will be. The minister mentioned cultural appropriateness and the number of people who will be required to work with different groups. That is why I was trying to understand whether, if further training is required to fill that need, there will be the opportunity for that to happen rather than supplementing it from Perth. That answers my question.

Hon NICK GOIRAN: The minister in the other place, Hon Roger Cook, the Minister for Health, on 22 October 2019 stated —

If telehealth cannot be used as a method of communicating with people for the purposes of access to voluntary assisted dying in Western Australia, the WA health department will adopt alternative implementation strategies.

I understand from the answers that the minister gave to Hon Adele Farina earlier this afternoon that one of those alternative implementation strategies is the rollout of care navigators. Can the minister confirm that that is the case and what the other alternative implementation strategies are?

Hon STEPHEN DAWSON: If the bill becomes law, as I have mentioned previously, there will be an implementation period of at least 18 months before the voluntary assisted dying legislation will become operational. That period will enable the Department of Health to develop, in consultation with the commonwealth, appropriate administrative measures to ensure compliance with state and commonwealth laws. Assessments may need to be undertaken in person with either patients travelling to practitioners or practitioners travelling to patients. If the bill passes, the Department of Health will provide packages to support access for regional patients when needed. Training for health professionals will reflect the outcome of the ongoing consultations between the state and commonwealth. I have mentioned this a couple of times, but the assessment process may need to be undertaken in person and patients may need to travel to health practitioners or practitioners may need to travel to patients.

Hon NICK GOIRAN: As I understand the minister’s answer, what Hon Roger Cook was referring to as other alternative implementation strategies consist of a care navigator model, getting the patient to travel to the practitioner and packages to support those two processes. Is the care navigator the first model and organising for the patient to travel to the doctor the second model?

Hon Stephen Dawson: Or the practitioner travelling to the patient.

Hon NICK GOIRAN: Or the practitioner travelling to the patient. Are those the three alternative implementation strategies that Hon Roger Cook, Minister for Health, referred to on 22 October?

Hon STEPHEN DAWSON: I do not know what was in the minister’s mind, but they are certainly the three opportunities being considered by the Department of Health at this stage. As we progress, other models could come to hand. They will be considered at that time, but certainly they are the three models that are under consideration at this stage. I understand that we are considering all care models. I am told that we will look at the Canadian provinces to see how they do it. We will ascertain the particulars of those and see whether they translate to the Western Australian context. Certainly the three models that the member has raised are the three that are under consideration now and that we know could work in Western Australia, but others could arise between now and the implementation phase.

Hon NICK GOIRAN: Let us take the first of those implementation strategies, which is the care navigator model. As I understand from answers to questions that the minister was asked by Hon Adele Farina earlier this afternoon, the intention of the government of this fortieth Parliament is to send out, if necessary, translators or interpreters to assist a care navigator who does not speak the same language as the patient. Can the minister confirm that there will be a dual cost—the cost of the care navigator going out to the patient and the cost of the translator or interpreter going out to the patient?

Hon STEPHEN DAWSON: If the most appropriate provision of interpreter services is face to face, that will certainly be the case and will certainly be paid for. It is worth keeping in mind the anticipated low number of people who may participate in the scheme. I am not sure whether the member is going to ask what we think the cost associated with that will be. We cannot confirm the particulars of costing at this stage, but it is certainly our intention to provide interpreter services face to face for the limited number of people who need them. The details and the model for implementation are not in the bill, as the member would be aware. These will emerge as the consultation process occurs. I am further told that the Department of Health already has agreements or referral protocols with relevant organisations to ensure that accredited interpreters are readily available.

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Hon NICK GOIRAN: Just to go back to my original question, can the minister confirm that there will be a dual cost—the cost of sending out the care navigator and the cost of sending out a translator or interpreter to facilitate that process for the care navigator, keeping in mind that the context of these questions is the minister’s earlier advice to the house that the government is not currently sure whether it will be possible for telehealth to be used? We are working on the basis of a worst-case scenario—that telehealth cannot be used—and the minister is telling me that one of the packages being considered by the government is to send out care navigators and translators. I am just confirming whether there will be a dual cost in that instance.

Hon STEPHEN DAWSON: In some cases, yes, there will be a dual cost.

Hon NICK GOIRAN: Let us carry this case study forward. The patient is out in a regional or rural place in Western Australia. A care navigator has been sent out, along with the cost of a translator/interpreter. At that point, if the patient wants to continue to proceed with voluntary assisted dying, would the government then need to fund the cost of a coordinating practitioner to go out to the same patient?

Hon STEPHEN DAWSON: A coordinating practitioner could be available locally for the patient.

Hon NICK GOIRAN: Can the minister explain to me why the government would waste taxpayers’ money on sending out a care navigator if there is a local coordinating practitioner?

Hon STEPHEN DAWSON: They are different functions, honourable member. A care navigator has a different function from a coordinating practitioner. In some circumstances, even if there were a local coordinating practitioner, there could be a requirement to provide the assistance of a care navigator earlier in the process. Perhaps the member can tell me exactly the point he is trying to get to so that I can answer him.

Hon NICK GOIRAN: The point I am trying to get to is that so far in this case study, we need to send out a care navigator and a translator or interpreter. I was suggesting that the third person who would need to be sent out is the coordinating practitioner, but then the minister introduced the rather strange concept of a local coordinating practitioner being present. It might be that I misunderstand what the government intends care navigators to do. My understanding is that the job of a care navigator is to inform the patient about the voluntary assisted dying process and give that patient information. The only reason they would be needed is if the person does not have ready access to a local coordinating practitioner. If they had ready access to a local coordinating practitioner, there would be no need for the care navigator because that practitioner would give them the information, as specified under the bill. I just want to clarify exactly the circumstances in which the government would send out a care navigator when there is a local coordinating practitioner available.

Hon STEPHEN DAWSON: The primary role of care navigators is to assist patients who need support in obtaining information about, or access to, voluntary assisted dying. If they know of someone locally who is happy to be a coordinating practitioner, the likelihood is that the person will not need to access a care navigator. If they know that there is someone locally, the care navigation service is not needed.

Hon NICK GOIRAN: On that basis, let us go back to the case study. A person in rural Western Australia does not have ready access to a practitioner under the VAD scheme, so they call out a care navigator. A care navigator is then funded by the government to go out to this person, along with a translator. After that process, the government would then presumably need to send out a coordinating practitioner to that same person; is that right?

Hon STEPHEN DAWSON: If that is necessary, yes.

Hon NICK GOIRAN: After that process, assuming that the coordinating practitioner has approved the process and all the various eligibility criteria have been met, as set out in the legislation, would the government then need to fund a consulting practitioner?

Hon STEPHEN DAWSON: Potentially, yes.

Hon NICK GOIRAN: When the government sends out the coordinating practitioner and then at a later stage the consulting practitioner, a care navigator in this case example requires the use of a translator. Let us assume for a moment that the coordinating practitioner and the consulting practitioner are also not adept in a variety of languages. Would the government also then send out a translator, whether it be the same person or another, to assist in the process?

Hon STEPHEN DAWSON: If required, yes.

Hon NICK GOIRAN: At the end of that process, as I understand the scheme before us, there is then a person called an administering practitioner or a term to that effect, I think, under the legislation. Would the government also then fund an administering practitioner to go out to that person to execute the act? As part of that process in this bill, the minister would be very well aware that before the final execution process takes place, there are provisions in the bill that say that the administering practitioner needs to be satisfied of certain things, including that the request is enduring. To make sure that that process is taking place safely and there has been no confusion whatsoever, would the government also send out a translator along with that administering practitioner?

Hon STEPHEN DAWSON: Again, possibly, yes.

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Hon NICK GOIRAN: In this case example, we have a care navigator and we have a translator; that is two people. On another occasion, we will have the coordinating practitioner and the translator, so there are four cost values associated so far. Then we are going to add the consulting practitioner and the translator, so we now have six people. Then we have got the administrator and the translator, so by my count that brings us to eight people. According to the government, there has been a very vigorous consultation process, including the work of the joint select committee and the ministerial expert panel. I think the minister indicated that there was consultation with a range of agencies, and the government has been busy monitoring what is happening in Victoria. The minister just introduced the fact that someone in government is checking out what is happening in Canadian provinces. Does the government have any information available about the anticipated cost of all of this travel?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: Would the minister agree with me that the cost of sending one palliative care specialist out to that person with a translator would be less than the cost of this entire voluntary assisted dying process for that same patient?

Hon STEPHEN DAWSON: I contended that it could be.

Hon NICK GOIRAN: Can the minister explain to me why it definitely would not be? The only circumstance in which I think it might not be is if, unbeknownst to me, palliative care specialists were charging the government an exorbitant fee for their personal attendance in comparison with the fee that would be charged by the coordinating practitioner, the consulting practitioner and the administering practitioner. I am not aware of that, but perhaps the minister can just clarify what fees the government anticipates will be charged by coordinating practitioners, consulting practitioners and administering practitioners?

Hon STEPHEN DAWSON: The reason I did not give the member a definitive answer is that we are talking about hypotheticals here. I cannot definitely say what the cost of something is, because, quite simply, I do not know what we are talking about. I do not know what costs more than the other. I would have to seek information about what the costs associated with participating in the scheme or what the costs of those specialists or the coordinating practitioner might be. They would certainly vary. They could depend on where it was in the state and a range of things, and I do not have costs like that in front of me now.

Hon NICK GOIRAN: All these people in this hypothetical case example are all going to the same location. Hon Robin Scott made some good points yesterday in his member’s statement. He is obviously far more knowledgeable about distances in regional and rural Western Australia, and the minister, as a member for Mining and Pastoral Region, will also have a better appreciation for those distances, than I. I do not really mind which location the minister, Hon Robin Scott or anyone else decides to choose for the purpose of this case example. My point is that they will all go to the same place, and for the lack of better choice of place—other members might have a better example—I will choose Kununurra. If taxpayers have to send to Kununurra from Perth a care navigator and a translator, a coordinating practitioner and a translator, a consulting practitioner and a translator, and an administering practitioner and a translator, is not the cost of sending eight people to Kununurra and back more expensive than sending a palliative care specialist, singular, and a translator, singular?

Hon STEPHEN DAWSON: Costs really are a moot point when dealing with suffering. Cost is not the determination for denying end-of-life choices. As a result of lobbying or the hard work of the people in this chamber, we are already making record investment in palliative care, and those services will be spread around the state. The other option we have available to us is that we could bring the patient to a centre. I alluded to an option earlier of the medical professional going to the patient, and in another case we could bring the patient to the medical professional or to a central spot. A decision has not been made about that, and that would obviously be dealt with during the implementation phase. The cost is not the determination for denying or, indeed, allowing access to voluntary assisted dying. We want to retain a patient-centred focus in the development of the support model, and these issues will be looked at during the implementation phase. I hear what the honourable member is saying and asking, and I appreciate the point he is making. This debate is on voluntary assisted dying and not on palliative care, but noting that both can go hand in hand, and the intention as a result of the recent state budget and announcements is that palliative care services be more readily available across the state.

Hon NICK GOIRAN: The reason I raise this case example is that the government, at clause 4(1)(d), has said —

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 have not put that in there, although I agree with the principle. The government has done so, and I am trying to make sure that we do not have a situation in which we fly eight people out to Kununurra or some other place, and we are not going to be willing to send out two people. The minister will respond and say that it is all about the patient’s choice, but there is no choice for the patient if the government is not willing to send out the palliative care specialist and the translator, but it is prepared to send the other eight people. That is the point I am making here, and I want a confirmation from government that under no circumstances will that ever happen, and that this government, which is passionate about voluntary assisted dying, will ensure that before it sends out eight people, it will send out two people if that is the choice of the patient.
Hon STEPHEN DAWSON: I have not said that the government would not send out palliative care services, and I have not said that the government would send out eight specialists over sending out two palliative care service providers. I make the point again that the government is providing a record amount of funding for palliative care services over the next four years. It is approximately $224 million, which is an additional $17 million on top of the $206 million of funding delivered in the 2019–20 state budget. Of the $206 million that was in the state budget, a total of $58.9 million will be provided to regional services. The government has announced $41 million towards palliative care in the 2019 budget, taking expenditure over the four years to 2023 to that record amount. This is part of the end-of-life choices and palliative care services package. As a result, more than 61 full-time equivalent staff will be employed over a phased approach across regional Western Australia. This will triple the staffing arrangements for palliative care support in regional Western Australia. This includes the establishment of new specialist district palliative care teams, comprising medical, nursing, allied health and Aboriginal health workers across the state.

Recently, an additional $17.8 million was announced and of that, $6.3 million has been allocated to improving metropolitan and regional community-based services for care closer to home, and to better meet the demand. The intention is that this will fund community-based services to be delivered predominantly through non-government organisations across the state. Of this, $2 million will be dedicated to rural and regional Western Australia to fund care services for patients who have a potential risk of admission to hospital or residential aged care requiring domiciliary home care services. A commitment of $2.5 million has been made to enable the WA Country Health Service to enhance rural and regional palliative care services by improving governance, to refine models of palliative care and roll out the services, ensuring that they best support the needs of rural and regional patients. The boost to governance means an additional 3.2 full-time equivalents will be employed to ensure high-quality palliative care in the regions that is patient centred and provided in the patient’s place of choice.

The Department of Health has already undertaken significant work in progressing a 10-year end-of-life and palliative care strategy to provide strategic statewide policy direction for improving the lives of all Western Australians through quality end-of-life and palliative care. This is occurring alongside progression of the palliative care recommendations of the joint select committee and the sustainable health review. I am further advised that the Minister for Health hosted a palliative care summit in August this year to progress the work, at which 160 delegates, including health professionals, consumers and community stakeholders provided their perspectives about how to reform and improve the way palliative care is developed and delivered in WA. Significant investment is happening in palliative care. I think Hon Jacqui Boydell, in her contribution to the second reading debate, suggested that it should not be a case of either/or, and I think there is a commitment from all members in this place to ensure that palliative care services throughout the state are enhanced and broadened.

The premise of this bill is about ensuring that we do what is best for the patient, so in relation to the hypotheticals that have been raised, when it is appropriate to have interpreters attend with health professionals to consult or talk to people about voluntary assisted dying, we believe that service should be provided.

Hon NICK GOIRAN: It is telling that it took the minister some four minutes to provide a response to something that was not my question. I do not need the minister to read to me pre-prepared notes about what the government is doing in palliative care. We have had the debate on palliative care. In fact, a motion was moved only yesterday by Hon Martin Aldridge dealing with a range of issues in health in Western Australia, including palliative care. We note that the government is doing things about palliative care, and I have previously congratulated the government for what it has been doing. I do not think it is doing enough, but that is not the debate we are having right now. I want an assurance from this government—at this point in time the minister is not willing to give it to us—that this government will not allow a situation in which it will allow the taxpayer to fund eight people to go to Kununurra to facilitate the voluntary assisted dying process, but it will not fund a palliative care specialist and an interpreter to go to that same place, if that is the choice of the patient. I am asking for that commitment from this government. The conscionable answer to that pretty simple question is, “Yes, absolutely”. The minister should be saying that, on behalf of the government, he gives a guarantee that we will do that. That is the conscionable answer, and that would be the end of this line of questioning, but instead the minister spends four minutes reading pre-prepared answers on an irrelevant part of this debate.

I say this with the greatest of respect; I know that the minister is not the minister with responsibility for this portfolio. He is representing that minister here. In order for us to make progress, I ask the minister—inevitably, I think he will agree with me that we will not finish the passage of this bill today—during the very short recess in the next few days, to discuss this matter with the Minister for Health with a view to reporting back to the house next week about whether this government will commit to funding a palliative care specialist and an interpreter to go to regional Western Australia when a patient makes that request.

Hon STEPHEN DAWSON: I provide the answers in this debate that I think are appropriate, and I am very happy with the answers I have provided thus far. I am not, however, in a position to give a guarantee on hypothetical cases, and I will not do so. I do not think it is fair for anybody to suggest that it is appropriate that I do that. In relation to the member’s request to bring an issue to the attention of the Minister for Health, the member knows that I have
done this before and I will continue to do it, because I am very happy to bring these issues to the attention of the appropriate minister, and I am very happy to report on that in the future. However, I think it is unfair for the member to suggest that I should be able to give a guarantee to the house today based on a hypothetical.

Hon Nick Goiran: I didn’t say today.

Hon STEPHEN DAWSON: The member was pushing me to give a guarantee on a hypothetical case. I cannot, I will not, and I never will, but I am certainly happy to take on board the question that the member has asked and raise it with the minister.

Hon NICK GOIRAN: Earlier in the debate on clause 1, the minister was responding to a request from Hon Kyle McGinn.

Hon STEPHEN DAWSON: Sorry, honourable member, there is a bit of noise behind me. Can you just say again what you just said?

The DEPUTY CHAIR (Hon Adele Farina): I will just interrupt there. Members who are having private conversations that are too audible, could you please leave the chamber and have those outside the chamber? There are difficulties with hearing, and Hansard needs to be able to record what is being said.

Hon NICK GOIRAN: Earlier in the debate on clause 1, the minister was responding to questions from Hon Kyle McGinn about Indigenous navigators. He made the good point that he would like to see more than just cultural competency courses being undertaken by these navigators, which the government has indicated will be done in a culturally appropriate way. In particular, I noted his desire for the minister to confirm that the intent is for the role of the Indigenous navigators to assist but not to coerce. I have to say that I am very concerned about the creation of navigators. Navigators, to me, sound like expert steerers, and I have previously said in this debate that steering is the elephant in the room—people feeling pressured to make a decision. That is why we are all familiar with an amendment that was moved in the other place by the member for Armadale that seeks to prevent doctors from raising the issue with the patient.

The minister has indicated to Hon Kyle McGinn that it is the intent of the Indigenous navigators to provide an assisting role, not a coercive role. How is that protected under the provisions of this bill?

Hon STEPHEN DAWSON: Obviously, there are provisions in the bill that prevent coercion. Clause 99, “Inducing another person to request or access voluntary assisted dying”, lays that out. Clause 99(2)(b) states —

penalty for this subsection: imprisonment for 7 years.

Summary conviction penalty for this subsection: imprisonment for 3 years and a fine of $36 000.

The primary role of care navigators is to assist patients who need support in obtaining information about, or access to, voluntary assisted dying. For example, those care navigators can help a person to find a coordinating practitioner or a consulting practitioner.

Hon NICK GOIRAN: Minister, these care navigators do not currently exist, as I understand it. The government will have to do some work to create these roles. How long does the government anticipate it will take to create these care navigator roles?

Hon STEPHEN DAWSON: Honourable member, during the 18-month implementation phase, the government intends to extensively consult on these roles. The member was particularly asking about the Aboriginal roles, was he not?

Hon Nick Goiran: Yes.

Hon STEPHEN DAWSON: The intention is to have extensive and detailed consultation, and work with Aboriginal communities and health services. As Hon Kyle McGinn pointed out, we want to enable the development of appropriate models of cultural, spiritual and practical support for Aboriginal people, so we will build on the consultation work that was undertaken by the ministerial expert panel and we will work closely with a range of stakeholders, including the Aboriginal Health Council of Western Australia, other Aboriginal health services, WA Country Health Service, other health service providers and the WA Primary Health Alliance.

The short answer—I apologise that I am not giving the honourable member too many short answers this afternoon!—is that that work will be done during that 18-month implementation phase. Whether it will take a week, two weeks or six months, I cannot tell the member. But upon passage of the bill, that work will be done during that implementation phase.

Hon NICK GOIRAN: Is there any prospect, by the government, that the bill will come into operation prior to these Indigenous care navigators being in place?

The DEPUTY CHAIR: May I draw the minister’s attention to the time. Does the minister think he can answer it very quickly?

Hon STEPHEN DAWSON: No. I was going to suggest that I need further information. I want to be clear on a particular point.

Committee interrupted, pursuant to standing orders.

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

Clause 1: Short title —
Committee was interrupted after the clause had been partly considered.

Hon STEPHEN DAWSON: The honourable member asked a question earlier about Aboriginal health workers.

Hon Nick Goiran: And navigators.

Hon STEPHEN DAWSON: Yes, and navigators. If the member does not mind, can I park that issue for today? I am still waiting for a response. I have received a text, but it is not a fulsome text. I want to have a fulsome answer for the member, so I will provide an answer to that particular point when we next sit.

Hon NICK GOIRAN: I am very happy to park that and we can take a look at it the next time the government decides to bring the bill on for debate. With regard to these care navigators, whether they be Indigenous or otherwise, what regulation will there be around the role of these care navigators? Obviously, this bill is very specific about the role of medical practitioners in rolling out voluntary assisted dying or euthanasia and assisted suicide in Western Australia, but what type of regulation will be in place around the role of the navigators?

Hon STEPHEN DAWSON: As the honourable member knows, the bill does not require regulations to be made. It has been drafted as a comprehensive piece of legislation to operate as it is. People in the care navigator role will be captured by standard professional regulations, depending on the nature of their practice. How they are regulated—small “r” regulated—will be an operational matter for the state. That will be worked out through the implementation process. As I alluded to earlier on, these positions will most likely be undertaken by nurses and could be undertaken by social workers in some instances. We alluded earlier on to provisions in the bill about coercion and other such stuff, and any person operating in the realms of the legislation would be captured by such proposed sections.

Hon NICK GOIRAN: In the defined terms on page 107 of the bill, which carry over to page 109, there is no reference to care navigators or navigators. My concern, therefore, is that these individuals will have quite a bit of licence with regard to their activities and interventions. I think the minister prefers the word “assistance”; there was some rebuttal by government about the use of the word “intervention”. Apparently, what is going on here is not an intervention, but some form of assistance. I see that the defined terms include “registered health practitioner”, “nurse practitioner” and “medical practitioner”. We as a Parliament are going to be very strict with those practitioners; we are going to insist that they adhere to statutory law. Yet the minister has just indicated that care navigators—whom I have a serious concern about, because, as I said earlier, I think they are going to be expert steerers—are going to be subject to some unspecified standard professional obligations. Has the government given consideration to ensuring that care navigators are also captured by the scope of this legislation?

Hon STEPHEN DAWSON: I am advised that the people undertaking the role of care navigator would still be subject to the Health Practitioner Regulation National Law (WA) Act and the codes of professional conduct under that act. The operational guidelines and policy around these positions will be developed by the Department of Health, and they will be published on the website.

Hon NICK GOIRAN: The minister says that in accordance with the advice he has just been given, we can be confident because the national law that applies to health practitioners will act as a safety net. That is in effect what the minister is saying. I remind the minister that he indicated earlier that the government is giving serious consideration to social workers being involved. Are social workers captured by that national law that the minister referred to?

The CHAIR: Members, noting the time, I shall now report progress to the house.

Progress reported and leave granted to sit again, pursuant to standing orders.
The DEPUTY CHAIR: I draw members’ attention to supplementary notice paper 139, issue 3, dated Thursday, 24 October 2019.

Hon STEPHEN DAWSON: I had better speak up before someone reminds me again. Thank you very much, Mr Deputy Chair. Last week, there were a number of things that I undertook to come back to the chamber with an answer on. However, before I do that, I want to remove any misunderstanding that I may have left last week. It is in relation to Hon Peter Collier’s questions about possible amendments that the government may accept. I just want to make it clear that we will, of course, consider proposed amendments to this bill, provided that the amendments are reasonable and that they do not undermine the bill, or, indeed, its policy and purpose. We will, of course, give careful consideration to each and every one that is put forward and, as I mentioned previously, this will be done as we get to each clause. Therefore, once we get to debate each clause, any amendments that are proposed will be considered at that time. Of course, if the government itself forms a view that an amendment is required, it will obviously notify the chamber in the usual way. That is what I referred to last week by putting amendments from the government on the supplementary notice paper. In case there is any question about whether the government will be open to amendments to the bill, I just wanted to clarify that.

I also have comments in relation to two issues Hon Nick Goiran raised last week. He asked whether social workers would be captured by the national law that I referred to. The answer is: no, they will not. Social workers are self-regulated allied health professionals. Social workers are healthcare workers but not registered health practitioners under the national law. The second issue he raised related to how long the government anticipates it might take to create care navigator roles. As I said previously, it is intended that the bill will become operative after the implementation phase of 18 months. The intention is that healthcare workers and registered healthcare practitioners who choose to participate will be trained and ready to discharge their obligations under the act. However, obviously, we will be working within the usual workforce constraints.

Hon PETER COLLIER: Thank you for that, minister. Can I just get clarity? I am a little confused after the minister’s comment. Regarding the amendments, I appreciate that the government will always consider any amendments that come from the floor—I have no problems with that one. I just want some clarification around the government’s amendments. That was the direction in which I was heading with my questions about amendments that the government was considering. I got the impression from the minister’s comments last week that the government was not only considering amendments but also actually drafting amendments at this stage. Can the minister confirm whether that is still the case?

Hon STEPHEN DAWSON: Certainly, that issue was dealt with last week, and it was indicated that the government was drafting amendments based on amendments that were raised in the other place or, indeed, amendments that were raised by stakeholders external to the Parliament. No decision has been made on the policy or the policy intent of those amendments, but, certainly, some amendments have, I understand, been drafted by the minister’s office. They are under consideration still.

Hon MARTIN Pritchard: Last Thursday, I removed from the supplementary notice paper an amendment that would have required a consulting practitioner to hold some specialty. I thought it might be worthwhile to canvass that a little bit, because it has been brought to my attention that that amendment had a lot of support outside the chamber and to some extent inside the chamber. I thought I would explain briefly why I removed that amendment. It was after a briefing that was organised by Hon Colin de Grussa and after he had spoken to some motor neurone disease specialists. They indicated that only four specialists service over 90 per cent of people in Western Australia. It came to my mind at that time that there could well be a situation in which either by contractual arrangement or through conscientious objection, or through availability, they would not be available. Therefore, even though people tend to fall in love with the drafting that they conjure—I was in love with my drafting—I thought it would be appropriate to remove my amendment because I accepted the view that was put to me by the minister and others that it could have created some real problems in the bill. But that does not necessarily change my mind with regard to what expertise should be required for prognosis.

That led me last week to make a number of intemperate comments about general practitioners. I have had some feedback on that. I accept that general practitioners have a whole-of-body specialty, so I would like to talk briefly about that. In reading the bill as it currently stands, it seems to give the impression that one day a person could arrive in their last six months of life or even less in some circumstances, seems to be an unnecessary precaution.

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I looked at the bill and it came to my mind that because of the amount of information that the general practitioner would have already collated, and the opportunity to refer to specialists but not get those specialists involved in the process—in other words, not limiting the availability and such—the coordinating practitioner, the GP, would be in a perfect position to make a determination, given all the information, and that the only oversight that I see would be necessary would be collating all that information in some reporting process and giving that to the board and the board basically ticking it off and saying, “Yes, based on all the information we have, we make a prognosis of less than six months”, and they would go through the process. That would severely limit the exposure a patient would have and how many times they would have to see a different general practitioner. It would also mean that people in the bush would have fewer problems, because in many towns, of course, there is only one GP. However, we cannot unscramble an egg; I understand that. I also understand that the government falls in love with the drafting it puts together. But I just wanted to raise those things.

I did not mean to denigrate general practitioners. I think they do play a role, but I think it is a collation and holistic role, and the fact that they have in most cases a relationship with the patient and the family, and those things can be of assistance. I have always been a general fan of the fact that a general practitioner be the coordinating practitioner; I just do not see the need for a consulting practitioner to be involved in the process because I think that will have limitations. That is why I withdrew the amendment that I was going to put forward at a later stage.

As I said, I am almost certain that specialists will be involved, but they would not necessarily have to be pulled in as a coordinating practitioner; rather, they could be part of the process in which the coordinating practitioner refers off to specialists and gains that information with the board having oversight. I think that would make it a lot simpler and it would have gained my support earlier. I do not believe that we gain much by going through the process twice when we are talking about people who have fewer than six months to live. Hopefully, that gives members some insight into why I withdrew the amendment. In its place, I will move amendments to, I think, clauses 25 and 36—I may be incorrect—that suggest that the coordinating practitioner has to identify whether they have the skills and training to make a prognosis, or other aspects, and if they do not have those skills or training, they refer off as the bill suggests. They will then have to take into account—not necessarily accept—each and every report and send all those reports, whether or not they support their view, to the board so that it has proper oversight. I have tried to toughen those areas to give me confidence in the bill. I know that I do not have the option, but I do not see the consulting practitioner as a safeguard. I see the consulting practitioner as going through the process twice just in case someone gets the process wrong in the first instance. I do not understand it and given that the voluntary assisted dying process is for patients who have only six months to live, it is unnecessary. I do not necessarily need the minister to make a comment. I thought it would be good for the chamber to understand why I withdrew the amendment and the concerns I had with it.

**Hon NICK GOIRAN**: Last week, the minister responded to concerns raised by Hon Kyle McGinn about the role of care navigators, particularly Indigenous ones, to assure him that the intent is that the role is to assist, not coerce. The member also sought an assurance from the minister that the standard for Indigenous navigators will be more than just completing a cultural competency course, and that resulted in my last question before we adjourned last Thursday, which was: given the strict parameters operating in the bill for medical practitioners, and given that the government is considering using social workers as navigators, what will be the strict system regulating the navigators? In effect, in the minister’s response this afternoon, he indicated that social workers are self-regulated and do not operate under the national law for health practitioners. What arrangements does the government plan to put in place to regulate the role of care navigators in the instance that they are social workers?

**Hon STEPHEN DAWSON**: As I alluded to earlier in answering Hon Nick Goiran’s question about whether social workers are captured by the national law, I said no, they are not. Social workers are self-regulated allied health professionals. Social workers are healthcare workers but not registered health practitioners under the national law. The National Code of Conduct for Health Care Workers 2014, which was a decision of the Council of Australian Governments, was developed to set standards for healthcare workers against which disciplinary action can be taken. In Western Australia, the Health and Disability Services Complaints Office commenced phase 2 of the implementation of process of that in June 2018. Phase 2 has included the progression of activities required for legislative change necessary to give effect to the national code in Western Australia. I understand the drafting instructions have been provided to parliamentary counsel. The preparation for drafting of the health and disability services complaints amendment bill to provide for the national code jurisdiction and the implementation of the code in Western Australia through regulations is progressing. The national code will set standards against which disciplinary action can be taken and, if necessary, a prohibition order will be issued in circumstances in which a healthcare worker’s continued practice presents a serious risk to public health and safety.

It is anticipated that social workers and, indeed, health workers, who undertake the navigator role will be employed by the Department of Health in the first instance and they will be subject to the department’s code of conduct and directions by their employer. It is likely that the care navigation process will be a nurse-led service. The Department of Health is of the view that a nurse-led model of care is preferred and that eventually a multidisciplinary team with other health professionals will develop. It is intended that the manager of any multidisciplinary team of care

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navigators must be a registered nurse. Registered health practitioners, including registered nurses, are subject to the Health Practitioner Regulation National Law (WA) Act 2010 and may be investigated by the Australian Health Practitioner Regulation Agency.

Hon NICK GOIRAN: Does that explanation simply mean that the social workers who the government proposes will be care navigators—or a group or a class of people who will be part of the care navigation scheme—currently do not operate under the national code of conduct for healthcare workers because, at the moment, the instructions to make that happen are with parliamentary counsel?

Hon STEPHEN DAWSON: None. As I have said previously, care navigators are not part of the bill. That issue will be dealt with during the implementation phase.

Hon NICK GOIRAN: I agree that it is not in the bill. This is the problem. The government is trying to assure regional members that they do not have anything to worry about with the bill before the house and that there will be good access in regional Western Australia because this government will spend taxpayers’ money to fund care navigators. That is part of the government’s rhetoric and narrative to provide regional members with an assurance about their concerns. Multiple regional members in this place have raised concerns about that, noting that “care navigator” is not a defined term or mentioned in any way in this bill. I am simply seeking to ascertain the extent to which the government has any plan to regulate that role. It seems to me that the government has not yet decided who is going to be a care navigator, let alone how they will be regulated. There have been some vague remarks about them being nurse led, but the government has not really made a decision on that. It thinks it might, in due course, in the fullness of time, bring in some social workers, who are self-regulated, but it is not really sure about that either, and it thinks that all these things will be taken care of in the implementation phase, which will take 18 months. The minister can understand why I do not necessarily receive any assurance or satisfaction when he says to Hon Kyle McGinn that he has nothing to worry about because the intention is that these care navigators will be there to assist and will not coerce, yet there is no regulation around the process of care navigators, there is no definition and there is no plan.

I will move to a different area. Last week, the minister indicated that, if necessary, the government would fund the cost of up to eight people to assist a person in regional or rural WA to access voluntary assisted dying, but he was unwilling to provide a guarantee that the government would fund the cost of one palliative care specialist and one interpreter to visit that same person if that was their preference. Has the minister now spoken to the Minister for Health and is he now able to provide that assurance?

Hon STEPHEN DAWSON: I did raise that issue with the minister’s office last week. I have raised the issue. I have told the minister of the member’s concern. I understand that people can access palliative care services remotely, in that they can access them over the phone. I certainly raised the issue with the minister’s office.

The member spoke about sending up to eight people to regional or remote Western Australia—those were the words he used. That was a hypothetical situation. I answered that that might well be the case in certain circumstances, but I also said last week that the likely number of people throughout the state who will access the service is likely to be small. This is not about cost; this is about ensuring that people in regional and remote Western Australia can access the service that will be allowed under this bill. I understand that palliative care services can be accessed over the phone at this stage.

Hon NICK GOIRAN: Is the government able to guarantee that it will fund the cost of one palliative care specialist and one interpreter, if that is the request of a Western Australian in regional WA?

Hon STEPHEN DAWSON: No, I am not in a position to guarantee that.
be a choice. Someone in regional Western Australia will have the choice of having eight people go out to execute the VAD act for them, but they will not be able to have two people to execute life in palliative care. People tell me that this is about choice, but we have just had evidence to confirm that that is fake for regional Western Australians. If I am wrong about that, the minister can correct the record at any time and confirm that the government will now take a different approach and will ensure and guarantee that regional Western Australians will have access to a palliative care specialist if that is their choice. At this stage, that is not the case. Now, minister, in response to —

Hon Stephen Dawson: Before you move on to another point —

Hon NICK GOIRAN: I have not finished.

Hon Stephen Dawson: You just invited me to answer at any stage, honourable member. Either you want an answer or you do not.

The DEPUTY CHAIR (Hon Martin Aldridge): Order; Hon Nick Goiran has the call.

Hon NICK GOIRAN: Thank you, Mr Deputy Chair; I think the minister is unfamiliar with the processes of this chamber.

The minister indicated earlier to Hon Peter Collier that the government will consider amendments if they are put forward. He indicated last week that he would not table the draft amendments that the government has in its possession. Has the government reconsidered whether it will at least reveal to the chamber to which clauses of the bill those draft amendments pertain?

Hon STEPHEN DAWSON: No, we have not reconsidered. Indeed, I do not propose to go over this issue again. Mr Deputy Chair, these questions were asked last week; I do not propose to answer them again today. I would argue that we are starting to veer into the area of repetition. I do not propose to continue having this debate on the same issue week in, week out. I will park that issue there for a second.

In earlier comments, Hon Nick Goiran invited me to stand at any stage to make further comment, but then he did not welcome that advice from me. I make the point that a record investment has been made by this government in palliative care services across the state. It is a significant $220 million investment over four years. It is beyond anything that any other government has put into palliative care services. I also indicated that it is not just about sending services to people in remote and regional Western Australia; there is also the ability to bring a patient from regional and remote Western Australia to a centre or, indeed, a city if that is more appropriate. The honourable member is trying to trip us up by saying that we said that eight people could go out to regional Western Australia. I did say that, but the likelihood is that patients who are seeking access to services will be brought to a central location. The government is making a significant investment in palliative care right around regional and remote Western Australia. I am confident that people around the state will be able to access palliative care services into the future as a result of this investment.

Hon NICK GOIRAN: Yes, I did invite the minister to rise and respond, but I obviously meant that he needed to first seek the call—that is the normal process in here. I did not mean that he could jump up and interrupt another member when they were still making a contribution.

The minister indicated that part of the process the government is relying upon is what the minister described as record funding for palliative care. I draw to the minister’s attention that on 8 August this year, Hon Martin Aldridge asked a question in this place that was responded to by the parliamentary secretary representing the Minister for Health. His question was on the subject of the additional $30.2 million of funding to expand palliative care services in the regions and asked —

Has the government now defined a plan to allocate the additional funding?

Hon Alanna Clohesy said no. Since 8 August this year, has the government now defined a plan to allocate the additional funding to expand palliative care services into the regions?

Hon STEPHEN DAWSON: I am advised that the WA Country Health Service is still working through that plan.

Hon NICK GOIRAN: Has WACHS been allocated any of the funding increase of $30.2 million?

Hon STEPHEN DAWSON: Certainly, WACHS has been provided with some extra funding, but I will place on the record what is known so far, bearing in mind that the WA Country Health Service is working through a plan at the moment. It has previously been announced that more than 61 full-time equivalent positions will be employed over a phased approach across regional Western Australia. That is a tripling of staffing arrangements for palliative care support for regional Western Australia and includes the establishment of new specialist district palliative care teams comprising medical nursing, allied health and Aboriginal health workers across the regions. As part of the extra funding, $3 million will enable 24-hour support via the WA Country Health Service telehealth hub. There is also some extra money in the budget—$6.3 million—specifically for improving metropolitan and regional community-based services for care closer to home to better meet demand. A further $2.5 million has been committed to enable the WA Country Health Service to enhance rural and regional palliative care services by improving

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governance to refine models of palliative care and roll out services, ensuring that they best support the needs of rural and regional patients. Some money is in the process of being given to the WA Country Health Service, but that plan is still being worked on.

Hon NICK GOIRAN: Of the $30.2 million that the government promised in the budget, how much has been provided to WACHS at this stage?

Hon STEPHEN DAWSON: I am advised that the money has been committed to WACHS, but the WA Country Health Service is now working exactly where that money will be spent.

Hon NICK GOIRAN: The minister mentioned that the plan is for there to be an extra 61 full-time staff towards this initiative by government. Over what time frame is that expected to be delivered?

Hon STEPHEN DAWSON: I am advised that the funding envelope is over four years, so it may take some of those staff a period of time to be employed, but certainly the money is there over the next four years.

Hon NICK GOIRAN: I understand that. That is not my question. I do not want to know about the funding. I realise that is over a four-year period. I am asking: over what time frame are the extra 61 FTEs that the government is working on expected to be delivered?

Hon STEPHEN DAWSON: The likelihood is that those staff will be employed over that four-year period. In terms of the exact breakdown a year, I would have to take that question on notice.

Hon NICK GOIRAN: How many of the 61 extra FTEs are in place?

Hon STEPHEN DAWSON: Again, we would have to take that question on notice.

Hon NICK GOIRAN: Does the minister have access to information that would indicate whether at least one of the 61 FTEs are in place?

Hon STEPHEN DAWSON: I do not have that information before me, no.

Hon NICK GOIRAN: How much time would it take to access that information?

Hon STEPHEN DAWSON: I am not aware, honourable member. The member has asked the question now. People are listening to this debate. As soon as it comes to me, I am happy to give it. But I am not in a position to say whether it will take days, weeks, months or years.

Hon NICK GOIRAN: Are any of the extra 61 extra FTEs planned to be palliative care nurse practitioners?

Hon STEPHEN DAWSON: It has not been determined. WACHS is working through what type of healthcare professionals may be needed and where in the state those professionals will be needed.

Hon NICK GOIRAN: How did the government come to the figure of 61? That is a very precise number of FTEs for the government to determine, yet when I ask the minister when this will be done and whether it includes nurse practitioners, the government does not know; the minister keeps saying that WACHS is working on it. I respect that that is the position. The minister cannot do anything to control that. But I am curious to know how the government is able to be so precise by identifying 61 FTEs.

Hon STEPHEN DAWSON: We would have to go back to WACHS and ask for that. Certainly, my advisers with me this afternoon do not have an answer to that question, nor do I know the answer. I understand that apparently it is based on existing clinical levels across the state and this amount will triple the staffing arrangements for palliative care staff in regional Western Australia. That is the extent of the information I have. For anything more, I would have to seek further information.

Hon NICK GOIRAN: Speaking of existing clinical levels, how many palliative care nurse practitioners are employed in Western Australia?

Hon STEPHEN DAWSON: I am advised that it is a constantly changing figure, so we will have to seek some advice from the department on that. We could not give the member an exact figure today.

Hon NICK GOIRAN: Does the minister have access to information at the moment that would indicate whether the number of palliative care nurse practitioners in Western Australia is in single or double digits?

Hon STEPHEN DAWSON: Again, I cannot give the member an answer to that question. I am absolutely happy to answer these questions. I do not have it before me. I am happy to get an answer for the member, but I do not have the answer in front of me.

Hon NICK GOIRAN: That is fine. There is no criticism on my part. The minister is doing the best that he can in the circumstances. Obviously, had this matter been referred to the Standing Committee on Legislation as was recommended and moved by Hon Rick Mazza, we would be able to get to the bottom of these things and the process would be far more expedient, but there was a decision to reject that proposal, so both the minister and I are operating as best we can. I note that the government made a recent announcement to commit a further $17.8 million to palliative care service provision in metropolitan and regional Western Australia. How much of that $17.8 million has been allocated to palliative care service provision outside the metropolitan region?

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Hon STEPHEN DAWSON: I am advised that of that $17.8 million, $2 million will be dedicated to rural and regional Western Australia to fund care services for patients who have a potential risk of admission to hospital or residential aged care requiring domiciliary home-care services.

A further $2.5 million has been committed to enable the WA Country Health Service to enhance rural and regional palliative care services by improving governance to refine models of palliative care and roll out the services to ensure that they best support the needs of rural and regional patients.

Hon NICK GOIRAN: Of the $17.8 million, we can say that $4.5 million has been allocated outside the metropolitan region—$2 million for regional services and $2.5 million for WACHS governance. Does the government have a plan about how to allocate this additional funding?

Hon STEPHEN DAWSON: Again, that is an issue that WACHS is working through at the moment. The regional funds need to be allocated in conjunction with WACHS. I might also add that there is a further amount of $6.3 million in that $17.8 million budget. That has been allocated to improving metropolitan and regional community-based services for care closer to home to better meet demand. I am told this will fund community-based services to be delivered predominantly through non-government organisations across the state. There is the $4.5 million that I mentioned previously and also an amount from that further $6.3 million that will be spent in regional Western Australia. I do not have a further breakdown of that. I think that information is being worked on now by the department in terms of how to break that figure down between metro and regional service provision.

Hon NICK GOIRAN: These community-based services that the minister referred to, is that the type of service that Silver Chain currently provides?

Hon STEPHEN DAWSON: Yes, it is.

Hon NICK GOIRAN: In which parts of regional Western Australia does Silver Chain currently operate and in which parts of Western Australia does the minister anticipate it will operate with the benefit of some of this $6.3 million funding?

Hon STEPHEN DAWSON: I am told that Silver Chain has a small footprint outside the metro area, or in regional Western Australia. I am further advised that that may have changed recently, so I would have to seek further information on where it provides services outside the metropolitan area. Generally, this type of service is currently provided by the state, so it is done by the health department. However, I will seek some further information about where Silver Chain currently provides a service and where this extra money could go and therefore ensure that services are being expanded in regional Western Australia.

Hon NICK GOIRAN: A lot of information has now been taken on notice. I reiterate that that is not the minister’s fault; he is doing the best he can in the circumstances he finds himself in. It is very difficult for a member, even a metropolitan member like me, to be satisfied that regional Western Australians will have access to palliative care when most of the answers need to be taken on notice, including something like where Silver Chain operates at the moment. If we were to have a map of Western Australia to try to identify where the gaps are in the system, we would be unable to do that on the basis of the information provided today because everything has had to be taken on notice. This concerns me because I note that in the other place, on 3 September this year, the Minister for Health said —

Voluntary assisted dying does not preclude or prevent palliative care; these are not either/or choices.

I will continue to quote from him in a moment, but it seems to me that the answers we are getting today indicate that it is an either/or choice because people in regional Western Australia will be guaranteed VAD but they will not be guaranteed palliative care. When the minister said in the other place that it is not an either/or choice, in actual fact the information to the Committee of the Whole House would indicate otherwise. The Minister for Health went on to say —

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.

The minister may be aware that the WA branch of the Australian Medical Association conducted a survey in recent times and that 91 per cent—that is 1,398—of its medical practitioners who were surveyed believe that all patients outside metropolitan areas to ensure that there is equitable access to both health care and VAD services. It seems to me that at the moment VAD will be offered and made available to people living in Western Australia, whether in metropolitan Western Australia or in regional or remote Western Australia, but specialist palliative care services will not necessarily be offered. Given the AMA’s survey and the overwhelming response of those doctors—inevitably, some would have been for or against the scheme—what conversations has the government had with the Australian Medical Association to address the concerns of those practitioners as outlined in the survey?

Hon STEPHEN DAWSON: The member’s earlier question related to palliative care services across the state. On pages 30 and 31 of the document “WA End-Of-Life and Palliative Care Strategy 2018–2028”, there is a very

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In my first question, I asked the minister whether he had seen that document. Leave granted. [See paper 3334.]

I did not explain that clearly enough. I was talking about the government consulting with the Department of Health and the AMA. I have a copy of the AMA’s proposal. I would like to make this available to all members. This is important information. I seek leave to table the document. Leave granted. [See paper 3334.]

The government continues to have conversations with the WA branch of the AMA in relation to the bill before us and any concerns it may have about it.

Hon Colin Tincknell: Has the Minister for Health had conversations with the AMA about those matters in the survey that I raised; that is, 91 per cent of medical practitioners surveyed by the AMA believe that all patients should be offered accessible palliative care prior to, or at the same time as, voluntary assisted dying? I understand that the government is having ongoing conversations with the AMA on a range of things, including the government’s secret amendments that it will not table or release, and it will not provide advice on which clauses it has briefed parliamentary counsel. I understand that those conversations are occurring, but at present I am more interested in understanding what conversations the Minister for Health has had with the AMA about access to palliative care in the regions, which, according to this survey, 91 per cent of medical practitioners in Western Australia support.

Hon Stephen Dawson: That is 91 per cent of those medical practitioners who participated in the survey. Obviously, it is very important to point out that not every medical practitioner in Western Australia participated in that survey. Obviously, questions were asked at a certain point. In relation to the issue raised by the honourable member, the answer is yes, those conversations have occurred.

Hon Colin Tincknell: Last week and also today the minister mentioned during answers to questions that he had been consulting with the Department of Health and the Australian Medical Association. Last week, I also received a submission from the AMA dated 23 October. I understand that it was also sent to other members. Has the minister seen that submission? I think it had 19 proposals in it.

Hon Stephen Dawson: I wish to make it clear that I have not been engaging with the AMA on behalf of the government. I did not make that point last week. I said that the government was engaging with the AMA through the Minister for Health, whose bill is before us today. I want to make that clear. I have certainly had conversations and meetings with the AMA, as have other members of this place, when the AMA sought to brief us on amendments. I have not led any conversations with the Minister for Health. I have seen the document that the member referred to.

Hon Colin Tincknell: I did not explain that clearly enough. I was talking about the government consulting with the Department of Health and the AMA.

I have a copy of the AMA’s proposal. I would like to make this available to all members. This is important information. I seek leave to table the document.

Leave granted. [See paper 3334.]

Hon Colin Tincknell: In my first question, I asked the minister whether he had seen that document.

Hon Stephen Dawson: The answer is yes; I have already indicated that.

Hon Colin Tincknell: Now that I have tabled that document, other members will be able to look at it and respond to it. What is the government’s position on the proposals that have been put forward in that document?

Hon Stephen Dawson: The government continues to have conversations with the WA branch of the AMA on the issues that it has raised around this bill. Those conversations continue to occur. Obviously, the AMA is a valuable stakeholder. The government is working with the AMA at the moment to identify its specific concerns and assessing how its concerns may be addressed.

Hon Nick Goiran: Hon Colin Tincknell has obviously added up the proposals and worked out how many have been put forward by the AMA. I think it is appropriate at this point that the government indicate to the chamber its position on each of those proposals put forward by the AMA. It will not be of any use to us when the bill has already passed; we need to know now. I will take the minister through each of them. I have a copy of the document that he tabled as well. The first proposal of the AMA is that patients must have access to relevant and assessed palliative care. It will not be of any use to us when the bill has already passed. I am in a position to say that conversations continue between the WA branch of the Australian Medical Association and the minister’s office on its concerns about the bill. Any
proposed amendments by government following those conversations will appear on the supplementary notice paper under my name when a final policy decision has been made by the government on any proposed amendments from the AMA.

**Hon COLIN TINCKNELL:** The first proposal from the AMA relates to clause 16. Can the minister guarantee that if we left it until clause 16 to discuss this, no other clauses from 1 to 15 would affect those proposals in a way that we may not know?

**Hon STEPHEN DAWSON:** I am not in a position to give the member any guarantee on that issue. The member is very welcome to ask those questions at clause 16, as he is very welcome to ask questions on clauses 1 to 16, but I am not giving him any guarantees.

**Hon NICK GOIRAN:** How are we supposed to progress this bill in these circumstances? The government says that it has briefed parliamentary counsel but it will keep any draft amendments secret. The minister said last week that the government was discussing it with “interested members”. I have indicated to the minister, as have other members, that we are interested members. The government has not approached me to discuss those secret amendments that it has prepared with parliamentary counsel at taxpayers’ expense in circumstances in which I have also sought to draft amendments via parliamentary counsel. I am unable to get all my amendments drafted because the government is hogging the time of parliamentary counsel, blocking the capacity of other members to prepare amendments while he continues to keep his amendments secret. That is my first point.

My second point is that the minister has just been asked by Hon Colin Tincknell about the government’s position on the amendments proposed by the Australian Medical Association. The minister told us that the conversations are ongoing but he cannot tell us what the government’s position is on any of its amendments or proposals. The honourable member asked the minister whether he can guarantee that the first proposal will not impact on clauses 1 to 15, and the minister said that he cannot provide that guarantee. How are we supposed to operate in Committee of the Whole House in these circumstances when we are this constrained? I am staggered that people in government think that this is an appropriate way to carry out lawmaking. This would not be an appropriate way to carry out lawmaking on an innocuous piece of legislation, but Western Australian lives are at stake with this bill, irrespective of where members sit on the continuum of views. I think we all agree that it is a serious bill that requires all of our intellectual capacity and commitment. At the moment we have a government hogging the time of parliamentary counsel and hiding amendments. It is not prepared to tell us its position on any of the proposals put forward by one of the key stakeholders. I do not know when the government thinks it is going to reveal its position on these things, but I remind the minister of the comment made by his Premier, his leader, in the other place on 5 September 2019 when amendments were trying to be put at some unsatisfactory time of the morning. I quote from page 6669 of *Hansard*. He said —

> 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 with doctors, the health department and the like. 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 the minister’s Premier. His Premier says that is the right way to deal with legislation, yet this is the attitude when Hon Colin Tincknell simply asks the minister questions about a key stakeholder, the Australian Medical Association. He says, “Sorry, we cannot tell you that. We are having ongoing conversations with the AMA.” When will the ongoing conversations with the AMA finish? Will it be when we get past clause 18? That would be spectacularly helpful! I am very disturbed by the contemptuous attitude that the government seems to have to the processes of the chamber. I would personally like to know what the government’s view on a number of these proposals is. It is one thing for the minister to say to Hon Colin Tincknell, “Sorry, you can ask that question when we get to clause 16.” That was about the first proposal.

Can I get the minister to turn to the second proposal from the Australian Medical Association, which says that VAD must not be initiated by the health practitioner. The AMA says that the relevant clause is a new clause, so clearly there would be no other time this question could be asked than in the debate on clause 1. That is according to the AMA, because the provision is not in any other clause in the bill. No doubt the minister wants to make progress; I have no doubt he wants to move to clause 2. Is the minister telling the chamber that he is not able to tell us the government’s position on the AMA’s second proposal as to whether voluntary assisted dying must be initiated by the health practitioner? The AMA says that would require a new clause. Is the minister saying he cannot provide any advice to the chamber or tell us where the government is up to in its consultation with the AMA—that he cannot tell us anything about that? Is that the government’s position?

**Hon STEPHEN DAWSON:** What I can tell the chamber is that items in the document that Hon Colin Tincknell tabled this afternoon remain the subject of discussion between the WA branch of the Australian Medical Association and the state government. Those conversations continue. If at any stage amendments that the government supports come out of those conversations, they will appear in my name on the supplementary notice paper. Those conversations continue; they continue today. Obviously, the WA branch of the AMA is a very important stakeholder, but conversations about the bill before us continue with other stakeholders, too, and certainly about

*Extracted from finalised Hansard*
Members, I am just examining where we are going with this debate. What we are starting to do is to debate specific recommended amendments to identifiable clauses in the bill before the chamber. As I said when we started consideration of clause 1, back when we were all a bit younger, I indicated that the way we would prosecute the examination of this bill, particularly in regard to clause 1, was that where matters were specific to certain subsequent clauses, that would be where the substantial amount of examination should occur. That being said, if we are to examine closely proposed amendments or suggested amendments to certain clauses that are later in the bill, it would have to be demonstrated to me, I think, that the purpose in so doing was relevant to a clause 1 debate. If any member wishing to do so can satisfy me on that point, of course they can proceed. The question is that clause 1 do stand as printed.

Extracted from finalised Hansard
Hon RICK MAZZA: Thank you, Mr Chairman. Thank you for your wisdom and advice on how we should proceed with clause 1, which has given me great confidence to get up and ask this particular question. Minister, last week we spoke briefly about the delivery of voluntary assisted dying into regional and remote Western Australia. I still have some concerns around that; it is the reason I moved a motion to refer the bill to the Standing Committee on Legislation, which, of course, was defeated.

On 22 August, I received from the office of Hon Roger Cook an email in relation to the use of telehealth. One of the answers we got back is that Victoria has at this stage instructed its health practitioners not to engage in telehealth, but to consult face to face. This is in relation to the commonwealth Crimes Act; the provisions in that act were included in 2005 to address cyberbullying.

One paragraph in a letter from the Western Australian Attorney General, Hon John Quigley, around 26 August, states —

I note that leading legal experts who have examined the Western Australian Bill have noted that it explicitly states that VAD is not suicide, which the Victorian bill does not …

By that, it would seem the Attorney General is suggesting that the Western Australian bill does not offend the commonwealth act. Can the minister advise whether legal advice has been sought on this very issue, because I think last week he indicated that the government would not be instructing practitioners to engage in telehealth? Can the minister advise whether there has been legal advice on this; and, if so, whether he is able to table that advice?

Hon STEPHEN DAWSON: I think we had a long debate on this issue last week and I have answered these questions previously. Unless the member has a further question in relation to this issue, I do not propose to go over it—I cannot possibly. We have already spent a fair few hours on this bill, on clause 1. This is a very important bill, and, of course, members should feel free to ask questions in relation to the bill, but I cannot, and I will not, answer questions on issues that I have already answered, and I believe I have answered this question previously.

Hon RICK MAZZA: I recall some debate around this; that is not to say that the answers we got were satisfactory —

Hon Stephen Dawson: By way of interjection, you might not believe it is satisfactory, but I believe I have answered the question.

Hon RICK MAZZA: That is where we are going to have a parting of the ways as far as that is concerned. I do not believe we have been able to establish yet how this is going to be delivered to regional and remote Western Australia. The minister spoke last week about the hub-and-spoke method of being able to deliver VAD to regional and remote Western Australia, but we still do not know the detail of that.

Earlier today, in answer to Hon Nick Goiran’s questions on palliative care, the minister spoke about bringing patients back to a central point, such as Perth, to be able to deliver that palliative care. In many cases, dying in a regional centre—because palliative care, obviously, is getting towards the very end of life—is not acceptable where cultural sensitivities and dying in country are concerned. The minister has not yet given us full details on how this will be delivered in regional and remote Western Australia, particularly when telehealth cannot be used.

Hon STEPHEN DAWSON: As I indicated last week, how it will work throughout the state will be worked out during the implementation phase. However, certainly, the bill has been drafted in full awareness of those challenges being faced by regional Western Australians, and it does seek to enhance accessibility through the inclusion of nurse practitioners and has provisions for the appropriate use of technology where appropriate, as I said. We acknowledge the challenge of service access across rural and remote WA, but it is not the purpose of the bill to address issues related to general healthcare services in regional and remote Western Australia; this is solely about voluntary assisted dying. The conversation earlier with Hon Nick Goiran was about palliative care; it was not about voluntary assisted dying. What I said about voluntary assisted dying was that we would use a hub-and-spoke model and that in some cases it may be appropriate for the specialists to go to regional Western Australia and in other cases it may be appropriate for the patient to go to the metropolitan area. Again, it depends on the particular circumstances of the individual and it also depends to a degree on the choice of the individual.

Hon RICK MAZZA: Thank you for that, minister. I asked one question that was not answered today. Has the government received legal advice about using telehealth; and, if so, will the government table that advice?

Hon STEPHEN DAWSON: That question was answered previously and the answer was no.

Hon MARTIN ALDRIDGE: There are a few outstanding issues from last week’s debate that I have reflected on during the recess, one of which is the issue that Hon Rick Mazza just raised, and I apologise, I just came in on the end of that debate. It was my understanding that we left the issue with the minister seeking some guidance from the Minister for Health and perhaps the Attorney General about the extent to which there is a preparedness to waive privilege on the legal advice so that we can gain a better understanding of the commonwealth Criminal Code Act 1995 and its application on this bill. Is that not the case? Has the minister engaged with the Minister for Health and the Attorney General about that matter?

Hon STEPHEN DAWSON: Those conversations have been had between the two offices—that is, the Minister for Health’s office and the Attorney General’s office. I am not in a position to table the legal advice.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: Just to clarify, the minister is not in a position to table the legal advice. Can I read into that that the Minister for Health and the Attorney General refuse to waive legal professional privilege on the advice they received from the highest level of government, who, I assume, is the Solicitor-General, the state’s solicitor?

Hon STEPHEN DAWSON: What Hon Martin Aldridge can read into that is that the government is not willing to waive privilege in relation to the advice.

Hon MARTIN ALDRIDGE: I thank the minister for that clarification.

The other question that I asked and on which the minister said he would get back to me was the date on which the commonwealth Attorney-General’s Department first corresponded with the state Department of Health about concerns about the Voluntary Assisted Dying Bill 2019 and the intersect with the federal Criminal Code Act. Is the minister in a position to advise me of that date? Further to that, has the government reconsidered its position about tabling that correspondence in Committee of the Whole?

Hon STEPHEN DAWSON: I am told that the date was 21 August. I am not in a position to table any correspondence.

Hon NICK GOIRAN: Further to this, last week when Hon Martin Aldridge was seeking documents from the minister, there was plainly some confusion on the part of government about what documents were being referred to. I take the minister back to the exchange that he and I had last week, in which he said —

This question relates to matters within the Attorney General’s portfolio, so I will have to seek further advice and provide an answer later today.

Of course, that did not happen, which is why I am following it up now. My response was —

I take the minister to the document that he tabled today, dated 28 August 2019. As Hon Martin Aldridge has just identified, it states —

The Western Australian Department of Health has recently received a communication from the Attorney-General’s Department …

That has nothing to do with the state Attorney General’s department. It has to do with the Department of Health. At the moment, the minister is representing the Minister for Health. It is not satisfactory to then palm this off and handball it to Hon John Quigley, who has nothing to do with this situation. Hon Martin Aldridge is asking about the Western Australian Department of Health and its interactions with the Attorney-General’s Department, and asking for that information to be provided. It seems to me very appropriate of the honourable member and it seems incumbent upon the government to provide a response.

The minister replied —

My answer remains the same: I have given an undertaking to seek further advice that I am not in a position to give now.

What is the outcome of the undertaking that the minister gave to the chamber last week?

Hon STEPHEN DAWSON: The undertaking was to seek further advice on this matter. I sought further advice and I am not in a position to table any correspondence about the issue the member just asked me about.

Hon NICK GOIRAN: From whom did the minister seek that advice?

Hon STEPHEN DAWSON: The advice was sought from both the Minister for Health’s office and the Attorney General’s office.

Hon NICK GOIRAN: When was that done?

Hon STEPHEN DAWSON: Conversations were had last Thursday, and I believe further conversations were had on Friday.

Hon MARTIN ALDRIDGE: It is a difficult position in which we find ourselves in that we are unable to consider these matters more specifically in a committee examination of the bill. Nevertheless, the government’s unwillingness to provide the correspondence from the commonwealth expressing its concern and indeed providing the advice on which the government is acting makes it very difficult for us as legislators to understand the path forward faced by government following the passage of this bill if, indeed, that is the case. I sympathise with the government because this is not necessarily a problem of its own doing, nor is the solution in its control. Ultimately, it is a matter on which the commonwealth will act in time, but it will create barriers for delivery. Given that we are not able to get some of that detail, I want to understand—I do not want to delay this matter any more than it needs to be delayed, but it really is only a clause 1 matter—the three elements of the operation of the bill that I see as likely to encounter problems with the federal Criminal Code Act; that is, the operation of care navigators, the operation of consulting and coordinating practitioners and the referral to seek further advice from a specialist or an appropriately qualified practitioner. My understanding from the committee stage thus far is that the operation of care navigators and referral for advice to an appropriate practitioner with relevant expertise would not be encumbered by the application of the federal Criminal Code Act. I ask the minister to confirm that in his reply. The real issue is the
consulting and coordinating practitioner, the roles of which are obviously clearly defined in the bill and are therefore clearly captured by the prohibition of using a carriage service under the federal Criminal Code Act. Can the minister confirm that?

**Hon Stephen Dawson:** Best practice would be that some of those conversations happen face to face. I also add that my adviser told me that the state continues to have discussions with the commonwealth. Once this issue is settled, practitioners and navigators will be instructed accordingly, but the conversations between the state and the feds continue.

**Hon Martin Aldridge:** From what I understand, the position of the state is that best practice in all those categories would be face-to-face communication. From the answers the minister gave to my previous questions, I understood, for example, that a referral to a specialist under the bill would not be encumbered by the provisions of the federal Criminal Code Act. I expressed some relief about that response in the committee stage. Is that now incorrect?

**Hon Stephen Dawson:** My advisers tell me that that is still the case.

**Hon Martin Aldridge:** That is good. If a coordinating practitioner or a consulting practitioner —

**Hon Stephen Dawson:** Just by way of interjection, I used the term “best practice”. It might be face to face. I have not said anything today that is contrary to the advice I gave last week.

**Hon Martin Aldridge:** Okay. If the consulting or coordinating practitioner needs to refer a patient, based on the information the minister has provided, that referral could take place using a carriage service without contravening the federal Criminal Code Act. Is that correct?

**Hon Stephen Dawson:** I am told that the referral will be on a particular eligibility criterion. It will not be about accessing voluntary assisted dying. Does that answer the member’s question?

**Hon Martin Aldridge:** Okay. Just to make sure that we are on the same page, if a coordinating practitioner refers somebody to a psychiatrist to determine capacity, that would obviously be for a determination of capacity as opposed to some other aspect of the regime that would likely trigger the anti-suicide provisions of the commonwealth.

**Hon Stephen Dawson:** That is correct.

**Hon Martin Aldridge:** Thanks, minister. It is good to get that clarity.

With respect to care navigators, obviously that path is a little more murky. I understand that their role will be to provide advice to patients around access to the regime and to physicians.

**Hon Stephen Dawson:** You might say “murky”, but I would say “less clear”, because we are waiting for the implementation phase to happen.

**Hon Martin Aldridge:** I assume that the minister is not able to provide any explicit advice on care navigators, because parts of their function may well avoid the federal Criminal Code Act, whereas other aspects could trigger the Criminal Code Act, depending upon the assistance they are providing to, or the role they are playing with, the patient. Is that fair?

**Hon Stephen Dawson:** That is correct, honourable member.

**Hon Nick Goiran:** Last week, when we were discussing the government’s inability to confirm whether telehealth will be able to be used to facilitate this scheme and why the Ministerial Expert Panel on Voluntary Assisted Dying failed to identify this legal difficulty, the minister revealed that the ministerial expert panel did not keep any minutes. The minister also undertook to ascertain the cost to the people of Western Australia of the ministerial expert panel. Does the minister now have that cost available?

**Hon Stephen Dawson:** I indicated that the ministerial expert panel had not considered that issue. I add that the Joint Select Committee on End of Life Choices did not consider that issue either.

**Hon Nick Goiran** interjected.

**Hon Stephen Dawson:** I am sorry; I am answering questions now. As the honourable member quite rightly pointed out earlier, only one person speaks at a time.

The cost of the ministerial expert panel over 2018–19 and 2019–20, when appropriate, was $225 517.66, and the consultation cost was $266 005.70.

**Hon Nick Goiran:** Approximately $225 000 was spent on the ministerial expert panel. Did I hear correctly that $226 000 was spent on the consultation process? I am happy to have that provided by way of interjection.

**Hon Stephen Dawson:** The member cannot have it both ways. I am always happy to do it by way of interjection, but that obviously needs to be reciprocated at the appropriate time. I will clarify the figures for the member. The cost of the MEP was $225 517.66. The consultation cost was $266 005.70.
Hon NICK GOIRAN: The overall work of the ministerial expert panel totalled nearly $500 000—it was spent partly on the ministerial expert panel itself and partly on the consultation process. The minister indicated that some costs fell into the 2019–20 period. I forget the date on which the ministerial expert panel handed down its final report. Was it in the financial year or last financial year?

Hon STEPHEN DAWSON: The panel handed down its report in June 2019, but I understand that some of the invoices were not submitted until the next financial year.

Hon NICK GOIRAN: On what basis are any invoices being sent to the government from the ministerial expert panel? Is it because individual members of the panel are invoicing the government? What type of invoices are we talking about?

Hon STEPHEN DAWSON: I am told that members of the ministerial expert panel could seek reimbursement for their time and for travel expenses to meetings or if they needed to go further afield. The consultation costs may well have included the cost of booking facilities for some of those meetings or forums and, indeed, the advertising of those forums. Those items would be captured by that consultation amount.

Hon NICK GOIRAN: Was the reimbursement amount for time the same for all members of the panel, or were different members able to charge different rates?

Hon STEPHEN DAWSON: It was based on advice from the Public Sector Commissioner. The PSC rate was set for the chair, deputy chair and members of the ministerial expert panel. It is important to note that not every member of the panel could access reimbursement. If some members were employed by the state, obviously they could not be reimbursed. I am further advised that this was a Public Sector Commission determination at public sector rates as opposed to any rates that people may be paid—or indeed QC rates—in the broader community. It was not those rates; it was our own.

Hon NICK GOIRAN: The minister mentioned last week that one of the few things the ministerial panel maintained was a meeting attendance register. Can the minister table that?

Hon STEPHEN DAWSON: We can table it. We will have to table it later today, honourable member. It has been accessed, but I will have to do it later in the day.

Hon NICK GOIRAN: The minister indicated earlier that the ministerial expert panel—or the panel that has some experts on it—elected to support the view of the Joint Select Committee on End of Life Choices and the minister referred the chamber to pages 64 and 65 of the panel’s final report. To what extent does the expert panel’s view differ from the Australian Medical Association’s view?

Hon STEPHEN DAWSON: Can the honourable member clarify—or maybe I can clarify it for the member—whether he is referring to the AMA’s view on 21 October 2019, which is the view expressed in the document tabled this afternoon?

Hon Nick Goiran: Yes, the twenty-third.

Hon STEPHEN DAWSON: Obviously, the AMA continues to have conversations with the government about these issues. I want to clarify that the member is talking about this document.

Hon Nick Goiran: Yes.

Hon STEPHEN DAWSON: I will seek further information for the member. I think there is agreement on that issue. Page 3 of the AMA’s document refers to the doctors being independent, which is the same as the ministerial expert panel’s advice that they should be independent.

Hon NICK GOIRAN: As I understand it, the minister has indicated to the chamber that there is agreement between the joint select committee, the ministerial expert panel and the Australian Medical Association. Therefore, will the government agree to the amendment proposed by the AMA?

Hon STEPHEN DAWSON: That is very tricky, honourable member. I again make the point that the government is in active dialogue with the AMA about its proposed amendments. Those conversations are continuing today, I understand. I made the point about clarifying whether the member is referring to this document before us, because my understanding is that as part of the dialogue with the AMA, there is some toing and froing, and I think people’s understanding of the issues continues to move. I am not in a position to say now what amendments may be moved, but I certainly indicate that active consideration is being given to the issues raised by the Australian Medical Association’s WA branch.

Hon NICK GOIRAN: I refute the suggestion by the minister that somehow I am the one being tricky here. The only one being tricky is the government, which has briefed parliamentary counsel, and it is hiding the amendments that it has drafted and it will not let the 36 members of this place know what those amendments are. That is trickery of the highest order, and, worse, this government will not tell us which clauses the amendments pertain to. There is no trickery by me or other members here. The only trickery is by the government and that is exasperating, and no way to make law at the best of times, let alone when the stakes are this high and the purpose of this bill is in effect to give doctors a licence to kill. That is what this bill will do. The result of this bill will be lawful killing of
Western Australians. That is why the stakes are so high. People have a view to say that that is what the community wants, and clearly that is what will happen, but I refute categorically that I am, or any other member here is, being tricky when the government is hiding amendments from us.

The minister can understand my exasperation because Hon Colin Tincknell earlier asked the minister whether he could guarantee that this would not have an impact on any clause between clauses 1 and 15, and the minister said that he could not give that guarantee. The difficulty I have is how do we progress from clause 1 to clause 2 when the minister is unable to provide the member with an assurance that the AMA’s first proposal, which the minister has identified has the agreement of the joint select committee, the ministerial expert panel and the AMA—those three bodies agree on this issue of independence—will not have any impact on clauses 1 to 15. Regardless, the minister wants us to progress past clause 1. I suspect that the minister understands the difficulty that members then have, particularly when all members of this place are expected to cast a conscience vote. We cannot be told what the government intends to do, other than that the conversations with the AMA are ongoing.

Can the minister indicate to the chamber whether the ministerial expert panel provided any advice to government on whether voluntary assisted dying should or should not be initiated by a health practitioner?

Hon STEPHEN DAWSON: Yes, it did.

Hon NICK GOIRAN: Where can we find this advice from the panel of experts?

Hon STEPHEN DAWSON: I am advised yes; the joint select committee made a recommendation and the ministerial expert panel agreed with it. The Ministerial Expert Panel on Voluntary Assisted Dying deals with that issue on pages 30 and 31 of its report.

Hon NICK GOIRAN: I understand the minister indicated that the view expressed by the joint select committee was endorsed by the ministerial expert panel, but to what extent does that differ from the proposal put forward by the WA branch of the Australian Medical Association?

Hon STEPHEN DAWSON: I presume the honourable member is talking about page 6 of the AMA’s document. If that is the case, this provision mimics Victoria’s legislation. Neither the joint select committee nor the ministerial expert panel supported this way forward.

Hon NICK GOIRAN: What is the position of government on this?

Hon STEPHEN DAWSON: The view of government is in the bill before us, honourable member. There is no prohibition.

Hon NICK GOIRAN: The minister said that the government is in ongoing conversations with the AMA about the bill and also about all 19 of its proposals. Unlike the first proposal—the minister indicated there is agreement between the joint select committee, the ministerial expert panel and the AMA—in this instance the minister said that there is agreement between the joint select committee and the ministerial expert panel, but the AMA does not share the same view. I am simply asking what the government’s position is. This demonstrates the problem with the government not being transparent in indicating where it is at with the 19 proposals put forward by the AMA. In this short exercise, we can see that there is a difference between proposal 1 and proposal 2. Obviously, it is not in the bill. I think the AMA identified that as well when it said that a new clause should be inserted at this point. I note that the AMA’s proposal indicates that the policy intent is —

To protect individuals who may be open to suggestion or coercion by registered health practitioners, not to discourage open discussions driven by the individual. It is not intended that every single subsequent discussion be initiated by the patient.

The AMA went on to say that 50 per cent of survey respondents think that registered health practitioners should be prohibited from initially suggesting the option of VAD. The suggested wording reflects section 8 of the Victorian VAD act. The minister indicated to us that the position of government on this is that it is not in the bill, but what is the position of government in its ongoing conversations with the AMA?

Hon Stephen Dawson: What is the question?

Hon NICK GOIRAN: Further to that, minister, what is the position of government in respect of the conversations it is having with the AMA on this proposal?

Hon STEPHEN DAWSON: I am not sure what the member is asking. If I can again refer to the fact that the government continues to have conversations with the WA branch of the AMA about the legislation before us. That document was obviously correct at a point in time. The document I have is dated 21 October 2019, but I think the honourable member might have said he has one dated 23 October.

Hon Nick Goiran: I have the one that was tabled today.

Hon STEPHEN DAWSON: The one that has been handed to me by the advisers here today is 21 October 2019. Does the member have a different document?

Hon Nick Goiran: I am dealing with the one that has been tabled.
Hon STEPHEN DAWSON: The tabled document that has been handed to me by the attendant says 21 October 2019.

Hon Nick Goiran: I accept that.

Hon STEPHEN DAWSON: I would not be surprised if the member has a different document because, as I have said, the conversations between the WA branch of the AMA and the government continue to take place. My understanding is that the AMA may well have formed a different view on some of these issues since that date. The conversation continues between the state and the AMA about possible amendments, as does the conversation continue between other people who are interested in moving amendments to the bill, and government too. This document was correct at a point in time. The honourable member said “50 per cent”, but I think he meant to say 54 per cent. I think that was a misreading. I will make the point again: this was from a number of people who participated in a survey. This was not every doctor or medical professional in Western Australia; a limited number of people participated in the survey. There are others with differing views, as there are differing views in different organisations involved in this space. Conversations continue; it is an ongoing dialogue. It does not mean we agree with the AMA or anybody else about amendments. Some issues that can be addressed during the implementation phase do not require amendments to the bill, but certainly the conversation continues with the AMA.

Hon COLIN TINCKNELL: I am having real trouble. I do not understand why the government will not inform us about what amendments it is considering. It is not just the AMA—medical specialists, palliative care doctors and nurses, psychiatrists, disability rights advocates, Aboriginal groups, suicide prevention advocates, politicians and thousands of other people from many other groups have said they have concerns. We are trying to find out what amendments the government is considering so we can make an informed decision in this place. I feel that we are getting close to the end of clause 1 and it worries me that many of these things will not be able to be brought up once we have gone past clause 1.

Hon STEPHEN DAWSON: With the greatest of respect, perhaps I can spell it out to the honourable member: the reason there are no amendments in my name at this stage is that everything is being considered. Those issues that have been raised by multiple stakeholders outside this place are under consideration by government. When the government agrees with amendments to this bill, they will appear in my name on the supplementary notice paper. That is the standard practice for any bill under consideration by this place. The member has been in this place for a couple of years now. When amendments to any bill being dealt with by this place have been agreed by government and a policy decision has been made in relation to amendments, those amendments appear on the supplementary notice paper, plain and simple. That is the process that is normally followed and it is the process being followed now when considering this bill. The government has not decided on, or agreed to, any amendments. The conversations continue to happen. Members will know whether amendments have been agreed upon when they appear on the supplementary notice paper. At this stage, again, there are none in my name.

Hon COLIN TINCKNELL: Is it standard practice for those amendments to be made after discussion on clause 1 has finished?

Hon STEPHEN DAWSON: It is standard practice for amendments to appear on the supplementary notice paper at any stage of the bill, before a clause has been debated. That is the standard practice and that is what is happening with this bill.

Hon NICK GOIRAN: The Minister for Health was reported in the media last week indicating that certain things with respect to this bill would be “deal-breakers”—I think that is the word he used—or words to that effect. Are any of the proposals that have been put forward by the AMA deal-breakers?

Hon STEPHEN DAWSON: I made it clear in my opening remarks this afternoon, and I will make it clear again, that the government will consider any amendments to the bill before us that we believe are reasonable and that do not undermine the bill, its policy and purpose. If they do not undermine the bill, its policy and purpose, we will certainly give them careful and objective consideration. We are dealing with clause 1. There are no amendments before me at clause 1, so there are no amendments for the government to consider at clause 1.

Hon NICK GOIRAN: Do any of the 19 proposals put forward by the WA branch of the Australian Medical Association undermine the bill?

Hon STEPHEN DAWSON: I am not in a position to answer what may or may not undermine the bill in relation to the proposed amendments that were on the bit of paper dated 21 October 2019. As I have said a few times, the government continues to have conversations with the WA branch of the Australian Medical Association on a number of proposed amendments. I understand that those conversations are very good, and we continue to have those conversations with the AMA. It is an appropriate and important stakeholder in relation to this bill. I am not in a position to go through each of the suggested amendments of that date because, to my knowledge, none of them appear on the supplementary notice paper in the way that they have been written by the AMA.

Hon NICK GOIRAN: It does not work like that. If amendments were on the supplementary notice paper and I asked the minister questions about them, he would say to me, “Hold fire on those questions until we get to that part of the bill.” Some of the proposals that are before us are not on the supplementary notice paper. We, as members with a conscience vote on this matter, need to know whether it is worth our while briefing parliamentary counsel on
any of the 19 amendments put forward by the AMA. Is it worth us investing the time of parliamentary counsel, at taxpayers’ expense, to do that? I do not want to do that if the minister and his government have already done that. That would be a waste of taxpayers’ money and it would be a waste of parliamentary counsel’s time. The minister wants to continue to keep that secret. That is why we continue to ask these questions.

Hon Peter Collier has been asking the minister for some time whether this government will consider any amendments. The minister’s final answer was that he would consider any amendments so long as they do not undermine the bill. When we asked him whether a particular proposal undermines the bill, he said that he cannot answer that question. How do we make progress in those circumstances? We are engaging in a circular circuit at the moment if, at every opportunity, the minister indicates that he cannot tell us what we are doing, he will not tell us what he is doing and he will respond to questions in due course only when they are on the supplementary notice paper. That leaves us with no choice but to brief parliamentary counsel on all and sundry and put all the amendments on the supplementary notice paper—we will probably end up having a massive supplementary notice paper—and work with the government to identify which ones it considers undermine the bill and which ones do not. I am not too sure that that is the most efficient way of progressing but if that is the only way the government desires to progress the passage of this bill, I am happy to accommodate that.

With respect to the 19 amendments that have been put forward by the AMA—it is clear that the government is not willing to tell us whether any of them undermine the bill—I intend to ask the minister about one of the proposals. I intend to do that because in each and every one of the other proposals, the minister will see in the document before him that the AMA has identified particular proposed sections that are relevant. I foreshadow for the benefit of his advisers that when we get to those proposed sections, inevitably questions will be asked about those matters. Perhaps some rigorous preparation can be done in readiness for those questions so that when we get to clauses 4, 5, 6, 15 and so on, we do not find ourselves in the situation in which I ask, yet again, having given a massive amount of notice, whether the government’s position is that this proposal undermines the bill and the minister says that he is not in a position to say anything. I am just giving notice now about an efficient way forward. That will require people to do some work on those particular proposed sections between now and then.

I want to take the minister to proposal 4 now because we cannot do it anywhere else. I will work from the document dated 21 October 2019 that was tabled earlier today. The title on page 8 is —

S4. Extra consult if no pre-existing therapeutic relationship

It identifies a necessary new section. A form of words is proposed. Was the government informed about this issue by the Ministerial Expert Panel on Voluntary Assisted Dying?

Hon STEPHEN DAWSON: In his earlier remarks, Hon Nick Goiran alluded to the circular conversation that we are having this afternoon. Madam Deputy Chair, I seek your guidance and the guidance of other Chairs. I ask whoever is presiding over this debate that when they hear the circular nature of this debate, they advise members of the standing orders about repetition. We should not be having circular conversations on the same issue multiple times. We should not be going back over the same points. I will just make that point. I did not seek a point of order at the time. However, the honourable member has pointed out that we are having circular conversations. In my mind, that means that we are dealing with the same issue again and again. Although the honourable member might not be happy with the answer that I am providing, it is the answer.

As I have said again and again, amendments that the government intends to move will appear in my name on the supplementary notice paper. There are no amendments in my name on the supplementary notice paper at this stage. We believe that the bill before us is a good one. There was a significant amount of consultation on the bill. We have taken advice from many experts and we have landed in the place where we are at. Notwithstanding that, I have also said that we continue to have conversations with members who want to move amendments. If other members want to move amendments, they should have those amendments drafted. I have said that any amendments will be considered at the appropriate time when those amendments are raised.

As to the last question, I am advised that in relation to page 8 of that document, that issue was not considered by the ministerial expert panel.

The DEPUTY CHAIR (Hon Adele Farina): Before I give the call to Hon Nick Goiran, in relation to the minister’s request that the Chair and Deputy Chairs take note of the circuitous discussion and reference to the repetitious debate, I draw the attention of members to standing order 48(1), which states —

A Member who persists in making irrelevant or repetitive arguments may be ordered by the President to discontinue the speech.

It refers to a speech, not questions. I also think that the Chair and Deputy Chairs are more than capable of presiding over the Parliament without instruction.

Hon NICK GOIRAN: Thank you, Madam Deputy Chair. If anything circular has been happening today, it has been the tedious repetition of the minister’s answers and the ongoing obsession by this government with secrecy and the unwillingness to provide transparency or real answers to questions. Yes, there are responses—there are

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responses that are words articulated out of the mouths of ministers—but they are not satisfactory answers. The minister indicated that the fourth proposal on page 8 of the document dated 21 October this year, tabled earlier today by Hon Colin Tincknell, was not covered by the ministerial expert panel, so it seems to me to be yet another area that this panel has failed to address—the panel that cost taxpayers half a million dollars. Between the panel and the consultation process it has cost the people of Western Australia half a million dollars, and the panel was unable to identify the problem with federal law, which the government still has not been able to resolve. Now we have another matter that the Australian Medical Association has identified that the ministerial expert panel was not able to identify. Let us remember that this is the panel that did not even think it was appropriate to keep minutes: “We will rack up a charge of half a million dollars to the people of Western Australia, but we will not do our job with sufficient professionalism to keep minutes.” I find that appalling and unacceptable, and I cannot believe that that has happened. Nevertheless, it is clear that is what has occurred to the tune of half a million dollars to the taxpayers of Western Australia.

Last week, when the minister was asked by Hon Martin Aldridge whether the bill’s so-called conscientious objection provisions apply only to individuals and not to institutions, he indicated that there was no need for this as no obligations are imposed on institutions. Which institutions has the government consulted about this?

Hon STEPHEN DAWSON: Noting that the conscientious objection provisions were first raised by the Joint Select Committee on End of Life Choices, which the ministerial expert panel agreed to, I can point to the organisations that were consulted as part of the ministerial expert panel’s final report. They are listed on pages 130 and 131 of that report. They are the organisations that were consulted about this bill, and they were consulted generally about it.

I will now take the opportunity, in the interests of transparency, to say that I am very happy to provide further information to the chamber. Hon Nick Goiran asked about the Ministerial Expert Panel on Voluntary Assisted Dying’s meeting attendance register, and I will table it. I ask chamber staff to provide the member with a copy of it. It lists the various members of the ministerial expert panel, the meeting dates and whether members attended those meetings.

[See paper 3335.]

Hon NICK GOIRAN: The minister referred us to pages 130 and 131 of the ministerial expert panel’s final report, and indicated that the organisations listed have been consulted, but he indicated to us earlier that this was done before the bill was made public. I recall last week asking the minister which organisations were consulted about the tenth draft, which the minister indicated was the draft version of the bill provided to certain agencies of government, but none of them seem to appear on this list. In any event, the list on pages 130 and 131 does not take us forward, because it applies to the time before the release of the bill. I go back to my earlier question: which institutions has the government consulted about the conscientious objection provisions raised last week by Hon Martin Aldridge?

Hon STEPHEN DAWSON: The institutions consulted about the tenth consultation draft of the bill that the honourable member just referred to again were the coroner, the Department of Justice, the Health and Disability Services Complaints Office, the Solicitor-General, the State Administrative Tribunal, the Department of Health, the Director of Public Prosecutions, the Public Advocate, the State Solicitor’s Office and the WA Police Force. The organisations listed on pages 130 and 131 of the ministerial expert panel’s report were, of course, the organisations that were consulted on the issue of voluntary assisted dying. The issue the member refers to would have formed part of the conversations with many of those organisations.

Hon NICK GOIRAN: The minister said the issue would have been part of the conversations with those organisations, but was it?

Hon STEPHEN DAWSON: Certainly, the issue was raised at various times. It would have been raised at a number of the public consultations and it would also have been raised in a number of the submissions received by the ministerial expert panel.

Hon NICK GOIRAN: Did any of those organisations that raised the issue with the ministerial expert panel express any concern about the need for a conscientious objection provision applying to institutions, not just individuals?

Hon STEPHEN DAWSON: I am advised it was not a common theme. It could have been raised by an organisation, so we would have to check, but I do not have that information before me.

Hon NICK GOIRAN: Do I take from that then that this issue is not specifically addressed in the final report?

Committee interrupted, pursuant to standing orders.

[page 8416]

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Dr Steve Thomas) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 1: Short title —

Committee was interrupted after the clause had been partly considered.

The DEPUTY CHAIR: Does the minister have anything to progress with before I open the floor?
Hon STEPHEN DAWSON: I certainly do. Before question time was called, I had begun to seek advice from my advisers. I am going to get that advice and I will provide an answer.

Hon Nick Goiran asked some questions about palliative care and asked us to drill down further. I have not got that information yet. We are still seeking that information. I was also asked whether there needed to be provisions in the bill for organisations to conscientiously object. Institutions do not have to participate in the actual process. They are not required to do anything in the voluntary assisted dying process. The Ministerial Expert Panel on Voluntary Assisted Dying received a submission from Bethesda Health Care. I will quote from page 52 of the final report of the Ministerial Expert Panel on Voluntary Assisted Dying. It states —

‘Bethesda is of the view that an individual healthcare provider or organisation should not be obliged to refer a patient that wants to access voluntary assisted dying on to some other person or service that is prepared to help them.

Note, however, that as part of our commitment to compassionate, patient-centred care, Bethesda (at this stage) would be prepared to provide the contact details for an appropriate co-ordination and navigation agency to patients if they request either information about voluntary assisted dying, or to access the process.’

That was mentioned in one of the submissions. Obviously, we have had just a short break. I have not been able to get further advice about which other organisations may have mentioned their objections to participating in the bill. That is one example.

Hon NICK GOIRAN: This is interesting. Thank you for drawing this to our attention. I note that last week other members asked questions about institutional conscientious objection. It has now been drawn to our attention that some exchange occurred between institutions and the ministerial expert panel. I note that on page 52 of the final report that the minister took us to, it also states —

In seeking to achieve a balance between these needs, the Panel determined that the most appropriate option was to recommend that practitioners and services that have a conscientious objection have an obligation to provide information to people seeking voluntary assisted dying but are not obliged to refer on. This would appear to be an acceptable ‘middle ground’.

The ministerial expert panel then quoted the submission by Bethesda Health Care, as articulated by the minister, and on page 53 stated —

The Panel is mindful that this is contrary to the Joint Select Committee recommendation that practitioners should be obliged to offer to make a referral.

It appears that there is a difference between the joint select committee and the ministerial expert panel. Where does the government sit in respect of that difference?

Hon STEPHEN DAWSON: The government agrees with the ministerial expert panel.

Hon NICK GOIRAN: Which part of the joint select committee’s report does the government disagree with?

Hon STEPHEN DAWSON: With the obligation to mandatorily refer.

Hon NICK GOIRAN: Where do we find that in the joint select committee’s report?

Hon STEPHEN DAWSON: Page 225 onwards of the committee’s report, “My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices”, has the “Voluntary Assisted Dying Legislation Framework” and page 228 has a part on “personal objection”, which says —

At the time the patient makes the first verbal request, any doctor with a personal objection to providing assisted dying must inform the patient of the objection and offer to refer the patient to a doctor who is willing to provide assistance.

Hon NICK GOIRAN: That is what the joint select committee said at page 228 under “personal objection” in the framework that it asked the government to consider. Do I take it that that is not what this bill does?

Hon STEPHEN DAWSON: That is correct. The bill does not have the referral obligation.

Hon NICK GOIRAN: The minister says that the government does not have the referral obligation, despite the fact that that is what the joint select committee suggested to the government. Are there other parts of what the joint select committee has asked the government to do that the government has rejected?

Hon STEPHEN DAWSON: I am advised that the government accepted the recommendations, in principle. Recommendation 21 was that the minister establish an expert panel, including health and legal practitioners and health consumers, to undertake consultation and develop legislation for voluntary assisted dying in Western Australia and that this report, together with the framework contained at the end of chapter 7, be considered by the panel. We accept the recommendations in principle. Further work was then done by the ministerial expert panel so a number of issues were amended, following consultation either on the advice of the ministerial expert panel or those other agencies that I mentioned earlier that were consulted as part of the consultation process.

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The DEPUTY CHAIR: Before I give Hon Nick Goiran the call, I will need members to make sure that they are pointing out a relationship between the question they are asking and the bill. I am generally being fairly relaxed because it is a wideranging debate, but there should be a connection between the questions and the bill.

Hon NICK GOIRAN: For the sake of clarity, I am following up on answers that the minister gave to Hon Martin Aldridge’s questions last week on clause 1 of the bill and, in particular, the so-called conscientious objection provisions, which, as I understand, from the exchange between Hon Martin Aldridge and the minister last week, applied only to individuals and not institutions. I am asking the government to clarify that. It has taken me to page 228 of the “My Life, My Choice” report and the heading “Personal obligation”. The government has confirmed that it has rejected the view of the joint select committee that there should be an obligation to refer the patient to a doctor who is willing to provide the assistance. It has indicated that with respect to the framework. The government has now indicated to us that the ministerial expert panel has considered this issue, taking us to pages 52 and 53 of the panel’s final report. It is now apparent that the ministerial expert panel holds a different view from the joint select committee and that the government has accepted the view of the ministerial expert panel but rejected the view of the joint select committee. I am trying to identify what other elements of the work of the parliamentary joint select committee the government has decided to reject and instead support the position of the unelected panel of so-called experts who, I might note, decided not to take any minutes, unlike the parliamentary committee.

The minister has taken us specifically to recommendation 21, which I note reads —

The Minister for Health establish an expert panel including health and legal practitioners and health consumers to undertake consultation and develop legislation for voluntary assisted dying in Western Australia, and that this report, together with the Framework contained at the end of Chapter 7, be considered by that Panel.

Does the government have in its possession a list of those things that were proposed by the joint select committee that have been rejected by government? Does it also have a list of those things that the ministerial expert panel has proposed to government that it has rejected?

Hon STEPHEN DAWSON: No, I do not have such a list.

Hon NICK GOIRAN: We will follow that up later. For the time being, I want to get back to this issue of the institutional conscientious objection and the view of the government to reject the position taken by the joint select committee. I ask the minister to turn to page 228, which is the page he referred me to, of the “My Life, My Choice” report. Under the heading “Personal objection”, the joint select committee in its so-called framework went on to suggest —

Where a person is an inpatient in a health service unwilling to provide assisted dying, that service must facilitate timely transfer to another service.

Can the minister indicate whether that is supported by the government? Was it supported by the ministerial expert panel? Is there a provision in the bill that makes that happen?

Hon STEPHEN DAWSON: I am advised that the answer to the first two questions is yes. However, there is no provision in the bill. I am further advised that it is good clinical practice for an organisation to do that.

Hon NICK GOIRAN: That provision in the framework found on page 228 says that the service must facilitate timely transfer to another service. Does the absence of something specific on that in the bill mean that a health service that is unwilling to provide assisted dying is not obliged to facilitate timely transfer?

Hon STEPHEN DAWSON: We are trying to find further information, but I am told that this is consistent with guidelines that have been issued by the Medical Board of Australia to practitioners. We are just trying to see what else we have in front of us.

Hon NICK GOIRAN: Last week the minister also indicated that if a patient has requested a transfer from an institution that will not permit voluntary assisted dying to be executed on its premises, the institution would need to facilitate that transfer. The minister has just indicated that that would be consistent with what the member referred to as “good clinical practice”. He further indicated that if a person in the institution was concerned that the patient had been coerced to transfer, they could approach the Voluntary Assisted Dying Board. When I asked the minister what the Voluntary Assisted Dying Board could do, he said it could approach the police. What powers do WA police have to intervene in that transfer process?

Hon STEPHEN DAWSON: I am not sure that is exactly what I said, so we are going to check Hansard from last week to see what exactly what I did say. That is our understanding and my recollection of what I said, bearing in mind I have said a significant number of things over the last week and a half or two and a half weeks, so let us check on that.

Hon NICK GOIRAN: We can certainly go back to that, but I do not make this stuff up. I spent time on Friday reviewing that and it is precisely what happened. If the minister wants a moment’s pause to consider that, I am happy to facilitate it. I will move on to a separate topic and we will come back to it. The minister also advised last week that WA police were one of a very small number of agencies that were given the luxury of seeing the tenth draft out of 14 drafts of the bill. Have WA police indicated what process they will put in place to ensure that these concerns by any person in an institution will be prioritised, given that an adverse outcome would in this instance be a guarantee of a wrongful death?

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Hon STEPHEN DAWSON: Operational implementation of the bill has not been discussed with WA police.

Hon NICK GOIRAN: What concerns did WA police raise about the tenth draft?

Hon STEPHEN DAWSON: I am advised that concerns were not raised by WA police.

Hon NICK GOIRAN: The advice of the chamber is that WA police raised no concerns about the tenth draft. If the institution in question—that is, the institution that does not permit voluntary assisted dying to happen on its premises—was an aged-care facility that is by definition the home of the patient, where would they be transferred in order to execute their VAD process?

Hon STEPHEN DAWSON: I am advised that the transfer would likely be to a hospital, although the patient could be transferred to another residential care facility. The most likely to place to transfer a patient would be a hospital. I am advised that we would expect facilities to work in a collaborative manner with other institutions to enable the transfer to take place, ensuring the patient is looked after as part of that process.

Hon NICK GOIRAN: Perhaps we will take up that issue of how the VAD board would deal with the situation of the police after the next adjournment when the minister has had an opportunity to review Hansard from last week. Can I then take the minister to the comments he made in response to Hon Martin Pritchard about whether a doctor is required to raise the topic of voluntary assisted dying with the patient? The minister mentioned that there was no obligation in the bill, but that it would be part of good clinical practice. In fact, I note that the minister made the same remark just this afternoon when we looked at the issue of transfer. He said it would be good clinical practice for a healthcare service to transfer a person if it was unwilling have the process executed on its premises. On what basis is voluntary assisted dying part of clinical practice? Is it some form of medical treatment, palliative care treatment or medical procedure? On what basis do we say it is part of clinical practice?

Hon STEPHEN DAWSON: I think we all heard different things. Would the honourable member mind asking me his question again, if he does not mind?

Hon NICK GOIRAN: Last week, when the minister was asked by Hon Martin Pritchard about whether a doctor was required to raise the topic of voluntary assisted dying, he mentioned that there was no obligation in the bill, but it would be good clinical practice. My question is: On what basis is voluntary assisted dying part of clinical practice? Is it because it is some form of medical treatment, palliative care treatment or medical procedure? On what basis does the government continue to refer to this in the context of good clinical practice?

Hon STEPHEN DAWSON: Voluntary assisted dying is the lawful option that the doctor in his or her professional view believes is an option that the patient may wish to consider. Preventing a medical practitioner from informing a patient about a legally valid option is an extraordinary measure that is fundamentally out of step with the basic principles of informed decision-making.

Hon NICK GOIRAN: Minister, hang on. Suicide is also a lawful option in Western Australia—that was a finding of the joint select committee. I think that the minister would agree with me that it would not be good medical practice for a practitioner to suggest suicide as an option for a particular individual. I am not asking the minister to start to have a debate with me about the government’s view on whether this is or is not suicide; I am simply making the point that it is a lawful option that is available to Western Australians at the moment—one that we do not countenance and do not encourage. It cannot simply be that just because something is a lawful option, it, therefore, falls into the category of clinical practice. I would ask the minister to revisit that answer.

Hon STEPHEN DAWSON: I am told that voluntary assisted dying is an end-of-life option that involves medical practitioners and, therefore, is clinical.

Hon NICK GOIRAN: Last week, the minister mentioned that the Director of Public Prosecutions was consulted on draft 10 of the bill. In evidence to the Joint Select Committee on End of Life Choices, on 27 February last year, the Director of Public Prosecutions, Amanda Forrester, told the committee —

… there is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem …

… at the end of the day it is one person’s say-so … The patient, of course, is deceased.

Did the Director of Public Prosecutions raise any concerns about draft 10?

Hon STEPHEN DAWSON: I am told that the final draft of the bill takes into consideration any issues that would have been raised by the DPP, the Solicitor-General and the State Solicitor’s Office.

Hon NICK GOIRAN: Yes; although, minister, I am only interested in the concerns of the DPP at this point. What concerns were raised by the DPP?

Hon STEPHEN DAWSON: I am not at liberty to tell the member that—cabinet-in-confidence provisions. These consultations happened as part of the drafting of a bill, so I am not at liberty to tell the member what comments were raised. But as I have indicated to the member, any issues raised by the DPP, the SG or, indeed, the SSO have been taken into consideration in the final draft of the bill.

Extracted from finalised Hansard
Hon NICK GOIRAN: Is the minister in a position to let us know which of the concerns of the Director of Public Prosecutions were addressed in this bill and which ones were rejected; is he able to tell us that?

Hon STEPHEN DAWSON: I am not.

Hon NICK GOIRAN: Right, so the situation we are in now is that the Director of Public Prosecutions has given evidence to the Joint Select Committee on End of Life Choices, a joint committee of both houses of this place, and the evidence by the DPP plainly demonstrated some concerns, as per the quote that I read earlier. We know that the government has consulted the DPP, but it will not tell us what concerns were raised by the DPP. It now shields those concerns behind cabinet confidentiality. When I asked the minister earlier this afternoon about the concerns the Western Australia Police Force raised, he said nothing then about cabinet confidentiality. He never once said to me, “I cannot tell you about this because it is cabinet-in-confidence.” But now when I start to ask questions about the DPP, he raises this shield. That makes me suspicious. That tells me—the implication is—that the WA police had nothing to say on this, but that the DPP had something to say and the minister does not want us to know what that is. That is what that tells me. In circumstances in which I was the only one of the eight members on the joint select committee who attended every meeting and every hearing, and I was present when Amanda Forrester told the committee —

... there is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem ...  

... At the end of the day it is one person’s say-so ... The patient, of course, is deceased.  

That set off a red alert, a big alarm, for me when I heard that, so much so that I prepared my own 248-page minority report. The DPP said that to the committee in evidence. I was there; I heard it. The transcript of that public hearing confirms exactly what I have just said. The government does not want us to know what the DPP has said to it.

The minister mentioned that the Department of Justice, State Administrative Tribunal, State Coroner and Health and Disability Services Complaints Office were the others, apart from WA police, who were consulted on draft 10 of the bill. How have their concerns been addressed in the bill and which of their concerns were rejected?

Hon STEPHEN DAWSON: I will say again, for the member’s benefit —

Hon Nick Goiran: I’ve asked a question.

Hon STEPHEN DAWSON: Well, I say again for the benefit of the member: all issues that were raised by the DPP, SG and SSO have been addressed in the final bill.

Hon NICK GOIRAN: Minister, I repeat my question: you mentioned that the Department of Justice, State Administrative Tribunal, State Coroner and Health and Disability Services Complaints Office—to be clear, that is four different agencies—were part of the few people who were consulted in respect of draft 10. I am asking whether they raised any concerns; and, if they have, have they been addressed by the bill or have they been rejected by the government? I am not asking about the State Solicitor’s Office, the DPP or WA police; I am asking about those other agencies.

Hon STEPHEN DAWSON: I am told that all issues that were raised by those organisations were considered as part of the final bill, and the final bill that is before us now has taken on board those considerations.

Hon Nick Goiran: You say that, minister, but how do I know that?

Several members interjected.

Hon NICK GOIRAN: There would be a very simple way for the government to demonstrate it. I am pleased that certain members are listening to this part of the debate. All it would require is for the government to table the response from the Western Australian police, the DPP, the State Coroner, the Health and Disability Services Complaints Office, the State Administrative Tribunal and the Department of Justice. By my calculation, that is six pieces of paper that the government would need to table. We would then be able to be satisfied as to whether the government has addressed the concerns of those agencies. The government says it is not prepared to do that. Curiously, the Chief Psychiatrist was not one of those the minister said was consulted on draft 10. On 14 December 2017, the Chief Psychiatrist said to the Joint Select Committee on End of Life Choices —

... the stakes go up when you are saying that someone is going to die.

Has he since been consulted?

Hon STEPHEN DAWSON: I am advised that no, he was not consulted on draft 10. The honourable member said that only a number of letters could be tabled. In fact, conversations happen across government—some by correspondence, some face to face and some by telephone—so consultation happened in a multitude of ways.

Hon NICK GOIRAN: To be clear, minister, at no stage during the drafting of this bill nor subsequent has the government consulted with the Chief Psychiatrist?
Hon STEPHEN DAWSON: I am advised that the Chief Psychiatrist presented to the Ministerial Expert Panel on Voluntary Assisted Dying as a subject matter expert. He was involved in that process.

Hon NICK GOIRAN: Did the Chief Psychiatrist raise any concerns with the ministerial expert panel?

Hon STEPHEN DAWSON: I am advised that there is no transcript of the conversation. I am aware that there was a great deal of conversation about decision-making capacity and the issue of coercion. They were the two issues that were most talked about in the conversations between the Chief Psychiatrist and the panel.

Hon NICK GOIRAN: Did the conversation between the panel and the Chief Psychiatrist happen on one day at a meeting or was it over the course of several days or was it by way of exchange of correspondence? How did this consultation happen with the Chief Psychiatrist as a subject matter expert—to use the minister’s words—by the ministerial expert panel, which charged the people of Western Australia half a million dollars while proceeding through a process without taking any minutes?

Hon STEPHEN DAWSON: I am advised that the Chief Psychiatrist attended a meeting with the panel. In relation to the honourable member’s comment, I am not sure whether he is suggesting that the $491 000 that funded the panel was a waste of money. I do not know what he is suggesting. Certainly, I have given the figure on how much it cost for the panel and the consultation that the panel undertook. I believe that it has been value for money. Certainly, there were a number of very learned and expert individuals on that panel. The value of their work can be seen in the final report. If the honourable member has a different view, he is entitled to that view, but certainly I think it was value for money and I commend the work that the panel undertook. The Chief Psychiatrist absolutely met face to face with the panel.

Hon COLIN TINCKNELL: Minister, I do not think that when someone asks a question they are suggesting anything; they are just asking a question. I have a similar sort of question. Can the minister give us a breakdown of how much the scheme will cost from the consultation process to rolling out and implementing the program? Can the chamber get some detailed information about the sorts of costs we are looking at?

Hon STEPHEN DAWSON: Honourable member, no, I do not have a breakdown like that. The final cost will depend on what the bill looks like. Certainly, I previously indicated on the public record the extra funding that has been provided for palliative care, but we do not have a breakdown of what it might cost to implement voluntary assisted dying should the bill pass this place.

Hon COLIN TINCKNELL: I understand that this is one of the government’s signature policies, but is it not the normal process for a government to work out the costs involved, budget for such a scheme and have some idea what each step of the process will cost? It is obviously a substantial amount of money and I think the members of this chamber deserve to have some idea of what it will be. I am happy to put this on notice, but I would like some indication of how we can be guided.

Hon STEPHEN DAWSON: I am told that should this bill pass this chamber and Parliament, there will be a requirement for the Minister for Health to submit a funding request to the Expenditure Review Committee of cabinet. That has not taken place. It will happen post the passing of the bill, because obviously once it passes, we will know what elements are in the bill and they can then be costed.

Hon COLIN TINCKNELL: One of the things that has surprised me with this bill is that a lot has been left to the implementation stage. It is very hard to feel confident about passing bills when we do not have all the details before us to make informed decisions. I understand that Western Australia has never had voluntary assisted dying, but Victoria has been through such a process. The expert panel would have looked at how other regimes have organised their VAD, dignified dying or euthanasia. Why has so much been left to the implementation stage and why have some of the issues not been addressed so that this Parliament can fully debate the pros and cons?

Hon STEPHEN DAWSON: I will talk about some of the services that will be provided under the Voluntary Assisted Dying Bill, including funding for individual services.

Sitting suspended from 6.00 to 7.30 pm

Hon STEPHEN DAWSON: Honourable members, before we broke for dinner, I was about to make a point in relation to the funding of voluntary assisted dying services. A question was asked by Hon Colin Tincknell, who is away from the chamber on urgent parliamentary business, about the funding attached to the Voluntary Assisted Dying Bill 2019. I was going to make the point that funding for the individual services that will be provided by practitioners will need to be compliant with current Medicare billing guidelines. Although some standard consultation items may be applicable, it is recognised that the time investment by practitioners may exceed what is usually provided for and will need to be further addressed during implementation planning.

I have some further information about funding. There has been $3.5 million allocated for the implementation of the Joint Select Committee on End of Life Choices’ voluntary assisted dying recommendations. This includes $1 million for 2019–20 and $1 million for 2020–21. As such, the component of the budget related to the implementation of the voluntary assisted dying recommendations made by the joint select committee is approximately $1.5 million. That is the further information in response to the question asked by Hon Colin Tincknell.

Extracted from finalised Hansard
With regard to the other questions that Hon Nick Goiran asked me about funding, I am still waiting on that information, but I will, of course, provide that information when it is provided to me.

**Hon Nick Goiran:** I would like to pick up on the questions that Hon Colin Tincknell asked about costs, but before I do that, prior to the dinner break, the minister said he was going to have a look at what he did or did not say last week with regard to the Voluntary Assisted Dying Board and the approach to police. Has there been an opportunity to do that, so I can ask those questions?

**Hon Stephen Dawson:** I just want to make sure that this is what Hon Nick Goiran is talking about. We have gone back to the Hansard from last week. Hon Nick Goiran asked —

What happens if the individuals within the institution have grave concerns that the person is being coerced, which I know this government does not want to occur and is why it is one of the principles in the bill? What capacity does the institution have to address those concerns or is it simply obliged to transfer the patient?

The answer I gave at the time was —

The facility could tell the coordinating doctor of its concerns. It could approach the VAD board with its concerns. If it reasonably suspects that coercion is taking place, it could also report that to the police. In relation to the transfer, I am advised that the transfer is a necessity of good clinical practice.

The honourable member then went on to ask —

The minister says that the individuals within the institution can approach the VAD board or the police, and, of course, that relates to my example of a patient requesting a transfer but the individuals within the institution are concerned that there has been coercion. What can the VAD board do in those circumstances?

My response was —

I am told the board can alert the coordinating doctor. The board can look into the case, it can alert the CEO of the department and it can also advise the police. Those options are all available.

That was what happened last week, but our understanding of what the member said tonight is that different words were used. In light of that, that is where we are at, so does the member want to ask a question?

**Hon Nick Goiran:** I agree; that is exactly my recall of what transpired last week. In that context, I will repeat the question I asked earlier. Last week, the minister indicated that if a patient requests a transfer from an institution that will not permit voluntary assisted dying to be executed on its premises, the institution will need to facilitate that transfer. He further indicated that if a person in the institution was concerned that a patient was being coerced to transfer, they could approach the Voluntary Assisted Dying Board. When asked what the Voluntary Assisted Dying Board could do, the minister said it could approach the police. My question was: what powers do WA police have to intervene in that transfer process?

**Hon Stephen Dawson:** I am advised that the police have powers to investigate criminal offences and powers to investigate compliance with the act. The police could investigate; that would have to take place first. Obviously, they would investigate whether coercion was taking place, but the CEO of Health could also investigate.

**Hon Nick Goiran:** The WA police can investigate. If coercion were taking place, it could investigate compliance under the act. Is there a criminal offence that they would be able to investigate in that instance?

**Hon Stephen Dawson:** I am being pointed to clauses 99 and 100 of the bill.

**Hon Nick Goiran:** Minister, are there any criminal offences in the Criminal Code—outside of this piece of legislation—that Western Australian police could use to investigate in the event that someone in an institution is concerned that coercion is taking place and the patient is being transferred to another facility that is going to execute VAD in circumstances of coercion? Is there a criminal offence that would apply in that case outside of this bill?

**Hon Stephen Dawson:** No, not with regard to VAD—not in the Criminal Code.

**Hon Nick Goiran:** Where in the legislation is the power for the Voluntary Assisted Dying Board to communicate that information to police?

**Hon Stephen Dawson:** It is in clause 117. Clause 117, in part 9, “Voluntary Assisted Dying Board”, outlines the functions of the board. Clause 117(c) reads —

> (i) the person holding or acting in the office of Commissioner of Police under the Police Act 1892;

**Hon Nick Goiran:** Prior to the adjournment, the minister was answering some questions from Hon Colin Tincknell about the cost of the scheme. The minister indicated that he could not provide a breakdown. The Australian Medical Association surveyed its doctors and, as the minister pointed out earlier, not everyone responded to the survey.

*Extracted from finalised Hansard*
Indeed, the outcomes of the survey are only from those who responded; it is not necessarily reflective of the views of every medical practitioner in Australia. Nevertheless, 863 respondents, which is 57 per cent, surveyed by the AMA believed that the state should provide all the funding and facilities required for voluntary assisted dying. Will the government provide all the funding and facilities for voluntary assisted dying if it is to be provided in our state?

**Hon STEPHEN DAWSON:** Honourable member, there may well be some cost to a patient who wants to access voluntary assisted dying. In my earlier response to Hon Colin Tincknell, I made the point that although some standard consultation items may be applicable under Medicare billing guidelines, it is recognised that the time investment by practitioners may exceed what is usually provided for and this will need to be further addressed during the implementation planning. But the likelihood is that that patient may need to pay to access a specialist, for example, in certain cases.

**Hon NICK GOIRAN:** Going back to the example that we were working through last week, the first step of the process, as I understand it, is for a coordinating practitioner to be involved. We identified that in some circumstances, there may be a need for an interpreter. What costs would a Western Australian patient be up for in circumstances in which a coordinating practitioner and an interpreter are involved?

**Hon STEPHEN DAWSON:** I have already indicated that there would be no cost for the interpreter, but if the coordinating practitioner was a specialist, the patient may need to pay the gap.

**Hon NICK GOIRAN:** If the coordinating practitioner was not a specialist, no payment would be required by the patient; is that right?

**Hon STEPHEN DAWSON:** This will be as per Medicare billing guidelines. Therefore, if there is a gap under Medicare billing guidelines, there will be a gap in certain circumstances under this bill.

**Hon NICK GOIRAN:** The minister indicated earlier that they would need to be compliant with Medicare billing guidelines. Is there a Medicare number that would apply in this situation?

**Hon STEPHEN DAWSON:** No.

**Hon NICK GOIRAN:** How can they be compliant with Medicare billing guidelines, as the minister has indicated to the chamber, if there is not even an applicable item number?

**Hon STEPHEN DAWSON:** I am advised that it will be a standard GP consultation.

**Hon NICK GOIRAN:** I will go back to my earlier question, minister. Is there an item number relevant to this process?

**Hon STEPHEN DAWSON:** There would be for a standard GP consultation. As to exactly what that number is, we would have to take that on notice.

**Hon NICK GOIRAN:** As I understand the advice to the chamber, minister, there is some form of Medicare item number that the doctors would need to be compliant with. If it is a GP, they will claim under that item number. If it is a specialist, they will claim under either the same number or a different number, and there will be a gap only for a specialist. If it is a general practitioner, there will be no problem and the patient will not need to pay anything.

**Hon STEPHEN DAWSON:** I am told that there could be a gap for the GP if they do not bulk-bill, for example.

**Hon NICK GOIRAN:** We have now identified two scenarios in which there could be a cost to the patient, and that could be whether the person is a general practitioner or a specialist; it really would not matter, as either way there could be a gap. However, the government will make sure that there is no cost for the interpreter. What is the story with the consulting practitioner?

The DEPUTY CHAIR (Hon Robin Chapple): Hon Nick Goiran.

**Hon STEPHEN DAWSON:** I am advised it is the same.

The DEPUTY CHAIR: I do apologise, minister; I called you Hon Nick Goiran.

**Hon Nick Goiran:** Take it as a compliment, minister.

**Hon Stephen Dawson:** I’ve been called worse.

Several members interjected.

**Hon NICK GOIRAN:** Minister, what is the situation when it comes to the administering practitioner?

**Hon STEPHEN DAWSON:** I am advised that it would also be the same.

**Hon NICK GOIRAN:** That is indeed interesting. Correct me if I am wrong, but does the administering practitioner not just inject the patient with the poison put together by the government for use in this instance? Why would there be a different cost for a practitioner to inject a patient with this poison depending on whether the practitioner was a GP or a specialist?

**Hon STEPHEN DAWSON:** We are seeking further information. I just make the point that in the first instance, the administering practitioner is likely to be the coordinating practitioner. If for some reason the coordinating practitioner cannot do that, it could be another medical practitioner or a nurse practitioner. The administering practitioner does
not just undertake an injecting role. Clause 58(5) states that administration by the administering practitioner can occur only if the administering practitioner is satisfied that the patient has decision-making capacity in relation to voluntary assisted dying, the patient is acting voluntarily and without coercion and that the patient’s request for access to voluntary assisted dying is enduring.

Hon NICK GOIRAN: The minister said that nurse practitioners could do the administration; on what basis can they charge in this process?

Hon STEPHEN DAWSON: I am told they have item numbers on the Medicare benefits scheme, too.

Hon NICK GOIRAN: Is there any gap for a nurse practitioner with their item number?

Hon STEPHEN DAWSON: We would have to check that, honourable member.

Hon NICK GOIRAN: The minister mentioned a few times that there could be a gap for the different processes. We have the coordinating practitioner, the consulting practitioner and the administering practitioner. These people can be either a GP or a specialist. In the case of the final administration act, it can be a nurse practitioner. In each of those instances, the minister indicated that there could be a gap. Has the government had any conversations or consultation with private health insurers to identify whether they will cover the gap?

Hon STEPHEN DAWSON: No, we have not.

Hon NICK GOIRAN: That seems strange, minister, because the government has been very quick to boast about how much consultation it has done for this whole process. It was clear from the process in the other house that the government does not like members asking any questions about this matter and it does not like any amendments. Why is that? It is because, according to the government, there has been massive consultation. I have heard some people in government suggest that there has been consultation on this bill for two years, which of course we know is false, because the bill has not been in existence for that period. We have already identified various holes in the work done by the Joint Select Committee on End of Life Choices and the panel that consisted of some experts, and now we are told that there has not been any consultation with private health insurers. The minister indicated earlier that the government is having ongoing conversations with various entities; are private health insurers one of those?

Hon STEPHEN DAWSON: Not at the moment, but the intention is to have a conversation with that industry during the implementation phase.

Hon NICK GOIRAN: I am sure that will be very comforting for those Western Australians who might want to know what the situation is before this law is passed. I am sure it will be very comforting for lawmakers who might want to know the answer to that question. Whenever we ask an uncomfortable question on this matter, the government once again uses its get-out-of-jail-free card and simply says that it is leaving it to consultation. What is the intended charge-out rate for care navigators?

Hon STEPHEN DAWSON: It will be a publicly funded service.

Hon NICK GOIRAN: When the minister says it will be a publicly funded service, does that mean there will be no gap and there will be no contribution required by a Western Australian who wants to access a care navigator anywhere, whether they live in West Perth, Kununurra, Esperance or anywhere in between? If people want access to a care navigator, they will have access to one, it will be publicly funded and they will not be required to pay anything.

Hon STEPHEN DAWSON: That is the intention.

Hon NICK GOIRAN: Of the various cost processes that will be in place with this legislation, whether it is a care navigator, coordinating practitioner, consulting practitioner or administering practitioner, is the cost of the care navigator the only cost the state government will be up for; and, if not, what other costs will the Western Australian government be up for?

Hon STEPHEN DAWSON: Essentially, the key costs to the state would be the cost of training, the cost of implementation of the scheme, the cost of the interpreters and the cost of the statewide pharmacy. Those are essentially the main ones. That is obviously on top of the navigators; I did not make that point.

Hon NICK GOIRAN: The minister has identified five cost centres—the care navigator, the training, the implementation, the interpreters and the statewide pharmacy. I will just deal with the statewide pharmacy. The statewide pharmacy already exists and already has the resources. Will it be necessary for there to be additional resources for the statewide pharmacy? Why would there need to be extra costs to the state there?

Hon STEPHEN DAWSON: It is not guaranteed that we would use the same service. If the bill passes, the detail of that will be worked out.

Hon NICK GOIRAN: At the moment, someone must be responsible for the statewide pharmacy service. I am not very familiar with the statewide pharmacy. For argument’s sake, let us say that the chief of the statewide pharmacy is called the chief pharmacist or the CEO of the statewide pharmacy. Can the minister indicate who the chief of that agency is; secondly, have they been consulted about this?

Hon STEPHEN DAWSON: I am told that the Chief Pharmacist has been consulted on the bill.

*Extracted from finalised Hansard*
Hon NICK GOIRAN: Did the Chief Pharmacist indicate how many additional resources would be required by the statewide pharmacy to facilitate voluntary assisted dying in Western Australia?

Hon STEPHEN DAWSON: No. Neither he nor we can answer that question until we know the shape of the bill. If the bill passes, we will be in a better position to work out the costs and the most appropriate way to dispense medication. It may be the existing service, but it could be the creation of a new central pharmacy service based at a tertiary hospital, for example, with a number of regional hubs. Again, that detail will be worked out upon the passage of the bill, and the costs will be worked out after that as well.

Hon NICK GOIRAN: If it were decided to go with a different approach, would that require a change of legislation other than what is in the bill?

Hon STEPHEN DAWSON: No, it would not.

Hon NICK GOIRAN: The minister has indicated that the state will bear the cost of interpreters. What is the anticipated cost of that on an annual basis?

Hon STEPHEN DAWSON: We do not have an anticipated cost of that at this stage. It is certainly something that we are alive to, if I can use that word. I have previously alluded to the fact that upon passage of the bill, the Minister for Health will need to seek funding through the cabinet Expenditure Review Committee process. There would be contingency for that issue, but we have not done any costing on the potential cost of interpreters. It is certainly Western Australian government policy to provide free interpreting services to support Australian citizens and Medicare-eligible residents who need help to communicate in English.

Hon NICK GOIRAN: The minister previously indicated that the government anticipates a death rate in this instance of 0.4 per cent of all deaths. The minister indicated that that figure is based as best as it can be on the Oregon data—we went through the exercise previously and I certainly indicated my view that the figure would be higher than that because of the differences between the systems. If it were 0.4 per cent of all deaths, what would that be as a raw number in Western Australia on an annual basis?

Hon STEPHEN DAWSON: Again, honourable member, we had a discussion about this last week. Notwithstanding there is a difference of opinion about whether we are closer to the system in Oregon, the Netherlands, Belgium or anywhere else, I provide this answer in the context of the way the question was asked. If it were to be similar to that in Oregon, in 2018, there were 14 873 deaths in Western Australia, so 0.4 per cent of that would be 60-odd deaths. However, again, as we have said, I do not propose to delve deeply into this issue again tonight and go back over old ground on whose figures are right. That is an approximate figure.

Hon NICK GOIRAN: The minister indicated that there were five cost centres—the care navigators, the training, the implementation, the interpreters and the statewide pharmacy. We have asked some questions on those. Would there not also be the cost of sending the care navigator, coordinating practitioner, consulting practitioner or administering practitioner out to the person in regional Western Australia, as we discussed previously? Would there not be costs associated with that?

Hon STEPHEN DAWSON: First of all, honourable member, I did not say “cost centre”.

Hon Nick Goiran: No; those are my words.

Hon STEPHEN DAWSON: Those are the member’s words. Just to be clear, I have not indicated that there are cost centres, because I think that has to be worked out in the implementation phase. One of the five costs that I indicated is the implementation of the scheme. Of course, the example that the member just gave would fall under that implementation line. But it would not just be flying doctors or specialists to regional Western Australia; it could also be bringing the patient to see a doctor. That falls under that same line as well.

Hon NICK GOIRAN: I accept that, minister. Perhaps, rather than cost centres, the better expression might be “cost lines” or “cost categories”.

Hon Stephen Dawson: In inverted commas—provided we understand that.

Hon NICK GOIRAN: Yes. I think we are on the same page on that. The implementation cost line or cost category includes any cost of travel, whether that be for the practitioner or patient involved. At the end of the day, the government, as best as it can, anticipates maybe 60 Western Australian deaths a year from this, but it is not really sure, and it is certainly not sure on the costs. We have identified that there will be a gap in certain instances. The minister indicated that there has been consultation with private health insurers. Has there been any consultation with Medicare to confirm that it will accept these types of practices as claimable under the various item numbers?

Hon STEPHEN DAWSON: Not especially, no, but we would follow the example that has been set in Victoria.

Hon NICK GOIRAN: What is this example in Victoria?

Hon STEPHEN DAWSON: These things are being claimed under Medicare in Victoria. Regarding line items and numbers, I do not have that information, but it is already operating in Victoria and we seek to emulate that.

Extracted from finalised Hansard
**Hon NICK GOIRAN:** Is the government in Western Australia confident that under the Victorian system, costs are being charged by the equivalent of a coordinating practitioner to Medicare and it is being paid for by Medicare? Is it the same for consulting practitioners and administration practitioners? Are all those individuals, even if they have a different name or terminology, billing Medicare and being paid? Is there no inconsistency, no problem, with the commonwealth law or administration, and all those creases have been ironed out? Is it not like the telehealth issue, when the joint select committee was asked to look into the intersection with federal law and did not do it? Is it not like the ministerial expert panel, when no-one thought about it? On this issue, the minister is giving us an assurance that this is not the first time that anyone in government has thought about the Medicare issue and the possible problems in intersecting with a federal scheme, keeping in mind that we have already identified that the federal law does not accept any assistance being provided for a suicide, which is precisely the problem with the telehealth clause and the use of a carriage service. Has this all been sorted out, there is no problem, and we are very confident we can provide an assurance to the chamber?

**Hon STEPHEN DAWSON:** Yes, that is certainly my advice.

**Hon NICK GOIRAN:** I have a wry smile on my face that the minister can say that in circumstances when there has been no consultation with Medicare. How there can be an assurance in circumstances of no communication, I do not know, but that is the advice that has been provided to the chamber.

Prior to the adjournment, we were looking at the consultation that occurred between the ministerial expert panel and the Chief Psychiatrist. The minister indicated that the Chief Psychiatrist was called in to the ministerial expert panel as a subject matter expert, one meeting took place and an exchange took place on two issues in particular, coercion and decision-making capacity. What did the Chief Psychiatrist tell the ministerial expert panel on the issue of coercion and decision-making capacity; and, how has that been addressed in the bill before us?

**Hon STEPHEN DAWSON:** First of all, the Chief Psychiatrist was invited to present, not called in or summoned or anything else, just to make it clear. I am not at liberty to disclose any specific advice; in fact, we do not have that. The advice I have at hand is that those conversations took place, and the issues that he raised were considered and form the basis of the bill before us.

**Hon RICK MAZZA:** On the issue of coercion, I note that if a patient elects to undertake VAD and they elect to use an administering practitioner, an independent person has to witness the administration of the substance. I note that if the patient elects to self-administer and they have a contact person who will access the substance and bring that home, there is no requirement for an independent person to witness the self-administration of that substance. I am a bit concerned about that. If no witness is required and a contact person could be a family member—there is nothing that will prevent a family member from being the contact person—there may be some risk of coercion. I wonder why the expert panel or the government did not consider it important to have a witness in that circumstance?

**Hon STEPHEN DAWSON:** A witness will not be required when a patient self-administers the medication. It would not be appropriate to require the patient to have a witness or a practitioner with them in a private place at the time of self-administration of the prescribed substance, unless the patient wishes to do so. However, most patients at this end stage have a network of support around them, such as family and palliative care or other support workers, and it is most likely that the patient who is the subject of self-administration will self-administer at home and be supported by family. The patient’s coordinating practitioner will encourage appropriate planning. When the decision is made for practitioner administration, a witness will be required to be present at the time of administration.

**Hon RICK MAZZA:** I am still struggling a bit here, though, because if there is an administering practitioner and a requirement for an individual witness to make sure that that is the wish of the patient at the time, from memory, the witness will have to sign a certificate at the end of that process, whereas with self-administration, the minister said there would be a network around the patient et cetera, but there is no guarantee of that. I am very concerned that there is a bit of gap with self-administration and someone could be unduly influenced, or coerced, at the end of life if they have a change of heart or mind. I wonder whether the government is considering any amendments in this area.

**Hon STEPHEN DAWSON:** No, we are not, and the member’s concern is noted.

**Hon ADELE FARINA:** Following on from the question that was asked by Hon Rick Mazza, I also share those concerns about the self-administration process, because I think it is sorely lacking in protections for the patient. How will we be sure that the patient self-administers if there is no medical practitioner or witness present to observe and witness that the patient actually self-administered?

**Hon STEPHEN DAWSON:** Honourable member, excuse me having my back to you. I note the honourable member’s concern. We have to remember that, at this stage, the person has gone through the assessment process of two doctors. They have confirmed their enduring voluntary decision. In addition, a contact person has been appointed who has obligations in relation to unused medication. If for some reason the concern is around the patient being coerced into self-administration, that is outside the scope of the Voluntary Assisted Dying Bill and that would be a criminal act. Obviously, people can be charged as a result of that. The decision has been made by government that once an enduring voluntary decision has been made by the patient to self-administer, they will be able to undertake that self-administration.
Hon ADELE FARINA: I do not think the minister has actually answered my question. My question is: how can we be certain that the patient has actually self-administered the lethal substance? A considerable period could have passed between the time when the substance is dispensed and when the patient chooses to ingest the substance. We do not know whether the patient will still have decision-making capacity. We will not know whether the patient will have ingested the drug voluntarily and we will not know whether their decision to access that will be enduring because there will be no need for a medical practitioner to be present to then sign documentation witnessing that all these elements have been satisfied. There will be no requirement for a witness to be present. I can see circumstances in which family members who are exhausted caring for the patient might rationalise within themselves, given that the patient has seen the doctors on two occasions, met all the eligibility criteria, provided the written authorisation that they want to access VAD and has the substance at home, that by putting the lethal substance into their coffee or their food and helping them along, they are fulfilling the patient’s wishes. It is a circumstance that could easily arise when the substance is readily available and there is no need for any witnesses to be present. That is my concern. I think this is one of the big holes in the so-called safeguards that are being provided in this legislation. At the most critical time and when people are likely to be highly stressed through lack of sleep and very vulnerable, we are providing no safeguard at all to ensure that the patient self-administered the drug.

Hon STEPHEN DAWSON: I had made the point earlier about the likelihood of most patients at this stage having a network of family or, indeed, friends, support workers or professionals around them when this act takes place. It is most likely that the network who is the subject of self-administration will self-administer at home and be supported by family. A doctor will have to certify the death and must be satisfied with the manner of death and that it complies with the Voluntary Assisted Dying Act or they will not complete the death certificate. In that case, if the doctor does not certify the death, an investigation will take place into the circumstances around what has happened. I do not think the member will get an answer that she is happy with. This is the decision that has been made. This is where we have landed. Although she may not be happy with that decision, this is where the government has landed on this issue.

Hon ADELE FARINA: If I understand the minister correctly, despite the very clear principles for the legislation set out in clause 4 of the bill, the government’s position is that provided the person has successfully met all the eligibility requirements, the drug has been dispensed to the patient and the patient has opted for self-administration, it does not really matter. The government is not interested in being certain that the patient has self-administered the drug. The minister has put to me that that is the government’s position. Is that correct?

Hon STEPHEN DAWSON: I guess, at the end of the day, it is a balance between autonomy and risk. This is the balance that has been struck. There are obligations on people who participate. For example, post self-administration having taken place, the contact person has to return the leftover medication to the pharmacy. The principles that a person performing a function under this legislation must have regard to include —

(a) every human life has equal value;
(b) a person’s autonomy, including autonomy in respect of end of life choices, should be respected;
(c) 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;

Respect for the person’s autonomy is within the principles. It is absolutely not the case that we do not care and say, “Sure, go for your life.” That is not what we are saying. We are saying that a balance has been struck whereby we appreciate the process people have been through and we believe we have safeguards around it.

Hon ADELE FARINA: How can the minister say that the provisions of the bill have regard for the principle of a person’s autonomy when, without a medical practitioner or witness present, we will not know whether the person voluntarily self-administered the drug? To me, this is as critical issue that flies in the face of having regard for the person’s autonomy and ensuring that it is protected.

Hon STEPHEN DAWSON: Requiring the person to have a medical practitioner or witness present takes away from the person’s autonomy. If at any stage in the process one of the practitioners involved has a concern about the person’s capacity, they will need to report that to the VAD board and the action could be stopped at that stage. We believe this is about balance and this is where we have landed with this issue.

Hon ADELE FARINA: I understand what the minister is saying about a doctor who has any concern having to report it. However, the patient may not have seen the consulting or coordinating doctor for two months—the drug may have been dispensed two months ago—so they will not have seen anyone and they will be at home in bed surrounded by maybe just their carer or one or two family members. I do not know how the medical practitioner, be it the consulting or the coordinating medical practitioner, can form any concern because they will have been out of the picture for two months. I do not understand how the minister’s answer addresses the concern I am expressing. I do not understand why someone who chooses voluntary assisted dying, and is dying in their home, but has a problem ingesting, so needs to opt for the medical practitioner administering the lethal drug, should be treated any differently from a person dying in their home and who has opted to self-administer. It is all about protecting the patient and ensuring that the patient’s wishes are honoured and respected, and reducing the risk that someone may administer the drug to the patient without the patient’s consent or knowledge.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: Most people who are at the end of life would be in contact with either a palliative care specialist, a doctor or a health specialist. We do not believe people would go for months without seeing somebody from the medical profession. There could be individual examples, but that is not my understanding of what happens. Some of this stuff happens outside of the process and outside of a framework. People take their lives on a daily basis—not necessarily on a daily basis, but it certainly happens outside of this process. What we are doing with this bill is putting a framework around it and putting safeguards in place so that we know that a process is in place around a person’s end-of-life choices. That, quite frankly, does not exist currently. The member may not be happy with it, but this is where we have landed in relation to this bill.

Hon ADELE FARINA: Where is the safeguard for a patient who has elected to self-administer and who finds themselves in a situation in which they might be going cold on the idea, but a family member has had enough of caring for the patient and thinks, “They have gone through the process. They have signed all the forms. They have agreed to this. I am not doing anything wrong by administering the substance for them”, and that is done without the patient’s knowledge and without their consent? Where in this bill and in this process is there a protection to ensure that a patient will not find themselves in that situation?

Hon STEPHEN DAWSON: The protection is outside the bill. It is in the Criminal Code. It would be a criminal offence if a person were to take that action. The process in the bill is how that would be carried out legally. If a person were to do something outside of that, they would be breaking the law. That is the protection. The Criminal Code contains a range of offences, as does the bill. Part 6 of the bill lists the offences. Proposed section 98 states—

A person commits a crime if—

(a) the person administers a prescribed substance to another person; and

(b) the person is not authorised by section 58(5) to administer the prescribed substance to the other person.

The penalty is imprisonment for life. That is a very strong deterrent.

Hon ADELE FARINA: I understand that those provisions exist. However, in order for those provisions—

Hon Stephen Dawson: You asked me where in the bill it was.

Hon ADELE FARINA: I appreciate that those provisions exist in terms of the offences and the penalties. The issue is that if a single family member or a single carer was caring for the patient, and they decided to administer the drug to the patient without the patient’s consent or knowledge, where are the witnesses who would support a criminal case and a prosecution? The reality is that in those circumstances, there are no witnesses, and the person has been killed. There is no protection for the patient under the legislation.

Hon Peter Collier: Mr Deputy Chair—

The DEPUTY CHAIR: I am just waiting for the minister to respond.

Several members interjected.

The DEPUTY CHAIR (Hon Robin Chapple): Members, please! I am controlling. I am asking the minister to finish his response to Hon Adele Farina, and then somebody else can have the call.

Hon STEPHEN DAWSON: I do not think there is an answer that will satisfy the member in relation to her question.

Hon PETER COLLIER: I want to reinforce the point that Hon Adele Farina has made. It is a valid point. It is too late, after the person’s life has gone, to reflect on what might have been. This is the point that I raised in my second reading contribution, and also last week. I acknowledge and I respect the will of the house with regard to the second reading speech, but I want to make sure that we have all the checks and balances that we possibly can to ensure that this piece of legislation is watertight. There is a fundamental issue here. It may be a philosophical issue between what the government wants and what has been delivered. There is a real possibility that the life of a person with a terminal illness may be ended not through self-administration of the lethal injection but by, potentially—believe it or not—a loving wife or a loving husband, who may decide that it is best that their loved one goes. That is highly feasible. It is highly likely that that could occur in this circumstance, without a check and balance. If there is only one witness, it is all well and good to talk about the Criminal Code, but who will be called as a witness to the case? The minister has made his point clear on this. I understand that. However, the minister has not satisfied me. I would like to think that somehow we can find our way through this, through an appropriate mechanism or an appropriate amendment. At this stage, this, yet again, opens up a Pandora’s box with regard to checks and balances in this piece of legislation.

Hon STEPHEN DAWSON: I appreciate the honourable member’s comments. I thought the member was having a go at me earlier for taking a minute to seek advice from the advisers. I apologise if that was not the case.

I had previously identified that a doctor will have to certify the death and must be satisfied about the manner of death and that it complied with the voluntary assisted dying act, or they will not complete the death certificate and it will become a reportable act. I also make the point that palliative care patients in the community have access to schedule 4 and schedule 8 medications. That is a fact of life that exists currently. In this bill, we are putting a safeguard around the process.

Extracted from finalised Hansard
Hon NICK GOIRAN: That was a very interesting exchange between Hon Adele Farina and the minister. That highlights to me that the government, among other things, has not read the minority report. I draw to members’ attention findings 105 to 116 of the minority report. The minister responded by saying that as far as he and the government are concerned, it is not normal for someone not to have an ongoing rapport with a doctor at end of life, and although two months might have passed, that really would not happen. I draw to members’ attention these findings in the minority report. Finding 105 states —

The law on assisted suicide in Oregon —

Keep in mind that the government says this bill is based on the Oregon model —

has been in force for more than 20 years and requires a prognosis of less than six months to live.

Finding 106 states —

The data from the Oregon Public Health Division between 1998 and 2015 indicates that the longest recorded duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was 1009 days.

Under the Oregon regime, people are supposed to have only six months to live. The longest recorded duration was 1 009 days. Finding 107 states —

The data from the Oregon Public Health Division in 2015 indicates that the longest recorded duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was 517 days.

Just in case members thought that was a rogue set of data between 1998 and 2015, we find out that in 2015, it was still 517 days. The minority report continues —

The data from the Oregon Public Health Division between 1998 and 2015 indicates that in 4 of the 17 years there was at least one case where the duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was more than two years.

In four out of the 17 years in that set of data, there were people who took the drug more than two years after it was initially provided. It continues —

The experience in Oregon demonstrates the inadequacies of safeguards due to consistent medical error in prognosis.

... In Oregon a 76-year-old cancer patient was assisted to suicide by his cancer specialist notwithstanding the presence of depression and the non-concurrence of the original doctor who referred the patient to the specialist for treatment.

I remind members that the Oregon experience does not allow for practitioner administration. It allows only for self-administration, which goes to the very heart of the concerns that have just been discussed. It continues —

In Oregon an octogenarian cancer patient was assisted to suicide notwithstanding that two doctors, including her own physician, were concerned about the presence of depression and refused to prescribe the lethal drug requested.

... The experience in Oregon demonstrates the ease with which the prolific practice of doctor shopping pierces the veil of even well intentioned safeguards.

... The data from the Oregon Public Health Division for 2016 indicates that in 79.4 per cent of assisted suicides no physician or healthcare provider was known to be present at the time of ingestion of the prescribed lethal drug.

It was 79.4 per cent of the time. That is nearly 80 per cent, so at eight out of every 10 of these deaths in Oregon, there was no physician or healthcare provider. That is not in accordance with my view of the world, but in accordance with the Oregon Health Authority Public Health Division’s own data. It continues —

The rate of suicide among Oregonians has been increasing even when assisted suicides are excluded from the data set.

... The inherent difficulty in prosecuting after the event is underscored by at least five assisted suicides in Oregon that occurred by illegal overdoses administered by a nurse.

... The experience observed in Oregon should be reason alone to militate against legalisation in Western Australia.

Extracted from finalised Hansard
When I hear the minister saying to Hon Adele Farina, who raised very reasonable concerns, “Sorry, the government can’t assist you with your concerns. There’s nothing that we’re going to be able to say that’s going to satisfy your concerns”, it is no wonder, because it should be self-evident and commonsense that if there is not going to be anybody in the room, there will be no safeguard. We know there is an elder abuse problem in Western Australia and that psychological and emotional elder abuse is a significant problem. It is as high and prevalent as financial elder abuse. My question is: what could possibly go wrong in this situation?

Earlier, the minister indicated that there had been no consultation with private health insurers or Medicare. Has the government taken any advice from either the Joint Select Committee on End of Life Choices or the ministerial expert panel to ascertain whether the private health insurer of some Western Australians will fund the gap for their voluntary assisted dying process, to go to the specialist and make sure that they have the coordinating practitioner, the consulting practitioner and the administering practitioner—it will make sure that there is no gap for that—but if they would like to have other life-saving treatment, it will not fund them for it? Has the minister obtained any advice from the joint select committee or the ministerial expert panel, after the plethora of consultation that has allegedly taken place? Has there been consultation on that point so that we can provide an assurance to Western Australians that they will not be left in the unenviable position of a private health insurer saying that it will fund them for the death option, but it will not fund them for the life option?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: I would like to ask the minister about the “My Life, My Choice” report. I draw the minister’s attention to recommendation 1, which states —

The Attorney General, in consultation with the Minister for Health, appoint an expert panel to review the relevant law and health policy and practice—and provide recommendations in relation to the following matters:

- the establishment of a purpose-built central electronic register for advance health directives that is accessible by health professionals 24 hours per day and a mechanism for reporting to Parliament annually the number of advance health directives in Western Australia.
- a requirement that health professionals must search the register for a patient’s advance health directives, except in cases of emergency where it is not practicable to do so.
- amendments to the current Western Australian template for advance health directives in order to match, as a minimum, the leading example across Australia, taking into account Finding 7 …
- consider how the increasing numbers of people diagnosed with dementia can have their health care wishes, end of life planning decisions and advance health directives acknowledged and implemented once they have lost capacity.

Has that been done by government?

Hon STEPHEN DAWSON: I am advised that this question has been asked and answered previously in this debate. The Attorney General gave an interim response to the Ministerial Expert Panel on Advance Health Directives. This matter was raised last week.

Hon NICK GOIRAN: When was the expert panel appointed, and who was on the panel?

Hon STEPHEN DAWSON: We do not have that information before us. Advance health directives are not captured by the bill, so we were not anticipating questions about that. It could well be outside the scope of the bill but, anyway, we do not have it in front of us. I would be happy to seek further information.

Hon NICK GOIRAN: Rest assured, minister, I never ask a question that is outside the scope of clause 1 or the bill. Can I ask the minister when this panel published its report, and whether it contained any recommendations related to voluntary assisted dying?

Hon STEPHEN DAWSON: We are seeking further information. I am advised that the advance health directive panel made a number of recommendations, but one recommendation was that the state government investigate how people with dementia could be included in a voluntary assisted dying scheme—or words to that effect.

Hon NICK GOIRAN: Let me assist the minister. Recommendation 23 of the Ministerial Expert Panel on Advance Health Directives states —

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.

What is the position of the government on recommendation 23?

Hon STEPHEN DAWSON: I am advised that the Attorney General has made it clear that the government does not accept recommendation 23 and will not accept that recommendation.
Hon NICK GOIRAN: Upon whose advice did the government determine to reject the recommendation of its own expert panel?

Hon STEPHEN DAWSON: That matter was considered by cabinet.

Hon NICK GOIRAN: It makes one wonder how cabinet makes its decisions when it decides, without any other information, “We’re going to accept some of the recommendations and we’re going to reject other ones, but we don’t actually provide any explanation as to why we accept some and reject others.” It also makes one wonder what is the point of the taxpayer funding expert panels in these circumstances. Do I understand correctly that the government is categorically of the view that it will not support this recommendation of that ministerial expert panel, it does not support it now, it is not under any conversation with the Australian Medical Association or other stakeholders, it is not one of these amendments that it has in its back pocket, ready to slip out at any moment during the progression of this bill, that this is one of those ones that is absolutely off the table, there is no point in a member bringing forward any amendment, the government is not going to consider it, it has already considered this, it is out of the question and, to put it in the words of the Minister for Health, it is a deal-breaker?

Hon STEPHEN DAWSON: We believe that decision-making capacity is a fundamental element of this bill, so no, that issue will not be considered.

Hon NICK GOIRAN: The minister mentioned earlier that the ministerial expert panel had invited the Chief Psychiatrist to give its advice, particularly around the issue of decision-making capacity. The minister indicated that there had been one meeting, but he cannot tell us what transpired at that meeting. How can we be confident that a meeting even took place, when the expert panel did not take minutes?

Hon STEPHEN DAWSON: Because I have told the member it took place, so I am confident it took place. My advisers have told me it took place, and I am confident that that information is correct.

Hon NICK GOIRAN: To be clear, the minister was not present at the meeting with the Chief Psychiatrist. There were no minutes but, on the basis of verbal advice that the minister has received today, we are told that there was one meeting with the ministerial expert panel, but there is no documentation to confirm that that took place. How do we know that the Chief Psychiatrist discussed coercion and decision-making capacity with the ministerial expert panel in the absence of any file note, briefing note, minutes, transcript or documentation? On what basis does the minister have the confidence to tell us that that is what the Chief Psychiatrist told the ministerial expert panel?

Hon STEPHEN DAWSON: I have great confidence in the advisers that I have with me and have had with me for the debate on this bill. I have relied on them thus far for everything I have told this chamber, and they have confirmed that that meeting took place, and I am very happy with that confirmation.

Hon NICK GOIRAN: Were any of the advisers present at the meeting with the Chief Psychiatrist?

Hon STEPHEN DAWSON: Just to clarify: although there are no minutes from meetings, documentation exists from a number of meetings. Whether one or more of the people with me now were at the meeting, I do not think is a matter for discussion this evening. But I have spoken to advisers who were at that meeting and have told me that the conversation took place.

Hon NICK GOIRAN: The ministerial expert panel, or the panel that contained some experts, at page 51 of its final report raises this issue of advance health directives on which, as the minister has indicated, the government’s position is that decision-making capacity is at the very heart of this bill, and that was the issue that the Chief Psychiatrist consulted with the ministerial expert panel on, so we are told. The minister will see that it states, at page 51 —

Nevertheless, community concern about dementia means that the role of advance planning under the voluntary assisted dying scheme is likely to remain a live issue.

Hon Stephen Dawson: Can you just identify again what you’re reading from?

Hon NICK GOIRAN: It is page 51 of the “Ministerial Expert Panel on Advance Health Directives: Final Report” of August 2019. I may have inadvertently —

Hon Stephen Dawson: Sorry; wrong ministerial panel.

Hon NICK GOIRAN: Yes. It is page 51 of the “Ministerial Expert Panel on Advance Health Directives: Final Report”. It states —

Nevertheless, community concern about dementia means that the role of advance planning under the voluntary assisted dying scheme is likely to remain a live issue.

I take that to mean that, irrespective of what we do in respect of the bill before us and the government’s position, the expert panel is saying that this is an issue that remains live with the community. What is the government planning to do to educate the community around the importance of decision-making capacity, given that it is the one recommendation that it has categorically ruled out?

Extracted from finalised Hansard
Hon NICK GOIRAN: I want to ask the minister some further questions about this, but I am not sure the minister has at his disposal this evening the final report of the Ministerial Expert Panel on Advance Health Directives. Instead, I will ask him some questions pertinent to this point in the Ministerial Expert Panel on Voluntary Assisted Dying’s final report. I take the minister to page vii, where the chairman states —

Although it is not within the Panel’s brief, nor does it appear in the JSC’s Legislation Framework, the Panel considers that it should acknowledge the strong body of opinion that has been expressed, during the consultation period and in submissions, that there should be legislation to enable a person to express, in an advance health directive, a wish to access voluntary assisted dying at a point where all enjoyment of life has disappeared and he or she no longer has capacity as, for example, in the case of dementia; and that such directive must be acted on. Those views, by members of the Western Australian public, have also been expressed in Canada and other jurisdictions. However, when this has been raised in submissions, or by those attending the public forums, Panel members have been at pains to explain that this will not form part of the Panel’s recommendations, as it is not within our terms of reference.

Why did the government exclude that from the terms of reference for the panel?

Hon STEPHEN DAWSON: I am advised that the government accepted the advice of the joint select committee that the person must have decision-making capacity throughout the process.

Hon NICK GOIRAN: Where do we find that as a view of the joint select committee?

Hon STEPHEN DAWSON: That issue can be found in the previously mentioned voluntary assisted dying legislation framework, which is on page 226 of the “My Life, My Choice” report of the committee.

Hon NICK GOIRAN: Thank you, minister. I can see that on page 226, under the framework and the heading “Capacity”, it reads —

In order to request assisted dying the person must have decision-making capacity in relation to a decision about voluntary assisted dying.

I am hearing from the minister that that was very important to the government, so important, in fact, that it decided to rule out and reject recommendation 23 of the “Ministerial Expert Panel on Advance Health Directives”. Is that right?

Hon STEPHEN DAWSON: I am advised that the issue was considered previously, although, obviously not recommendation 23, because that came out at a later stage after the government had considered the issue.

Hon NICK GOIRAN: Yes, but, minister, to be clear, the government’s view is that decision-making capacity is crucial and that is why it has insisted upon it being in this bill. That is why it has also—albeit, separately—decided to reject recommendation 23 of the “Ministerial Expert Panel on Advance Health Directives” because its view is that decision-making capacity is crucial; it is fundamental to the overall scheme.

Hon STEPHEN DAWSON: The ability to make a decision is a fundamental principle in this bill.

Hon NICK GOIRAN: That being the case, if it is so fundamental, as the minister has indicated, why does the minister and the government dismiss the concerns raised by Hon Adele Farina about self-administration? What confidence does the government have that at the time of self-administration, the person has decision-making capacity? Let us remember that the minister has just informed the chamber that it is crucial; it is fundamental and it is at the heart of the scheme. At the time of self-administration, when there are no witnesses present and there is no practitioner present, what confidence does this government have that that fundamental principle, the decision-making capacity, that thing that was most important to this government—so important that it rejected recommendation 23 of the other expert panel—will be present in those circumstances?

Hon STEPHEN DAWSON: I have answered the questions of Hon Adele Farina, perhaps not to her satisfaction, granted, but I have answered those questions previously.

Hon Nick Goiran: Not to my satisfaction.

Hon STEPHEN DAWSON: Not to the member’s satisfaction, but I have answered those questions, so I do not propose to provide a further response on that issue.

Hon COLIN TINCKNELL: As the minister can see, these are the concerns that all the experts, other than the Ministerial Expert Panel on Voluntary Assisted Dying, have shown concern for, and today we have not had any explanations. We do not see any encouragement from the government to seriously look at amendments when people have concerns. We are very worried about wrongful deaths that could happen. In the initial vote of 25–10, many members who voted that initial yes had concerns. I am talking to this government about amendments and at this stage there does not seem to be any give whatsoever. It is like there is only one expert panel and no-one else—no other professional or specialist—has any idea what they are talking about. Can the minister give us any confidence
that this government will seriously look at these amendments and these concerns of the members in this place, who are representing the community out there in WA? Can the minister please give us some confidence that there will not be any wrongful deaths?

**Hon STEPHEN DAWSON:** With the greatest of respect, the honourable member has been out of this chamber this evening on urgent parliamentary business at various times. I have indicated to the chamber tonight that of course the government will consider amendments. There are no amendments for clause 1 of the bill. In fact, there are no amendments in the member’s name for us to consider that I have received.

**Hon Colin Tincknell** interjected.

**Hon STEPHEN DAWSON:** There you go; we will consider those when we get to those clauses. As I have said, we will consider amendments and we will consider those when we get to the clauses for debate, but there is no amendment in front of us for clause 1. I have indicated that conversations are taking place and I am certainly aware of a number of other members of Parliament who are involved in discussions with the Minister for Health. I am certainly aware of the Australian Medical Association being involved in conversations about amendments. I am not aware of the member being involved in conversations about amendments. I am certainly happy to facilitate a conversation between the member and the Minister for Health’s office, if that is what the member wishes. But I indicate again that the government is open to amendments, provided they do not alter the bill substantially or in a way that detracts from the purpose of the bill. Amendments will be considered when we get to those clauses, but there is certainly nothing before me for clause 1.

**Hon COLIN TINCKNELL:** For the minister’s information, I do have some amendments and there will be some more coming. I have been talking to members of the government, as well as opposition and crossbench members, and also the Minister for Health about amendments on many occasions over the last three months.

**Hon NICK GOIRAN:** On this question of dementia, where in the Joint Select Committee on End of Life Choices’ majority report is it that the committee considers whether voluntary assisted dying should be provided through an advance health directive?

**Hon STEPHEN DAWSON:** While my advisers find that information for me, the honourable member is now asking questions that are really starting to skirt outside of the bill that is before us. He is asking questions about expert panels, which is outside of the bill that is before us today. I am happy to see what answer can be provided, but I would say that the policy of the bill had been decided at the second reading. When the member is asking me questions about external things that could have an impact, I tend to think that we are straying.

**Hon NICK GOIRAN:** To alleviate the concerns of the minister, I remind the chamber that recommendation 23 of the government’s own Ministerial Expert Panel on Advance Health Directives was —

> 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.

That is what the government’s own ministerial expert panel recommended. Those are its words. They are not my words; it is not the minority report, hence why I am asking about it now. Earlier I referred to page 52 of the “Ministerial Expert Panel on Advance Health Directives: Final Report”, but I was trying to avoid raising it with the minister because I was cognisant of the fact that he does not have the report at his disposal. At page 52 of the report, that particular expert panel raises these questions on this issue for consideration —

(i) Should the making of an advance voluntary assisted dying directive be subject to the same decision-making capacity requirements as other voluntary assisted dying decisions?

(ii) Should there be a ‘cooling off’ period before the advance voluntary assisted dying directive takes effect?

(iii) What information would need to be given to the person making an advance voluntary assisted dying directive?

(iv) When should an advance voluntary assisted dying directive be implemented (for example, when the person has lost capacity and meets the eligibility criteria for access to voluntary assisted dying)?

(v) Who should be responsible for determining that the person meets the eligibility criteria and has lost capacity, and that their advance voluntary assisted dying directive should be given effect (for example, a substitute decision-maker or an independent tribunal)? How would that person or body decide whether or not that person is, for example, experiencing suffering that cannot be relieved in a manner the person considers tolerable?

(vi) How are the protections going to be implemented, and by whom?

(vii) What happens if a person, having made an advance voluntary assisted dying directive and having lost capacity, makes it clear that they do not wish to die?

_Extracted from finalised Hansard_
Those questions specifically in relation to voluntary assisted dying were not raised by me, but by the government’s own ministerial expert panel. I am trying to ascertain what consideration the government has given to those various questions put forward by the expert panel and I seek some clarification from the minister on what those answers might be.

Hon STEPHEN DAWSON: I would just point out that this question is on the report of the Ministerial Expert Panel on Advance Health Directives, not the Ministerial Expert Panel on Voluntary Assisted Dying, and, of course, we are dealing with the Voluntary Assisted Dying Bill. Notwithstanding that, I have made the point, and I am happy to make it again, that the Attorney General has categorically ruled out advance health directives applying to voluntary assisted dying. The member would know the obvious complexities in relation to advance health directives.

Hon NICK GOIRAN: That is fine. I am happy to pursue another theme, given that the minister does not have that information before him. But I reiterate the point that it is the government’s own ministerial expert panel, not on voluntary assisted dying, but on advance health directives, that has said that these questions need to be considered if and when voluntary assisted dying legislation is implemented in Western Australia. That is what we are doing at the moment. The government is asking us to approve the implementation of voluntary assisted dying and its advance health directives expert panel has asked these questions. The government does not want those questions asked now. I do not know when they could be asked.

Hon Stephen Dawson: By interjection, would you like me to answer that?

Hon NICK GOIRAN: Sure.

Hon STEPHEN DAWSON: I said earlier that these questions have been considered by government and by cabinet and as part of the formulation of the bill before us. The questions have been considered and ruled out categorically. They were asked by a ministerial panel examining a different issue; albeit, they refer to an issue before us now. The questions have been asked and the response was that they have been ruled out categorically.

Hon NICK GOIRAN: Last week, Hon Rick Mazza moved a motion to have the bill referred to the Standing Committee on Legislation. That motion was unsuccessful. Had that motion been successful, the committee would have routinely considered the fundamental legislative scrutiny principles. Have those principles been considered by government in the drafting of this bill?

Hon STEPHEN DAWSON: The honourable member might have to ask his question in a different way because neither my advisers nor I appreciate what the question is. Obviously, none of us is reflecting on the Council’s decision last week, because that decision was made and this bill did not go to a committee at that stage. If the member could perhaps ask that question in a different way, we might understand what he is getting to.

Hon NICK GOIRAN: When a bill is referred to the Standing Committee on Legislation, the committee does a number of things. One of the things the committee does routinely and customarily is to consider the fundamental legislative scrutiny principles. It is actually not that uncommon for those principles to be appended as an annexure to its reports. It is something that it does very customarily and very routinely. I am asking whether the government has considered any of those principles as part of the drafting of this bill.

Hon STEPHEN DAWSON: Not being on that committee and not having served on that committee, I am not sure what those principles are. Perhaps if the honourable member wants to mention those principles, my advisers and I can consider those matters and tell him whether they were considered in the drafting of the bill.

Hon Dr SALLY TALBOT: I am very familiar with the fundamental legislative principles, as Hon Nick Goiran knows very well, because it is something that the legislation committee considers. However, the issue I want to raise is whether we are really doing justice to the very measured advice that the Chair of Committees gave to this chamber when we started the Committee of the Whole House stage. He drew our attention very carefully and, as I say, in a very considered way to the scope of the clause 1 debate.

I have listened to this debate for many hours, as most of us have. I do not think I have seen the chamber as consistently full as it has been for the last two weeks, with members listening to this debate. I can only complement the minister on his patience and the forensic nature in which he answers these very detailed questions, but I think we are on the verge of getting to the point at which a couple of honourable members are effectively asking the minister to do their work for them. We made the point in the second reading debate and I would stress that the second reading debate settled the policy of the bill. The policy of the bill is not set out in skeletal legislation; it is set out in the 184 clauses before this chamber. We are at the stage at which we have established the policy of the bill, but a couple of honourable members are constantly referring to the huge body of work that went into informing these 184 clauses. All that material is available for honourable members to read, and I know most members in this chamber have read every word of every inquiry that has been done into this bill. To get to the point at which Hon Nick Goiran is asking the minister to expand on fundamental legislative principles, which he knows are a loose way of formulating an inquiry into legislation, is way beyond anything that we are supposed to be considering in clause 1. It concerns me that I had thought that if we all honoured the set of principles that the Chair of Committees put to us nearly a week ago, when we started the Committee of the Whole House stage, we would not be at this stage now.

Extracted from finalised Hansard
The DEPUTY CHAIR (Hon Matthew Swinbourn): The member did not raise a point of order, so I take on board her comments. I will note that standing orders on debates apply to the committee stage as well. The debate must be, and remain, relevant. There are rules in relation to tedious repetition and things of that kind. Noting that a clause 1 debate is very broad, I remind members to make sure that their contributions remain relevant to the four walls of the bill before us.

Hon ADELE FARINA: I am really concerned about a deficiency in the bill, and that is in the provisions about the safe storage of the voluntary assisted dying substance. I touched on this in my second reading contribution. I am particularly concerned that no obligation is imposed on aged-care facilities for the safe storage of the VAD substance dispensed to a patient to ensure that other people who live in that aged-care facility do not access that drug and administer it to themselves. The mother of a friend of mine lives in an aged-care facility. The patient in the room next to her has dementia and frequently wanders into her room and takes things, believing that they are hers. It concerns me that this bill does not have any provisions about the obligation of aged-care facilities for the safe storage of the VAD substance. I ask the minister: where do we find those provisions and those requirements for the safe storage of the VAD substance?

Hon STEPHEN DAWSON: Honourable member, I think the question was: where in the bill does it mention storage?

Hon Adele Farina: Does it mention safe storage anywhere?

Hon STEPHEN DAWSON: We are finding that information. While we do, obviously, all medications should be stored securely. The Department of Health is of the view that advising and educating people on safe storage and medication management is very appropriate and, indeed, effective, but we are not seeking to police storage within a person’s home. In line with the Department of Health’s “Guiding principles for medication management in the community” and the national Poisons Standard, patients using medicines in the community will be encouraged to store their medicines in a manner that maintains the quality of the medicine and safeguards the consumer, their family and visitors in their home. Appropriate methods for storage will be further developed with expert clinical advice during the implementation stage of the bill. Clause 71 of the bill refers to information to be given when supplying the prescribed substance and, in particular, my advisers are drawing my attention to clause 71(2)(b), which prescribes that the authorised supplier must inform the recipient in writing how to store the substance in a safe and secure way.

Upon dispensing the substance to the patient, contact person or other agent of the patient, the authorised supplier must provide written information about the safe and secure storage of the substance; how to prepare and self-administer the substance; information about the disposal requirements of any unused substance; and that the patient is not under any obligation to self-administer the substance. As I said, those requirements are set out in clause 71.

Hon ADELE FARINA: I understand the provisions regarding a person living at home. My concern is about a patient living in an aged-care facility who has been deemed eligible under the VAD process and has had the VAD substance dispensed to them. There does not appear to be any obligation in the bill, that I can see, that requires the patient to inform the aged-care facility that they have had the VAD legal substance dispensed to them, and there does not appear to be any provisions in the bill about the obligation of the aged-care facility to ensure that that substance is safely stored, because it has an obligation to the safety of all patients living within the aged-care facility. I find that this is another area of significant deficiency in the bill and these things have not been addressed. The minister mentioned that this is something that can be looked at later, but where is the head of power in the bill that provides for the executive or the CEO of the Department of Health to impose requirements on aged-care facilities’ safe storage of the VAD substance, and where are the offences if they do not adhere to those requirements?

Hon STEPHEN DAWSON: First of all, I make the point that schedule 4 and schedule 8 poisons would likely already be in that nursing home or that aged-care facility.

Hon Adele Farina: They would probably all be locked away.

Hon STEPHEN DAWSON: Not necessarily. If they are locked away already, then they will be locked away as part of this process. I cannot see anything changing, but the federal Department of Health “Guiding Principles for Medication Management in Residential Aged Care Facilities” currently exists.

Hon ADELE FARINA: The minister referred to a document and there being some regulations already. Will he table those?

Hon STEPHEN DAWSON: I do not have them to table, but I referred to a document and I am happy to tell the member what that document is again. It is the commonwealth government Department of Health’s “Guiding Principles for Medication Management in Residential Aged Care Facilities”. We can take the detail on notice. To be helpful, I am happy to find the document tomorrow. I am also advised that there are safety and quality accreditation standards for aged care, which would also touch on this issue. Further, regulation 107 of the Medicines and Poisons Regulations 2016 indicates that the CEO of the Department of Health can give directions about the storage or use of poisons.
Hon ADELE FARINA: Minister, if an aged-care facility fails to ensure the safe storage of a VAD lethal substance and a patient—not the patient to whom the VAD substance was prescribed—dies as a consequence of ingesting the VAD substance, what penalties or offences are available to prosecute the aged-care facility for that death?

Hon STEPHEN DAWSON: In relation to the storage of schedule 4 and 8 poisons, section 22 on page 23 of the Medicines and Poisons Act 2014 refers to the storage, handling and transport of a poison other than in accordance with the regulations. The penalty is $45,000 or three years’ imprisonment.

Hon NICK GOIRAN: Minister, do any clauses in the bill make any rights, freedoms or obligations dependent on administrative power?

Hon STEPHEN DAWSON: I am advised that certain provisions in the bill are reviewable by the State Administrative Tribunal.

Hon NICK GOIRAN: Which provisions are reviewable by SAT, minister?

Hon STEPHEN DAWSON: Part 5 of the bill identifies the issues that are reviewable by the tribunal.

Hon NICK GOIRAN: Is it by virtue of the mechanism that the minister identified, which are the various clauses in part 5, the basis on which the bill is consistent with the principle of natural justice?

Hon STEPHEN DAWSON: In relation to the specific matters, yes.

Hon NICK GOIRAN: Minister, do any clauses in the bill allow for the delegation of administrative power?

Hon STEPHEN DAWSON: There are provisions in the bill that allow the CEO to undertake that, but certainly if the member is talking about the decisions of SAT, then no.

Hon NICK GOIRAN: When there is capacity for the CEO to do certain things under the bill, is there the capacity for the power of the CEO to be delegated?

Hon STEPHEN DAWSON: In relation to the CEO being able to designate, section 95 of part 7 of the Medicines and Poisons Act 2014 refers to designation of investigators. The honourable member has now asked three questions about the fundamental legislative principles that would have been investigated had this bill gone to a standing committee. A decision was made by this chamber not to send the bill to a committee for that purpose, so I do not think it is appropriate that the member go through a list of things and ask if they have happened in relation to the bill. The policy of the bill has been decided previously. If he has clause 1 questions, he should ask clause 1 questions. I am not sure that these are appropriate questions to be asked at clause 1, given the policy has been decided and we have previously decided not to send the bill to a committee for further consideration.

Hon NICK GOIRAN: In the minister’s response, he referred to “designating” but I mentioned “delegating”. I do not know whether there is a difference in the response that needs to be provided or the answer remains the same regarding what capacity the CEO has to delegate any powers he or she might have under this legislation.

Hon STEPHEN DAWSON: Honourable member, that is a very good question. I would like to take some further advice about that, so we will take that on notice.

Hon NICK GOIRAN: I am glad I asked one of the questions from the fundamental legislative scrutiny principles and I appreciate the acknowledgement that it is a good question that needs to be considered. I look forward to hearing about that tomorrow.

Does the bill reverse the onus of proof in criminal proceedings?

Hon STEPHEN DAWSON: There is no express provision reversing the onus.

Hon NICK GOIRAN: Does the bill confer power to enter premises and search for or seize documents or other property? Obviously, in this context, we would also be thinking about the poison that is available.

Hon STEPHEN DAWSON: Yes, it is under part 7 of the bill.

Hon NICK GOIRAN: Would this power require a warrant to be issued by a judge or other judicial officer?

Hon STEPHEN DAWSON: I am advised that it would in some circumstances.

Hon NICK GOIRAN: Does the bill provide appropriate protection against self-incrimination?

Hon STEPHEN DAWSON: I will need to take some further advice on that point.

Hon NICK GOIRAN: Just to confirm, the two matters that have been taken on notice are whether there are any clauses in the bill that allow for the delegation of administrative power, and whether the bill provides appropriate protection against self-incrimination. That brings me to my next question: does the bill adversely affect rights and liberties or impose obligations retrospectively?

Hon STEPHEN DAWSON: I will have to take further advice on that, too. I note that I will take advice on the three things that have been raised in the current discussion, but I also indicated earlier that I will be taking advice on other issues. I just wanted to clarify that.

Extracted from finalised Hansard
Hon NICK GOIRAN: I thank the minister for his diligence in making sure that we are recording each of the matters that are being taken on notice. Does this bill confer immunity from proceedings or prosecution?

Hon STEPHEN DAWSON: Without adequate justification?

Hon Nick Goiran: Just full stop.

Hon STEPHEN DAWSON: Okay. I will take some advice on that, too.

Hon NICK GOIRAN: Does the bill provide for the compulsory acquisition of property? I am particularly interested to know about property in the sense of the voluntary assisted dying substance or poison.

Hon STEPHEN DAWSON: Items can be seized by the investigators, if that is what the member is asking.

Hon NICK GOIRAN: The tenth of the fundamental legislative scrutiny principles routinely used by the Standing Committee on Legislation when considering bills is whether a bill has sufficient regard to Aboriginal and Islander traditions and customs. Is the government aware of the concerns raised by Senator Dodson about the impact of this bill on Aboriginal Western Australians; and, if so, how is the government addressing those concerns?

Hon STEPHEN DAWSON: Yes, I am aware of comments made by Senator Patrick Dodson about the bill before us, as we are aware of comments made by other Aboriginal people about the bill. It may have been in answer to an earlier question asked by an honourable member or it may well have been a comment made by another honourable member during the second reading stage, but members were told that Kate George, an Aboriginal person, was a member of the Ministerial Expert Panel on Voluntary Assisted Dying. We had an Aboriginal person on the panel and consultation took place with a number of Aboriginal people. In fact, it might have been Hon Jacqui Boydell who identified in her contribution to the second reading debate that a number of Aboriginal people and organisations attended some of those fora on the bill around the state. We are aware of a multitude of views from Aboriginal people on the bill. I again make the point that, as a number of members would recognise, Aboriginal people are not a homogenous group and different views are held by different Aboriginal people. One view from an Aboriginal person does not indicate that all Aboriginal people in Western Australia are of the same opinion.

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

Legislative Council

Wednesday, 30 October 2019

[page 8547]

VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 29 October. The Chair of Committees (Hon Simon O’Brien) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 1: Short title —

Progress was reported after the clause had been partly considered.

Hon STEPHEN DAWSON: Last evening when we last discussed the Voluntary Assisted Dying Bill 2019, I indicated that a number of questions would be taken on notice and that I would seek to provide further information to Hon Nick Goiran about those items. It is my intention to answer as many of those as I can. We are still waiting on a number of others, which, hopefully, will arrive over the course of the evening or tomorrow. Hon Nick Goiran asked when the Ministerial Expert Panel on Advance Health Directives was appointed and who was on that panel. The term of the panel commenced on 1 January 2019. The membership of the panel comprised Mr Simon Millman, MLA, member for Mount Lawley, who was the chair; Dr Jacquie Garton-Smith, general practitioner; Ms Janet Wagland, general manager of Brightwater Care Group; Ms Lana Glogowski, chief executive officer, Palliative Care WA; Ms Carol Conley, senior assistant state solicitor, State Solicitor’s Office; Ms Rhonda Parker, chief executive officer, Alzheimer’s WA; Mr Nigel Haines, consumer advocate; Ms Pauline Bagdonavicius, the Public Advocate; and Dr Audrey Koay, executive director of patient safety and clinical quality, Department of Health.

A further question was in which parts of regional Western Australia does Silver Chain currently operate and in which parts of Western Australia does the minister anticipate it will operate with the benefit of some of the $6.3 million in funding. The Silver Chain community-based palliative care program comprises community-based specialist palliative care, including home-based respite for clients in the metropolitan area; a palliative care specialist nurse consultation service for the Perth metropolitan area; and a 24-hour telephone advisory service available to health professional staff providing palliative care in rural areas of Western Australia. Silver Chain operates various remote area nursing posts at the Abrolhos, Beacon, Bencubbin, Eucla, Hyden, Lancelin, Shark Bay, Walpole, Brookton, Eneabba, Leeman and Minganew. These are not palliative care services but they include
services to some patients who are at the end of life. Decisions about the operationalisation of the $6.3 million funding will sit with the Department of Health and relevant health service providers, and will be subject to government procurement processes.

There was a further question about GP Medicare billing: is there an item number relevant to this process? I am advised that item numbers specific to voluntary assisted dying are not part of the Medicare benefit schedule book. However, there are several consultation item numbers relevant to general practitioners, depending on the duration, location and time of consultation; for example, item 23 for a standard consult in the surgery during routine hours or item 36 for a long consult in the surgery during routine hours.

A further question from Hon Nick Goiran was: what is the situation when it comes to the administering practitioner? I would like to clarify my earlier statement on the administering practitioner by further advising that whether an MBS item number is applicable depends on the purpose of the consultation. Where the consultation is for the purpose of actual administration of the voluntary assisted dying substance, this would not be claimable.

Hon Nick Goiran: That’s news.

Hon STEPHEN DAWSON: The honourable member asked some questions last night and I am providing the answers now, which I am very happy to do.

Hon Nick Goiran: Different information.

Hon STEPHEN DAWSON: I am very happy to provide answers. I take some of these questions on notice because the advisers beside me may not have those answers, and it is very important that we make sure that we provide proper answers to the chamber and that is obviously what I am doing today, and certainly providing clarification on that issue.

Hon Nick Goiran asked a further question about whether there was any gap for a nurse practitioner with their item number. I am advised that according to the Medicare benefits schedule book, the benefits paid are set at 85 per cent of the relevant item number available to nurse practitioners. Whether there is any gap for the patient will depend on the fee of the nurse practitioner involved.

A further, quite lengthy question, about Medicare charges in the Victorian system was asked: are they billing Medicare and being paid? I am advised that in Victoria, billing practices are undertaken consistent with what has been outlined in my responses as relevant to the MBS.

Hon Nick Goiran asked further questions last night based on a Queensland requirement, I am told. In Queensland, fundamental legislative principles require that legislation, both bills and subordinate legislation, should have sufficient regard to the rights and liberties of individuals and to the institution of Parliament.

I maintain that the following questions are outside the realm of clause 1 but I will respond to them.

Hon Nick Goiran asked: in what capacity does the CEO have to delegate any powers he or she might have under this legislation? The bill does not contain a specific clause regarding the delegation power of the CEO. The intent is that the CEO will have the final sign-off for any duties under the bill. However, if we wish the CEO to delegate, as may be an administrative necessity over time, we may rely on section 9 of the Health Legislation Administration Act 1984 as the overarching delegation power. This is because that act applies to the acts, the administration of which is committed by the Governor to the Minister for Health—see section 4. The administration of the Voluntary Assisted Dying Act will be committed to the Minister for Health.

Hon Nick Goiran asked: does the bill provide appropriate protection against self-incrimination and does it confer immunity from proceeding of prosecution? I am advised that part 8 of the bill, clauses 112 to 114, deal with providing protection from liability. These protections are consistent with the protections in the Victorian act. The protection is in section 133 of the Medicines and Poisons Act 2014 and the protection provided to persons providing surgical or medical treatment, including palliative care under section 259 of the Criminal Code Western Australia. It will obviously be appropriate to discuss these under the relevant clauses.

Hon Nick Goiran asked: does the bill adversely affect rights and liberties or impose obligations retrospectively? I am advised that the bill does not seek to affect the rights and liberties of individuals nor of institutions. That is why the government emphasises the voluntary nature of this scheme and that a registered health practitioner is under no obligation to participate, as per clause 9. This bill also seeks to balance those rights with the duty of care owed to patients, such as providing them with approved information and facilitating a transfer to a participating hospital or health service. These actions are consistent with the Australian Medical Association position statement on conscientious objection, specifically in relation to the provision of information as per part 2.3 of the AMA position statement, which states in part —

A doctor with a conscientious objection, should:

- inform the patient of their objection, preferably in advance or as soon as practicable;
- inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
- take whatever steps are necessary to ensure the patient’s access to care is not impeded;

Extracted from finalised Hansard
It is not intended that this bill operate retrospectively, as such, a retrospective clause has not been drafted. However, if the bill becomes law, a person who was diagnosed with a terminal illness prior to the commencement of the Voluntary Assisted Dying Act will be able to seek access to voluntary assisted dying, subject to, and in accordance with, the Voluntary Assisted Dying Act in the same way as a person who is diagnosed with a terminal illness after commencement.

I think that is all the information I have so far in response to the questions asked last night.

Hon Nick Goiran: Just as well we had a recess overnight because we have just been provided with substantially different information from government than what was provided yesterday. I want to spend a moment dealing with the new information the minister has provided about the cost of the administering practitioner. The information the minister has just provided to us, as I heard it, indicated that that will not be claimable under Medicare. The performance of the administering practitioner will not be able to be claimed under Medicare. Can the minister confirm that is the case?

Hon Stephen Dawson: The further advice is that the administration of the substance itself is not claimable. The assessment of the patient’s capacity, voluntariness and enduring decision is claimable.

Hon Nick Goiran: Are both those functions or roles performed by the administering practitioner under this legislation?

Hon Stephen Dawson: They may be, but not necessarily.

Hon Nick Goiran: In what circumstances would that not be the case, minister?

Hon Stephen Dawson: I am advised that if the coordinating practitioner is the administering practitioner, the cost may be captured overall; however, if they are different people, it is unlikely.

Hon Nick Goiran: This is what happened yesterday. I am reading from the uncorrected Hansard. I asked the minister about this. The minister’s response was —

These things are being claimed under Medicare in Victoria.

I then said —

Is the government in Western Australia confident that under the Victorian system, costs are being charged by the equivalent of a coordinating practitioner to Medicare and it is being paid for by Medicare, and it is the same for consulting practitioners and administration practitioners—all those individuals—even if they have a different name or terminology, that they are billing Medicare and are being paid? Is there no inconsistency, no problem with the commonwealth law or administration, and all those creases have been ironed out? Is it not like the telehealth issue, when the joint select committee was asked to look into the intersection with federal law and did not do it? Is it not like the ministerial expert panel, when no-one thought about it? On this issue, the minister is giving us an assurance that this is not the first time that anyone is government is thinking about the Medicare issue and the possible problems in intersecting with a federal scheme, keeping in mind that we have already identified that the federal law does not accept any assistance being provided for a suicide, which is precisely the problem with the telehealth clause and the use of carriage services. Has this all been sorted out, there is no problem, and we are very confident we can provide an assurance to the chamber?

The minister then said, according to the uncorrected proof —

Yes, that is certainly my advice.

That is where we left things yesterday. We are now finding out something quite different. When I ask the minister now under what circumstances Medicare will be claimable, the minister uses words like, “Well, this may be the case.” In other words, the government has no idea whatsoever on this issue. We have even had an adjournment overnight, and there still has been no clarification on this. Has anyone in government, minister, thought over the last 24 hours since we last had this debate to speak to anyone at Medicare, number one, or someone in Victoria who is involved in this system, to clarify what is claimable and what is not claimable?

Hon Stephen Dawson: Mr Chairman, with the greatest respect, I gave information yesterday. I said yesterday that was my advice, and I have given a clarification today, and that is where we sit.

Hon Nick Goiran: Minister, has anyone spoken to anyone at Medicare, or to anyone in Victoria who administers this scheme, about what is claimable and what is not claimable?

Hon Stephen Dawson: Yes. I am advised that advisers have spoken to Victoria.

Hon Nick Goiran: What is the outcome of those conversations?

Hon Stephen Dawson: The outcome of those conversations is reflected in the advice that I have given the chamber today.
Mr Chairman, the honourable member has raised particular questions and issues about clauses in the bill. I would ask that the member defer those questions to when we get to those clauses in the bill. We are starting to get bogged down on clause 1. Some of those issues are in specific clauses in the bill. I think, honourable chairman, that we will have to start deferring particular questions about clauses in the bill to those particular clauses, and not have that debate at clause 1. Obviously, the policy of this bill has been agreed at the second reading. If we are starting to get into the detail of the bill and move off clause 1, I think the best place to deal with that detail is when we debate those particular clauses.

**The CHAIR:** We are concerned with the detail and machinery of the bill. The minister is right. When specific matters of detail are covered by clauses in the bill, that is where they should be contemplated.

I was looking at the bill in relation to the matter just raised concerning Medicare payments and so on. The fact of the matter is that I did not draw attention to another clause, because the bill is silent on this matter, so there is nowhere else to talk to it. That is the immediate matter that we have just dealt with. However, minister, if there is a more appropriate place to contemplate any further matters—that is, under a specific provision later in the bill—please draw that to attention, because I share the view that that is where those matters should be discussed. But, for now, we are contemplating clause 1.

**Hon NICK GOIRAN:** Thank you, Mr Chairman. I am the first to be happy to defer any questions that the minister thinks are better suited under another clause to that particular clause. However, at not one stage yesterday, nor in the brief discussion that we have had today, or last week, has the minister identified a question that I have asked that should have been asked under a different clause. I meticulously make sure that I do not do that. If the minister thinks that there is a clause under which we can have a discussion around Medicare, he should let me know, and I will happily defer until then and we will move on to a different theme. The minister is the one who chose today to rise to clarify the incorrect information that was provided to the chamber yesterday. The minister has now provided updated information that he says is pursuant to conversations that have been had with either Medicare or the Victorians.

**Point of Order**

**Hon STEPHEN DAWSON:** In my comments earlier this afternoon, I pointed out that questions were asked by Hon Nick Goiran such as whether the bill confers immunity from proceedings or prosecution. I pointed out that refers to clauses 112 to 114 of the bill. The honourable member said that I did not point that out at any stage. I have pointed it out, so he is actually factually wrong. That is not a point of order.

**The CHAIR:** That is a unique experience, that the person raising the point of order advises me that there is no point of order! I am not sure whether I should feel miffed or delighted. I think I will go for the latter. That way, there is a better chance that we will proceed with our consideration of this bill in the best humour, even though at times it can be heavy going, of course. I congratulate all members on the way that they are dealing with these difficult matters and the decorum that everyone is exhibiting. We will continue to do that as we draw consideration of clause 1 to its conclusion.

**Committee Resumed**

**Hon NICK GOIRAN:** I can assure the minister that there is nothing amusing about anything that is occurring, least of all the fact that the government continues to hide amendments from members of Parliament that it has sought to have drafted by parliamentary counsel. That is why we are having to take a bit longer.

**Point of Order**

**Hon STEPHEN DAWSON:** That issue has been canvassed multiple times at clause 1. I have answered that question about possible government amendments multiple times, and now Hon Nick Goiran is making that point again. It has been made countless times already. I have answered that question. I would ask Hon Nick Goiran to move on and not to keep repeating.

**The CHAIR:** The point of order is that the matter raised is repetitive. The minister is quite right; it has been raised a number of times. Hon Nick Goiran, unless you are raising this matter to deal with some fresh point, we should move on to new material.

**Committee Resumed**

**Hon NICK GOIRAN:** Thanks, Mr Chairman. I know it is difficult for the government because of its conduct in respect of this matter and the lack of transparency. One of the questions the minister said he would take on notice yesterday was the number of palliative care nurse practitioners. Is the minister in a position to give us that information now?

**Hon STEPHEN DAWSON:** Not yet, Mr Chairman. I indicated in my earlier comments when I commenced today that these were the answers to questions asked yesterday that I had answers to thus far. I am still waiting on further answers. If any answer has not been given thus far, it is because I have not got the answer yet.

**Hon NICK GOIRAN:** Does the minister have a list of the questions that he is currently engaging staff and the like to obtain answers to, so that we can make sure that there is no misunderstanding?

*Extracted from finalised Hansard*
Hon STEPHEN DAWSON: I have indicated to the chamber that there are outstanding questions. We have gone through the uncorrected Hansard from yesterday and we are using it to identify the outstanding issues in questions that have been asked. I am not providing a list today. The honourable member is welcome to ask chamber staff for a copy of the uncorrected Hansard, if that is what he wishes, but that is what we are using as the basis of questions that need further answers.

Hon NICK GOIRAN: This is the difficulty, Mr Chairman: because the government says it is working on answers to questions, if I then want to ask what its answer is to this particular question, I am told, “No, you can’t ask that because you’ve already asked it once before.” The government expects me to trust that it is busy working behind the scenes to answer questions, but it will not confirm which other questions it is working on. This is more trickery from this government. It makes it very difficult to make progress when we are expected as lawmakers to proceed with handcuffs on and a blindfold.

One of the questions that the minister has responded to is the capacity of the CEO to delegate. The minister referred us to section 9 of the health administration act. I do not see any reference to the health administration act. I think that was the name of the act the minister referred to. I do not see any reference to the health administration act in any other clause, so before I ask my questions I just want to make sure, minister—because I know the minister is very sensitive about whether questions get asked under other clauses—is there any reference to the health administration act in another clause of the bill?

Hon STEPHEN DAWSON: The act that I referred to in my answer was the Health Legislation Administration Act 1984. I referred to section 9 of that act. No, it does not appear in the bill before us.

Hon NICK GOIRAN: What relevance does section 9 of the Health Legislation Administration Act have to the matters before us in this bill?

Hon STEPHEN DAWSON: The question was whether the CEO has powers to delegate. That act says that the CEO has overarching delegation power. I also made the point that these questions were asked in relation to fundamental legislative principles, which is a requirement in Queensland legislation, but, of course, it is not one here.

Committee interrupted, pursuant to standing orders.

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Martin Aldridge) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 1: Short title —

Committee was interrupted after the clause had been partly considered.

Hon NICK GOIRAN: In the minister’s answer earlier this afternoon, prior to questions without notice, he referred to what I understood is a likely gap in the fees that would be relevant for nurse practitioners. The minister referred to a figure of 85 per cent. Can the minister clarify what that means? Does that mean that Medicare will cover up to 85 per cent of the fee of a nurse practitioner? How does that 85 per cent figure relate to the gap that will be required to be paid by a patient who wishes to access voluntary assisted dying?

Hon STEPHEN DAWSON: We will have to check that information and we will provide an answer to the chamber later in the evening.

Hon NICK GOIRAN: The minister has indicated that the government is in ongoing consultation and discussion with the Australian Medical Association (WA). The AMA did a survey and 90 per cent of those who responded—that is, 1368—believed that the government should regulate these fees and charges. Is the minister indicating to the chamber that the AMA has never raised with the government that it should regulate the fees and charges for this process?

Hon STEPHEN DAWSON: No, we are not considering it. My advisers say that, to the best of their knowledge, it has not been raised with us.

Hon NICK GOIRAN: The minister has indicated that the government is in ongoing consultation and discussion with the Australian Medical Association (WA). The AMA did a survey and 90 per cent of those who responded—that is, 1368—believed that the government should regulate these fees and charges. Is the minister indicating to the chamber that the AMA has never raised with the government that it should regulate the fees and charges for this process?

Hon STEPHEN DAWSON: My advisers tell me that we are not aware of it being raised, but we are going to check the AMA document that was tabled yesterday, dated 21 October 2019, to see whether it was raised in that format. We will check that document and provide an answer to the chamber based on that.

Hon NICK GOIRAN: Was the issue of regulating the fees that will be chargeable raised with the Ministerial Expert Panel on Voluntary Assisted Dying, and did it provide any information to government on that?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: The ministerial expert panel did not make a recommendation on this issue. We would have to go back and check the submissions to the ministerial expert panel to see whether it was raised by any organisation as part of that submission process, but we are not aware of that at this stage. We will have to go back and check that.

Hon NICK GOIRAN: To the best of the government’s awareness, this issue was not raised in the ministerial expert panel process. Is this matter now under consideration by government?

Hon STEPHEN DAWSON: We have gone back and checked the Australian Medical Association (WA) document from 21 October that was tabled yesterday and there is a proposed amendment in relation to that issue in that document. I have previously indicated that the government is involved in conversations generally with the AMA (WA) on its amendments, so I suspect that all the amendments are under consideration at this stage. However, no decision has been made by government on any of them.

Hon NICK GOIRAN: For what it is worth, I think it would be worth giving serious consideration to that amendment. I cannot make a case for the law of Western Australia telling a legal practitioner involved in a workers’ compensation case that under no circumstances should they charge more than the scale fees, and then allow a medical practitioner who is involved in taking the life of a person—it may well be with the consent of the individual and may meet all the criteria under the legislation—to have unlimited capacity to charge for that service. I cannot make a case for that. I think that is morally wrong. I hope the government will agree that if it is good enough to tell legal practitioners how much they can charge in a workers’ compensation case, it surely must be good enough for the government to tell a medical practitioner how much they can charge for so-called voluntary assisted dying. I hope the government will give serious consideration to that. I do not know what level of consideration it is giving to that amendment because, as we have previously discussed, we are operating with handcuffs and blindfolds on in this debate.

One thing the ministerial expert panel did was undertake some consultation with Aboriginal people. I draw the minister’s attention to page 30 of the ministerial expert panel report, where it 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.

How has this issue that was identified by the ministerial expert panel been taken into account in the bill before us?

Hon STEPHEN DAWSON: On the last point, we are seeking some further advice and I will provide that shortly. In relation to Hon Nick Goiran’s mention of the fees payable to law practitioners in Western Australia, I am not full bottle on those and certainly was not part of the Parliament when decisions were made on that issue. I hear what the member is saying and his views on that issue. He has a strong view that medical practitioners who participate in this process should be regulated by a similar scheme, if I can use those words. I have noted the member’s comments about that.

The member has again talked about our hands being tied. Again, we are following the same processes that are followed when other bills are before this chamber; that is, when the government or, indeed, anybody decides to move amendments to legislation before the chamber, they of course need to lodge those amendments with the clerks and they then appear on the supplementary notice paper for the bill. He might say that his hands are tied, but plainly and simply we are following the same process that has been followed in this place for a very long time. Of course, we all understand that customs and practices in this place are a very important part of our daily lives. He might say that his hands are tied, but I would say, as I have said previously, that we are considering a range of amendments based on the feedback of honourable members in this place and indeed health stakeholders, including the Australian Medical Association and the Royal Australian College of General Practitioners. We continue to consider those amendments. Once the government has made a decision on those amendments, we will, of course, put them on the supplementary notice paper as we would for any other bill.

In response to that last specific question, we continue to seek that advice, so I will sit down for a second and provide an answer once it is ready.

In response to Hon Nick Goiran’s question about the consultation findings on page 32 of the “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report” and the comments that he read to the chamber from the Aboriginal Health Council of Western Australia, I am advised that the advice received from Aboriginal communities and organisations informed a range of expert panel recommendations, particularly the guiding principles; recommendation 12, regarding care navigators; and recommendation 29, regarding education and training to promote culturally competent practice. As recommended by the Aboriginal Health Council of Western Australia in its submission to the ministerial expert panel, a navigator program will be planned, designed and implemented in a culturally appropriate manner, and suitable training and ongoing support will be provided to care navigators. Community awareness and communication programs about voluntary assisted dying will also be developed to ensure that everybody in the community, including Aboriginal people, has accurate and appropriate information on this choice.
Hon NICK GOIRAN: The minister referred to the submission by the Aboriginal Health Council of Western Australia. I note that page 31 of the ministerial expert panel’s report says —

‘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’.

As I understand it, that quote on page 31 is a submission by the Aboriginal Health Council of Western Australia. How is that addressed in the bill?

Hon STEPHEN DAWSON: Again, the advice received from Aboriginal communities and organisations informed a range of ministerial expert panel recommendations generally, so the honourable member can read in whichever quotes in here, but certainly my advice is that all the submissions were considered by the ministerial expert panel. Following the consideration of those submissions and the consultations that took place across the state, the ministerial expert panel landed on the recommendations in the “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report”.

Hon NICK GOIRAN: The Aboriginal Health Council of Western Australia also said to the ministerial expert panel —

‘As Aboriginal families often live together, with multiple generations sharing the same house, there is a safety concern about the unregulated presence of highly harmful medication in the home.’

How has that been addressed in the bill?

Hon STEPHEN DAWSON: All medication should be stored securely. The department is of the view that advising or educating people on safe storage and medication management is more appropriate and effective than a fixed legislative requirement for a specific method. It is not our intention to police storage within a patient’s home. In line with the Department of Health’s guiding principles for medication management in the community and the national poisons standard, patients using medicines in the community will be encouraged to store their medicines in a manner that maintains the quality of the medicine and safeguards the consumer, their family and visitors in their home. Appropriate methods for storage will be further developed with expert clinical advice during the implementation stage of the bill. It is anticipated that specific medication protocols will be developed and implemented to ensure the safe storage, preparation, administration and disposal of unused voluntary assisted dying substances. The bill sets out the minimum requirements for the supply, storage and disposal of the prescribed substance.

I am further advised that the consultation findings will be reflected in the training of doctors.

Hon NICK GOIRAN: The minister indicated that somebody within government has given advice that an educative approach for storage is better than a legislative fix, I think the phrase was. Is that the approach that has been taken in Victoria?

Hon STEPHEN DAWSON: The ministerial expert panel provided a snapshot of eight different jurisdictions and their medication management. None stipulated a time line for the process nor specific disposal requirements; rather, consistency with existing protocols and the use of internal policy guidelines and education seems to be the preferred approach. The ministerial expert panel noted that apart from Victoria, no jurisdictions legislate for locked boxes and there is no evidence of misuse with voluntary assisted dying medication elsewhere in the world. In Western Australia, schedule 4 and schedule 8 poisons, which will make up voluntary assisted dying substances, are already dispensed to people without discrete storage requirements such as a locked box. The Victorian legislation differs from Western Australia in this regard.

Hon NICK GOIRAN: The minister mentioned that there is no evidence of any misuse. Is that something that the ministerial expert panel has said or is it subsequent advice from within government?

Hon STEPHEN DAWSON: I am advised that the issue was part of the ministerial expert panel’s considerations, but it was also an issue considered by the Department of Health in the formulation of this bill.

Hon NICK GOIRAN: To be clear, both the ministerial expert panel and the Department of Health have said to the government that there is no evidence of misuse of the poison, substance or drug when it comes to storage. Is that the advice from both the ministerial expert panel and the Department of Health?

Hon STEPHEN DAWSON: The ministerial expert panel noted that there was no evidence available on this issue. I am further advised that the Department of Health looked for evidence and could not locate any.

Hon NICK GOIRAN: I think the minister told us in a previous answer to a question that the system in Oregon is just self-administration, not practitioner administration. Finding 115 on page 206 of the minority report states —

The inherent difficulty in prosecuting after the event is underscored by at least five assisted suicides in Oregon that occurred by illegal overdoses administered by a nurse.

Extracted from finalised Hansard
If there is only self-administration and not practitioner administration in the Oregon system, and the data in Oregon indicates that death has occurred at least five times because of an illegal overdose by a nurse, would that not be an issue of concern? How was that substance obtained? We are talking about storage, and someone clearly had access to the poison. I also note finding 111 of the minority report —

In Oregon an octogenarian cancer patient was assisted to suicide notwithstanding that two doctors, including her own physician, were concerned about the presence of depression and refused to prescribe the lethal drug requested.

These cases in Oregon seem to suggest at face value that something is not quite right there. It is not clear to me why the ministerial expert panel would be in a position to advise the government, “There’s nothing to see here, folks. There’s no problem.” Is the minister in a position to explain that?

Hon STEPHEN DAWSON: The assertions made in the honourable member’s minority report would need to be checked and I will have to take some further advice on that. But he is making assertions about the Oregon legislation. Our bill is different from Oregon’s. Perhaps it was in my second reading reply or the second reading speech in which I alluded to the summary of safeguards that we have attached to the bill that is being discussed before us. The ministerial expert panel noted that there was no evidence on this issue and the Department of Health looked for evidence. We will, of course, seek some further advice about the minority report and I will provide further explanation about that once we have been able to ascertain the extra information we are looking for.

Hon COLIN TINCKNELL: Does the minister believe that death certificates should be truthful?

Hon STEPHEN DAWSON: I think the honourable member is asking me for my opinion on an issue.

Hon Colin Tincknell interjected.

Hon STEPHEN DAWSON: Hang on; I am on my feet.

I suggest that the question is out of order. The honourable member is welcome to ask questions about the bill before us. We are, of course, at clause 1 of the bill and have previously decided on the policy of the bill. If the honourable member has questions about specific clauses in the bill, perhaps he should ask questions about those clauses at those clauses. It is not appropriate to ask me about my opinion.

The DEPUTY CHAIR (Hon Martin Aldridge): Before I give the call to Hon Colin Tincknell, I am not able to locate it presently, but I am certain the bill has a provision that relates to the issuance of death certificates. I caution the member that if he is intending to ask specific questions about a clause, that is not a matter to be dealt with at clause 1.

Hon STEPHEN DAWSON: Just to clarify, death certificates are mentioned in or linked to clause 81 of the bill. Perhaps the honourable member might want to ask questions about that issue generally at clause 81. It is certainly not appropriate to ask me what my opinion is of death certificates.

Hon COLIN TINCKNELL: If this chamber decides to legislate for voluntary assisted dying, no stigma should be attached to the Voluntary Assisted Dying Bill or any determination made to prohibit any reference on the death certificate to death by voluntary assisted dying. There is a reason for the question. I understand that the advice is that a death should not be attributed to VAD on the death certificate. Why is that the case? If this chamber, this Parliament and society choose to legalise voluntary assisted dying, what is the stigma that is attached to that?

Hon STEPHEN DAWSON: Again, clause 81(6) of the bill states —

The medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

That is dealt with in the bill. It is not a clause 1 issue; it is a clause 81 issue. In relation to stigma in the community, I am not answerable for people’s views and who thinks what is stigmatised or otherwise. These questions are most appropriately asked at clause 81.

Hon NICK GOIRAN: I will follow up on the concerns raised by the Aboriginal Health Council of Western Australia with the Ministerial Expert Panel on Voluntary Assisted Dying around the need for safeguards because of the unregulated presence of highly harmful medication in the home, and the revelation by the minister that the government has chosen to take an educative approach to this and not a legislative fix. Earlier we discussed the situation in Oregon, which uses only self-administration. Does Oregon take an educational approach to the storage issue or does it take a legislative fix?

Hon STEPHEN DAWSON: The honourable member is asking about the Oregon legislation. That is not the bill that we are debating this evening. That is different legislation. I have been very generous in answering questions about legislation in other countries and whatever else, but for him to continually ask me questions about the Oregon legislation in particular, it is outside the scope of this bill. I am happy to answer questions about the bill before us, but asking me about what is in the Oregon legislation is a very different issue from asking me about the bill that is currently being considered by this chamber.
Hon NICK GOIRAN: I do not think the minister understands the basis for the question. The Aboriginal Health Council of Western Australia sent a submission to the ministerial expert panel. The government has spent half a million dollars getting the ministerial expert panel to provide advice to government. The minister indicated to us earlier that the ministerial expert panel and the Department of Health have suggested to him and government that the best approach would be an educative approach, not a legislative approach. That is fine; government can decide to do that, but it does not address the concern of the Aboriginal Health Council that states —

‘As Aboriginal families often live together, with multiple generations sharing the same house, there is a safety concern about the unregulated presence of highly harmful medication in the home.

The council has raised this concern. I want to make sure that the government has made the right decision by choosing an educative approach, not a legislative one. It is open to us and to the minister whether we put amendments on the supplementary notice paper to take a legislative fix. I am trying to understand the basis upon which the government has said, “No, that is not necessary. We are going to take an educative approach.” One of the reasons might be that the Oregon system takes an educative approach. The minister indicated earlier that the government is taking a lot information from, and putting a lot of weight on, the Oregon approach. That is fine; the government is entitled to do that. I am simply trying to ascertain whether that is one of the reasons the government has chosen an educative approach and not a legislative one. That is the basis of my question. I am not asking for specific detail about the Oregon legislation at all. The answer will help us to understand the basis upon which the government has formed the decision to take an educative approach, not a legislative one, to storage and to compare and contrast that with the Oregon approach. It may be that the expert panel has already looked at this. I would be happy if the minister could point us to that in the panel’s report and then we could move on to another issue. That is the basis of the question. I do not think it is unreasonable for the Aboriginal Health Council of Western Australia to submit its concerns about unregulated practices for lethal medication in the home when the minister has indicated to us that there will be no regulation but simply education.

Hon STEPHEN DAWSON: With the greatest of respect, the honourable member’s question was about Oregon. He asked me specific questions about Oregon. That is not in the bill that is before us now. By all means, ask me questions about this bill and I will be happy to provide answers. The member asked questions about the Oregon legislation and what was in it —

Hon Nick Goiran: No, I didn’t.

Hon STEPHEN DAWSON: Yes, he did.

The DEPUTY CHAIR: Order!

Hon STEPHEN DAWSON: Perhaps the member misunderstood himself. That is certainly my understanding of what was asked. The member asked about what was in the Oregon legislation. With the greatest respect, Deputy Chair, I am not answering questions about the Oregon legislation. I am happy to answer questions about the bill that is before us. Any comments made by organisations in their submissions to the ministerial expert panel were considered by the panel. As I have said previously, advice received from Aboriginal organisations or, indeed, Aboriginal communities have been considered and informed a range of expert panel recommendations. It is open to the honourable member if he wants to move an amendment about the storage of medication. That course of action is open to him and he should do that at the appropriate time. But I have made the point that generally the submissions received by the ministerial expert panel were considered by the panel and it made recommendations based upon those submissions. Obviously, the government has taken on board the ministerial expert panel’s recommendations and that has helped to formulate the bill that is before us this evening.

Hon NICK GOIRAN: We do not know whether we can move an amendment on storage based on the Oregon model because the minister will not tell us whether it is a model that we can follow—that is the problem. But again, that is the approach taken by government, which is to frustrate, not facilitate—that is okay.

I take the minister to recommendation 24 of the Joint Select Committee on End of Life Choices. It 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 minister will see that the preamble to the framework sets out certain things that the legislation should or should not do. Has a criminal defence been provided, as referred to in the framework; and, if so, which clause does that; and, if not, why not?

Point of Order

Hon Dr SALLY TALBOT: Once again, can I just say that a number of us are listening very closely to this debate. We have to pay tribute to the efforts by Hon Nick Goiran to do what he informs us is helping him to understand what the Chair of Committees has referred to as the detail and the machinery of the bill. That is a commendable
thing for him to be trying to do. But I personally harbour a suspicion that something else is going on, because I have just done a rough calculation. It seems to me, as I said last night when I took a similar point of order, that we are still on clause 1. Clause 1 has a relatively narrow reference to it. We have 184 clauses in the bill. If Hon Nick Goiran keeps proceeding at this rate in an attempt to inform himself about the detail and the machinery of the bill, it will take us between nine and 10 years to get through this bill.

The DEPUTY CHAIR (Hon Martin Aldridge): Hon Dr Sally Talbot, could you please bring your point of order to a point.

Hon Dr SALLY TALBOT: I will get to the point. I was laying that out as a context for my point of order; that is, it is reasonable for us to look to the Chair, and I pay tribute to the quality of the chairing, which I think has been excellent throughout this last week. I would ask the people who are in the chair to look at some of these aspersions that are being cast, the imputations that are being made, about the minister and about the government’s process. So far in the last hour or so we have heard handcuffs, blindfold and oversensitive and, of course, the member refers constantly to what he calls the “so-called ministerial expert panel”; although I notice that he tends not to do that when certain advisers are at the table. I ask the Chair to encourage the honourable member not to cast these aspersions. The minister is providing very, very fulsome answers. In addition, I would like to point out that I personally have been in briefings, with both people who support the bill and people who do not support the bill, in which the minister and all the minister’s staff have said over and again, “We will brief you as many times as you need to be briefed to understand what’s going on with this bill.”

The DEPUTY CHAIR: Hon Dr Sally Talbot, you can take your seat. I understand that your point of order—when you finally got to it—was about personal reflections and imputations. I do not think that the threshold has been exceeded with respect to that point of order, so there is no point of order. I remind members that we are dealing with clause 1. The procedural notes for members say that the short title debate does no more than give members the opportunity to range over the clauses of the bill, foreshadow amendments and indicate, consistent with the policy of the bill, how its form or content may be improved. I have been listening very carefully to the debate. It is not always easy to follow where a question is going and link it back to a clause of the bill, but the questioning does relate to the storage of substances. Some clauses in the bill relate to aspects of storage, but my understanding of the questions being asked by Hon Nick Goiran is that they are consistent with the policy of the bill and consistent with the advice that I have just read out, which is looking at ways and considering options to improve the substance of the bill. I will continue to monitor the debate very carefully, but there is no point of order.

Committee Resumed

Hon STEPHEN DAWSON: Thanks, Mr Deputy Chair. I will have to ask the honourable member to ask his question again, because he ranged over a number of areas and I just want to pinpoint exactly what he is asking for so we can actually get him an answer.

I make the point that I have not sought to frustrate the passage of this bill over the debate, and if anyone suggests otherwise, I take issue with it. I have been fulsome in my responses. I have sought to provide answers to the questions that have been asked on issues as broadly as I possibly could, so for people to suggest that I am being tricky or frustrating or anything else, I take great issue with that. Again, I will ask Hon Nick Goiran whether he might repeat his question so we can give him an answer.

Hon NICK GOIRAN: Mr Chairman, I do not know what that was all about by Hon Dr Sally Talbot, but, plainly, she was not listening to the question that I asked, so I will repeat it, because her untimely interruption stopped the government from being able to respond to what was otherwise a pretty straightforward question. Minister, I once again refer to the Joint Select Committee on End of Life Choice report, which Hon Dr Sally Talbot will be very familiar with, in particular page 225, recommendation 24. Hon Dr Sally Talbot will be aware that recommendation 24 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.

Minister, I was referring to the preamble there and asking you whether a criminal defence has been provided, as referred to in the preamble; and, if yes, which clauses do that; and, if not, why not?

Hon STEPHEN DAWSON: I appreciate and I thank the honourable member for re-asking his question. Of course, without having the page in front of us makes it very difficult to answer the question. We did not have it at that stage but we have now. The question the member asked referred to recommendation 24, which refers to recommendation 21. Without having the specifics in front of us, it made it very difficult, so I was not seeking to slow down the debate; I was seeking to make sure we knew exactly where the honourable member was going so that we could provide a proper answer to his question. Having established that, we are now in a position to get an answer and I will provide it shortly.

I am advised that yes, there are protections. This issue could be asked under part 8, which is “Protection from liability”.

Extracted from finalised Hansard
Hon NICK GOIRAN: The framework that the committee has asked the government to consider refers to changes to prosecution guidelines. Have prosecution guidelines been changed?

Hon STEPHEN DAWSON: No prosecution guidelines have been changed, but, obviously, we will see what happens with the passage of this bill. If government thinks there is a need to change those guidelines upon the passage of this bill, that will be considered at that stage.

Hon NICK GOIRAN: Was the prospective change to prosecution guidelines something that the government specifically consulted with the Director of Public Prosecutions?

Hon STEPHEN DAWSON: No, the specific issue has not been discussed with the DPP yet, but the intention is to discuss the issue with the DPP post the passage of the bill—if I can be so bold as to suggest the bill might pass at some stage.

Hon NICK GOIRAN: The framework refers to a recommendation from the joint select committee that the legislation should provide for self-administration of lethal medication when an eligible person is physically able to self-administer and in cases in which the person is eligible but physically incapable of self-administration, the legislation should permit a doctor to administer the lethal medication. In discussions about a later part of the framework, the minister previously indicated that the government had rejected one aspect of it with regard to personal objections. Has any aspect of this been rejected, or is this fully implemented in the bill; and, if it is, what clauses give effect to this part of the framework?

Hon STEPHEN DAWSON: Can I clarify this? Is the member asking whether any element of the framework is being rejected?

Hon Nick Goiran: Just in respect of this portion here on assisted dying.

Sitting suspended from 6.00 to 7.00 pm

The DEPUTY CHAIR: I note that we have new supplementary notice paper 139, issue 4.

Hon NICK GOIRAN: Before the dinner break, the minister was taking advice about the issue of the framework, so I will take the minister to the framework that the joint select committee recommended the government use as its guide for the bill. We are looking at the provision at page 225 under the category “Assisted dying”, verifying that what the framework says under “Assisted Dying” has been agreed to by government or rejected. If it has been agreed to, which clauses of the bill implement those provisions?

Hon STEPHEN DAWSON: The joint select committee said that practitioner administration should occur only if the patient is physically incapable of self-administration. The issue is dealt with in the bill at clause 55, so we have gone in a slightly different direction than suggested by the joint select committee.

Hon NICK GOIRAN: If we want to know more about the reason the government is deviating from the framework at this point, is there any place to discuss that other than clause 1?

Hon STEPHEN DAWSON: The member could discuss it at clause 55.

Hon NICK GOIRAN: At this point, with issue 4 of the supplementary notice paper now being available to us, can the minister indicate to the chamber the position of the government on the range of amendments that are on the supplementary notice paper?

Hon STEPHEN DAWSON: Obviously, the supplementary notice paper was issued only in the last hour or so. It spans 64 pages. My understanding is that it has around 400 amendments. Obviously, those amendments will be considered by government, along with the other amendments that have been put on the supplementary notice paper by other members of this place. It is my intention to give a government response to each amendment at the clause on which the amendment is raised.

Hon NICK GOIRAN: Which of the clauses for which amendments are listed is the minister in a position to deal with this evening and provide a government response to?

Hon STEPHEN DAWSON: As I indicated, I am happy to deal with each clause when we get to each clause. Obviously, there is an amendment standing in Hon Nick Goiran’s name at clause 1. The member is welcome to move that if he wants and I am happy to give him an indication at that stage of the government’s response.

Hon NICK GOIRAN: I want to be clear: the government has had enough time to develop a position on all the amendments on the supplementary notice paper and, therefore, because it has had sufficient time to consider all the amendments, the minister is in a position to proceed forthwith with the bill.

Point of Order

Hon ROBIN CHAPPLE: I think the minister has made it quite clear that as we come to clauses, a decision will be made by the government and the members of this chamber on how we will determine each clause. To ask the government to come up with a blanket position in relation to each clause is not the way we normally do Committee of the Whole.

Extracted from finalised Hansard
The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, your point of order is valid. It is not the normal course of conduct for the government to have to indicate its position on all proposed amendments on the supplementary notice paper. I think it is an acceptable practice, as the minister has outlined, to respond to each of those proposed amendments if and when they are moved by the relevant member. It is often the case that amendments that are put on the supplementary notice paper are not moved. In the interests of progressing the debate, if a member wishes to move an amendment, they can. That point of order stands.

Committee Resumed

Hon NICK GOIRAN: I make the observation that it is not uncommon for members to withdraw amendments, and that is often done with the benefit of advice from government. I note that an amendment that appeared on an earlier issue of the supplementary notice paper was subsequently withdrawn by an honourable member because of advice he had obtained from the government. Obviously, that would be possible now if the government was able to indicate its position. However, if the government is not in a position or is unwilling to do so, I will simply move the amendment standing in my name. I move — Page 2, line 4 — To delete “Assisted Dying” and substitute —

Euthanasia and Assisted Suicide

The DEPUTY CHAIR: Hon Nick Goiran has moved the amendment in his name at 125/1, on page 2, line 4, to delete “Assisted Dying” and substitute “Euthanasia and Assisted Dying”.

Hon NICK GOIRAN: I just want to make the observation, Mr Deputy Chairman, that the amendment is to substitute the words “Euthanasia and Assisted Suicide”, not “Euthanasia and Assisted Dying”.

The DEPUTY CHAIR: My apologies. I misread that.

Hon STEPHEN DAWSON: I am in a position to indicate that the government will not be supporting this amendment. Honourable members may well recall conversations and questions about the title of the bill and why we landed on the nomenclature “Voluntary Assisted Dying Bill”. For the purposes of the debate in front of us, I want to remind the chamber that the bill makes clear that the prerequisite for the decision to be voluntary is absolutely essential. This is why we use the term “voluntary assisted dying” and not euthanasia or suicide. Euthanasia refers to the situation in which death is induced to relieve suffering. However, this term has significant and mixed connotations. Historically, it has reflected abuse in voluntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value. More recently, people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient. Even when the term “voluntary euthanasia” is used, it does not entirely capture the intent that a person is being assisted in taking their final steps, with the choice ultimately residing with the patient. Furthermore, the term “voluntary assisted dying” still evokes a sense of patient passivity in the process. By contrast, the term “voluntary assisted dying” reflects that this death is a process that is requested and led entirely by the patient.

Hon ALANNAH MacTIERNAN: I would like to comment. I totally oppose this amendment. The minister has set out the basic case. However, it is important to add that the purpose of this bill is to assist, and provide the opportunity to, people who have already had a terminal diagnosis—a diagnosis that on the balance of probability will see them dying within six months, and 12 months in the case of a neurodegenerative disorder. This is very much not about suicide. This is about assisting and providing the opportunity to people who already have an illness that will lead to their death in less than 12 months. It is absolutely vitally important that we make that distinction. That is at the very heart of the bill. As the minister said, the idea of agency on the part of the patient is very important. It is clearly important to understand the fundamental principle that this is being made available to people who already have a diagnosis that they will die within the next 12 months.

Hon ROBIN CHAPPLE: Obviously, people give a lot of thought to the amendments that they put in, but certainly the thought that has gone into this will not be supported by the Greens.

Hon AARON STONEHOUSE: I seek some clarification from the member who moved the amendment. I have not yet had a chance to look at issue 4 of supplementary notice paper 139, and to familiarise myself with all the proposed amendments, but, since I last looked at it, it has become a bit thicker. Can the member clarify for my benefit whether he intends to define “euthanasia” in a later clause, and, if so, how that will be defined, because that might help me to understand what it would mean to change the title of the bill?

Hon NICK GOIRAN: That is a good question from the honourable member. To deal with the matter that was raised by Hon Robin Chapple, I might remind the member of the title of his previous private member’s bill.

Hon Robin Chapple: I saw the error of my ways!

Hon NICK GOIRAN: Very good. That is a response.

I say to Hon Aaron Stonehouse that, yes, it is my intention, irrespective of what the chamber does with clause 1, to insert a definition of “voluntary euthanasia”. Clause 5 of the bill lists the different terms to be used.

Extracted from finalised Hansard
I draw the honourable member’s attention to the amendment in my name found at 145/5 on page 6 of issue 4 of supplementary notice paper 139. Members will see that I have foreshadowed that I will move to insert at page 8, after line 11, a definition of “voluntary euthanasia” as follows —

… means the administration of a voluntary assisted dying poison to a patient by the administering practitioner for the patient in accordance with this Act and includes steps reasonably related to that administration taken in accordance with this Act;

While we are dealing with this issue, I draw to the honourable member’s attention that I also intend to retain “voluntary assisted dying” within the bill. “Voluntary assisted dying” is defined in clause 5, “Terms used”, on page 8 of the bill. The definition states —

**voluntary assisted dying** means the administration of a voluntary assisted dying substance and includes steps reasonably related to that administration;

That formed the basis of the framework for my proposed definition of “voluntary euthanasia” to be inserted at line 7 on page 8. I also draw to the honourable member’s attention the amendment standing in my name at 143/5 at the top of page 6 of the supplementary notice paper. That amendment seeks to amend the definition of “voluntary assisted dying” by deleting “administration of a voluntary assisted dying substance and includes steps reasonably related to that administration;” and inserting “process by which a person is given assistance to die in accordance with this Act, whether by voluntary euthanasia or by assisted suicide;”. To make a long story short, “voluntary assisted dying” in this bill would be defined as “voluntary euthanasia” and “assisted suicide”. There would be definitions of “voluntary euthanasia” and “assisted suicide”.

I take members to the top of page 3 of the supplementary notice paper and the amendment standing in my name at 127/5, which seeks to insert —

**assisted suicide** means the self-administration of a voluntary assisted dying poison by a patient in accordance with this Act and includes steps reasonably related to that self-administration taken in accordance with this Act;

I have taken this approach because earlier in the examination of clause 1, the minister indicated to us that the form of voluntary assisted dying that the government wants us to have in Western Australia includes two parts—self-administration and practitioner administration. Under my amendment, self-administration would be assisted suicide and practitioner administration would be voluntary euthanasia. That is consistent with the glossary of terms found in the “My Life, My Choice” majority report of the Joint Select Committee on End of Life Choices. I draw the honourable member’s attention to the definition of “voluntary assisted dying” found at page 23. It says —

The provision for self-administration of lethal medication where an eligible person is physically able to self-administer. In cases where the person is eligible but physically incapable of self-administration, a medical practitioner may administer or provide the medication.

In addition, the definition by the joint select committee on euthanasia found on page 20 states —

Euthanasia means the intentional termination of the life of a person, by another person, in order to relieve the first person’s suffering …

Euthanasia can be voluntary, non-voluntary or involuntary. Voluntary euthanasia means euthanasia performed in accordance with the wishes of a competent individual …

That is precisely what this bill does. As defined by the Joint Select Committee on End of Life Choices in its majority report, not the minority report, the combination of voluntary euthanasia and assisted suicide equals voluntary assisted dying. Further, I draw to members’ attention that the definition of “assisted suicide” is also set out in that same report at page 17. It states —

This term is used in some jurisdictions to describe interventions which assist individuals to end their lives. It places emphasis on the person’s active decision-making and involvement.

Members might recall that there was a dialogue last week between me and the minister about this point. The minister referred to that and said this had already been dealt with. What the minister and his advisers decided not to let people know last week, which I now draw to their attention, is that the use of the word “intervention” is quite common. I draw to members’ attention the uncorrected *Hansard* from last week and this exchange between the minister and me. I quote —

**Hon Nick Goiran**: Self-administration and practitioner administration are the two forms that have been indicated. Are both of those things interventions?

**Hon Stephen Dawson**: We are of the view that they are an assistance. They are the words that we are using. I do not know what the member is trying to get me to say.

**Hon Nick Goiran**: I am just asking whether it is an intervention or not.

**Hon Stephen Dawson**: The advisers are telling me that it is not.

*Extracted from finalised Hansard*
Hon NICK GOIRAN: Why is it not an intervention?

Hon STEPHEN DAWSON: It is a question of definition, because “intervention” means coming between someone.

I draw to members’ attention that the government of Western Australia, the Department of Justice’s Registry of Births, Deaths and Marriages, has a form which is a medical certificate of cause of death. Nine manners of death can be ticked by the practitioner for the medical certificate of cause of death. Of course, the government did not want us to know this last week. When we asked questions about intervention, it made sure that this was hidden from us. As I discovered on Friday, in actual fact there are nine manners of death. The nine are disease, accident, war, intentional self-harm, could not be determined, assault, unknown, pending investigation, and legal intervention. It was unfortunate that we were misled last week with that advice. Obviously, what the Joint Select Committee on End of Life Choices said was an intervention is quite common practice as defined in medical certificates of cause of death in Western Australia.

I encourage members to support the amendment standing in my name, in particular to demonstrate that there has been consistency on this. Members might be familiar with the minority report that I tabled in August last year. In particular, I draw to members’ attention this definition from the report —

The term ‘assisted suicide’ is used in this Report to refer to both ‘voluntary euthanasia’ (where lethal medication is administered by a medical practitioner upon the request of a patient) and ‘physician-assisted suicide’ (where access to lethal medication is provided by a medical practitioner, and self-administered by the patient).

Hon Alannah MacTiernan made some remarks about the use of the word “suicide” and of course that is a different concept. The report goes on to state —

‘Suicide’ is defined as an action taken to intentionally end one’s own life, and despite cultural and historical connotations, the term is neither disparaging nor a judgment. Assisted suicide simply identifies both voluntary euthanasia and physician-assisted suicide, and provides clarity, as other terms such as aid in dying, medical aid in dying, dying with dignity and physician assisted dying could all equally be used to describe palliative care practices.

The DEPUTY CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: Mr Chairman, the reason I moved the amendment standing in my name is that during both the second reading debate and consideration of clause 1, multiple members said that language is important. Several members have said they do not understand why the government is trying to tell the people of Western Australia that we are doing something when what people generally understand this to be is voluntary euthanasia and assisted suicide. For those reasons, I have moved the amendment for the consideration of members.

Hon KYLE McGINN: I rise to put forward my views on the amendment. From the start, when this legislation was raised, going back a while to the media release from the Minister for Health, it has been called “voluntary assisted dying”. It is the term I put on my survey when I put it out and what I have been speaking about when I have been out in the electorate. It is something that people are well aware of in Western Australia and assumed would be in the name of the bill. I think that there has not been a huge response. The honourable member just said that people see it as euthanasia and assisted suicide. I disagree and say that people in my electorate see it as voluntary assisted dying. I will not be supporting the amendment.

Hon RICK MAZZA: There was quite a bit of debate on the name of this bill in the other place, even to the point of dissecting the word “euthanasia” and what it means in ancient Greek. Mr Peter Katsambanis pointed out that the word in Greek means “a good and graceful death”. I do not know why there is resistance to using the word “euthanasia” if it means a good and graceful death. I would prefer that the bill be called what it is—that is, a voluntary euthanasia and suicide bill. I do not know why we need to use other words. Other jurisdictions around the world use the terms “voluntary euthanasia” or “assisted suicide”. I am quite comfortable with the amendment and will be supporting it.

Hon AARON STONEHOUSE: I thank Hon Nick Goiran for his detailed explanation of the rationale behind this amendment. The report of the Joint Select Committee on End of Life Choices describes euthanasia in terms that are inconsistent with the practice of a physician or medical practitioner administering voluntary assisted dying. I may have missed Minister Dawson’s comments in response to this amendment earlier as I was making my way from urgent parliamentary business into the chamber to catch the debate on this amendment, but absent of a compelling argument against such an amendment, I see that there is quite a bit of merit in this amendment to the title of the bill because it will provide a degree of clarity about the two types of voluntary assisted dying that will become available with the passage of this bill. At this point, I am inclined to support this amendment in the absence of a compelling reason not to.

Hon DIANE EVERS: Just briefly, I will not be supporting this amendment because “euthanasia” in the current usage usually means someone doing something to someone else. In this case, it is the person making the choice to have that done and they have full responsibility for it, but they are not capable or do not want to have to do it themselves. I will not be supporting this amendment.

Extracted from finalised Hansard
Hon NICK GOIRAN: I understand exactly why Hon Diane Evers has said that. It was dealt with in the “My Life, My Choice” report. It specifically deals with the distinction between the definitions of “euthanasia” and “voluntary euthanasia”. It is for exactly those reasons that I have used the terms “voluntary euthanasia” and “assisted suicide”. If the member looks at the amendment that stands in my name, she will see that I am seeking to delete the words “assisted dying” and substitute the words “euthanasia and assisted suicide”. The outcome would be that the bill would be called the “Voluntary Euthanasia and Assisted Suicide Bill”.

Hon COLIN HOLT: I indicate that I am not supporting the amendment. I am backing the process that has occurred over the last two years—an extensive select committee of both houses, an extensive report and a ministerial expert panel to get to this point—as well as the government’s indication regarding the bill. I am backing that process. I understand the reasons put forward by those supporting this amendment. I just do not agree with them, and I will be voting against this amendment.

Hon AARON STONEHOUSE: This might already have been foreshadowed in the questioning leading up to the movement of this amendment, but I suppose there are implications here. If the title of the bill is amended to include “voluntary euthanasia” and “voluntary assisted suicide” and there are later amendments to the bill to remove the capacity for medical practitioners to administer voluntary assisted dying, we would have to come back again and perhaps amend the title of the bill once more to change it back to referring to voluntary assisted dying or voluntary assisted suicide—whichever wording the chamber deems appropriate. Has consideration been given to that? Hon Nick Goiran has asked questions to get an indication of what amendments the government might consider. Is the minister able to give us some indication of where the government currently is on the question of medical practitioners administering voluntary assisted dying? If it is the intention of the government to contemplate amendments to medical practitioners administering voluntary assisted dying, there is no need at all to change the title of the bill. In fact, we might want to deal with matters relating to medical practitioners administering voluntary assisted dying when we get to that clause, and then come back and consider the title of the bill at a later stage, once we have had a chance to see how this regime will work after amendment, if indeed any amendments are agreed to by the chamber.

Hon STEPHEN DAWSON: I indicate that the government supports the bill as it stands. We are not of a mind to make further amendments, as Hon Aaron Stonehouse has suggested. Given that the honourable member has asked the question because he was away from the chamber on urgent parliamentary business, I am happy to re-advice the chamber of the reasons why we are not supporting the amendment. Certainly, I have made it clear that euthanasia refers to a situation in which death is induced to relieve suffering; however, the term has significant and mixed connotations and historically has reflected abuse through involuntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value. More recently, people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient. Even when the term “voluntary euthanasia” is used, it does not entirely capture the intent that a person is being assisted in taking their final steps, with the choice ultimately residing with the patient. Furthermore, the term “voluntary euthanasia” still evokes a sense of patient passivity in the process. In contrast, the term “voluntary assisted dying” reflects that this death is a process that is requested and led entirely by the patient.

Suicide is completely separate to and distinct from voluntary assisted dying. Suicide connotes the loss of life of a person who is typically not dying, 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 when they are already dying—a process that is requested and led entirely by the person, whereby they are given the support and care they require in their end-of-life stage.

There were questions on this issue last week—I cannot remember what day it was, but it was certainly last week—and I advised the chamber that “voluntary assisted dying” is language that has been used for the last number of years, certainly across Australia. In 2013, a bill was introduced in the Tasmanian Parliament that had that title and used those words. In 2017, a bill that used those words was introduced in the New South Wales Parliament. Indeed, the Victorian inquiry into end-of-life choices referred to “assisted dying” in its final report. The Victorian Ministerial Advisory Panel on Voluntary Assisted Dying referred to “voluntary assisted dying” in its discussion paper in January 2017. The Victorian ministerial advisory panel also referred to “voluntary assisted dying” in its final report, which was tabled in July 2017. As I said, New South Wales used those words in a bill that was introduced in that state, albeit that it was not passed. Of course, the Western Australian Joint Select Committee on End of Life Choices referred to “voluntary assisted dying” in its final report, tabled in August 2017. The Western Australian Ministerial Expert Panel on Voluntary Assisted Dying referred to “voluntary assisted dying” in its discussion paper that was tabled in March 2017.

The government supports the language that currently stands in the bill, and we do not support the change that has been proposed by Hon Nick Goiran.

Hon NICK GOIRAN: Just to deal with the point raised by Hon Aaron Stonehouse, I think there is a clear indication that the government is not interested in any amendments to this bill. Despite the fact that during the debate on clause 1 we have discovered that the government has —

Extracted from finalised Hansard
**Point of Order**

**Hon STEPHEN DAWSON**: I have not said at any stage that the government was not interested in any amendments to this bill, so I ask the honourable member not to make up stories like that. I have indicated that we are open to amendments. What I said to Hon Aaron Stonehouse was that we are not accepting amendments about that particular issue, so please do not put words in my mouth.

**Hon Nick Goiran**: Please do not waste time with pointless points of order.

**Hon Stephen Dawson**: Please do not make stuff up.

**The DEPUTY CHAIR (Hon Matthew Swinbourn)**: Members! I have not called you as yet, Hon Nick Goiran. If members could make their best efforts to accurately reflect each other’s positions rather than engaging in hyperbole, it would be helpful to all. There is no point of order.

**Committee Resumed**

**Hon NICK GOIRAN**: What I said to the honourable member is that I think we can see that the government is not interested in any amendments. I think we can see that. The government is quite entitled to say, “No, we are very interested in amendments.” That is fine. When the minister gets the call, he can let us know how keen the government is on amendments. I think we can see that the government is not really interested in amendments. The reason I say that is that if the government were really interested in amendments, we would know about them, but we do not. That is why I think, with due consideration to the important point made by Hon Aaron Stonehouse, that if the government were indicating that it was thinking about moving one of these two amendments, whether the practitioner is involved or not involved, I would be quite happy to move an amendment to my amendment at the moment. We can call this the “Voluntary Euthanasia Bill” or we can call it the “Assisted Suicide Bill”. I do not mind, but it is clear to me that the government does not intend to make those changes, and it is for those reasons that I put the amendment on the supplementary notice paper—because it is consistent with the scheme of what the government wants. It wants both methods in, and I cannot see that there will be any genuine appetite by government to change that, hence the amendment.

**Division**

Amendment put and a division taken, the Deputy Chair (Hon Matthew Swinbourn) casting his vote with the noes, with the following result —

Ayes (5)

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<tr>
<th>Hon Rick Mazza</th>
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<th>Hon Nick Goiran (Teller)</th>
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<td>Hon Charles Smith</td>
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Noes (28)

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<th>Hon Martin Aldridge</th>
<th>Hon Peter Collier</th>
<th>Hon Laurie Graham</th>
<th>Hon Samantha Rowe</th>
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<td>Hon Ken Baston</td>
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<td>Hon Jacqui Boydell</td>
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<td>Hon Robin Chapple</td>
<td>Hon Sue Ellery</td>
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<td>Hon Dr Sally Talbot</td>
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<td>Hon Jim Chown</td>
<td>Hon Diane Evers</td>
<td>Hon Michael Mischin</td>
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<td>Hon Donna Faragher</td>
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<td>Hon Alanna Clohesy</td>
<td>Hon Adele Farina</td>
<td>Hon Martin Pritchard</td>
<td>Hon Pierre Yang (Teller)</td>
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**Amendment thus negatived.**

**Hon ADELE FARINA**: Minister, a number of clauses in the bill deal with the unused substance, so, clearly, this was a concern by the bill’s drafters. I also note that clause 69(5) states that a single dose of the substance is to be prescribed. I am curious to understand what is the likelihood of there being unused substance?

**Hon STEPHEN DAWSON**: My advice is that it is very unlikely that medication would be left over. It is intended that a single dose will be prescribed in an amount sufficient to cause the death of the patient, and that will be according to the patient’s specific, individual requirements—for example, comorbidity.

**Hon ADELE FARINA**: Does the patient need to consume the whole of that single dose for it to be effective to cause death?

**Hon STEPHEN DAWSON**: That is likely. Appropriate medical protocols will be developed around this issue and the patient accordingly advised. The likelihood is that the patient will be advised to take the full dose that is prescribed.

**Hon ADELE FARINA**: I understand that in Victoria the current practice is to dispense 15 grams of nembutal, which may be enough to cause the death of two adults. This dosage accords with the dosage prescribed in the Netherlands, which in 2012 was increased from nine grams to 15 grams because about 15 per cent of patients were not dead within the desired time frame and were then euthanased by the attending medical practitioner. In the Netherlands, a medical practitioner is required to be in attendance for self-administration to address complications if and when they arise. Thank goodness, it had the foresight to do that, given that there have been problems in 13 per cent of cases. In view of this practice internationally and in Victoria, would it be reasonable to assume that a similar quantity would be dispensed in Western Australia?

*Extracted from finalised Hansard*
Hon STEPHEN DAWSON: I am advised that we cannot comment on the system in Victoria. In Western Australia, the choice of lethal medication for a particular patient will be a clinical decision made by the coordinating practitioner from an approved list of schedule 4 and 8 poisons only. It is a matter for the patient’s coordinating practitioner. A fully qualified medical practitioner with additional training on voluntary assisted dying will determine what dosage and formulation they consider appropriate to make up the voluntary assisted dying substance. It is intended that as part of the implementation of the bill a clinical panel 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 supply, dispensing and ensuring safe management of these medications. Further, it is expected that this clinical panel will include appropriate representation from pharmacy, medical and nursing experts from a health and clinical perspective.

Hon ADELE FARINA: In cases when a patient ingests only part of the substance, becomes unconscious and thereforedoes not die, what is the likelihood that the patient will be able to self-administer the rest of the VAD substance?

Hon STEPHEN DAWSON: I am told that it is likely that the type of schedule 4 or 8 poison approved for 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. These issues will be considered by the clinical panel and CEO during the implementation phase.

Hon SIMON O’BRIEN: I have two questions. Firstly, it strikes me as incredible that we will have a state-sanctioned system of assisting people to end their lives, but with recognition that the substance, the poison, that the government is proposing will be dispensed will not actually do the job. That strikes me as absolutely extraordinary and is a further reason why clause 1 should not be further complicated.

What initially got me to rise to my feet was something that the minister said in response to the question before the last one. I wonder whether he can clarify: did he say that he cannot or will not comment on what we know from Victoria, or has he been forbidden to comment on Victoria? I did not quite catch what he said.

Hon STEPHEN DAWSON: Member, I did not say any of those things. I said I cannot comment. Hon Adele Farina was asking questions about nembutal and extra grams prescribed for the use of a patient in that jurisdiction.

Hon Simon O’Brien: Were you just saying you have no immediate knowledge of that?

Hon STEPHEN DAWSON: Exactly, so I cannot comment on what is used over there.

Hon Simon O’Brien: It’s how it came across.

Hon STEPHEN DAWSON: Sure—that is what I was indicating. We do not have knowledge of that. The Victorian scheme is different. All I can talk about is the one that is before us now. In relation to the dosage issue, I have been advised that the intention is that the amount of medication supplied would be sufficient for the patient according to their individual circumstances and that there would, therefore, be no medication remaining after administration.

Hon AARON STONEHOUSE: I want to follow up on this line of questioning. What factors would the medical practitioner assessing the patient go into to determine the dosage of the voluntary assisted dying substance?

Hon STEPHEN DAWSON: I did indicate this, but I am happy to do so again. I advised that what is prescribed would depend on each patient themselves—their particular condition, their weight and 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.

Hon AARON STONEHOUSE: Will the medical practitioner who assesses a patient for their dosage consider whether the patient has a tolerance to barbiturates?

Hon STEPHEN DAWSON: Yes, they would.

Hon AARON STONEHOUSE: In case members are not aware, there are people who use barbiturates as a recreational drug. They can build up a tolerance to them over time to a point at which a dose that would otherwise kill another person would be a recreational dose for them. The line between what might be a recreational dose and a lethal dose can vary quite a lot from person to person. It can be a very, very small amount from what I understand. How might a medical practitioner identify whether someone is a barbiturate user who may already have a tolerance to barbiturates? Is there a line of questioning that they would employ? Would there be something in their medical record they could look at to identify someone who has a tolerance?

Hon STEPHEN DAWSON: I am told that the medical practitioner would review the record of the person, and it may not be a barbiturate; it could be another substance. Schedule 4 and schedule 8 poisons are used by certain patients in the community at the moment, so the poison, if I can use that word, that is used for a particular patient may well be unsuitable for another patient based on those factors that I previously identified, such as weight et cetera.

Hon AARON STONEHOUSE: I believe there might be some cross-tolerance, if that is the right term to use. Someone may be a user of another drug, but the use of that drug could cause them to build up a tolerance to barbiturates as well—correct me if I am wrong. If someone was identified to have a tolerance to a barbiturate, what other substances might be used as an alternative—not specifically which substances, but perhaps what category might they fit into?
Hon STEPHEN DAWSON: I am told that if the practitioner had a query, they would seek a specialist opinion. There are other drugs on the list of schedule 4 and 8 poisons. I guess, upon consideration of the patient’s medical history or, indeed, the medication that they are prescribed to take, if there was a question, they would seek specialist opinion on what other substance from the schedule 4 and 8 list may be used.

Hon ADELE FARINA: How long after the dispensing of the voluntary assisted dying substance may a patient hold onto it without actually taking the substance before some trigger sounds either with the Voluntary Assisted Dying Board or with the coordinating practitioner?

Hon STEPHEN DAWSON: I am told that this issue will be looked at operationally during the implementation phase. It is the government’s view that it would be inappropriate to put a time constraint on a patient within which they must keep or take the medication. Stipulating such a time frame risks coercing the patient into taking the substance sooner than they would otherwise choose to.

Hon ADELE FARINA: I understand that concern. However, if the patient has not died within six months and is still alive 12 months or two years down the track, surely, at some point, there is a need for the coordinating practitioner to touch base with the patient again, perhaps to undertake another assessment of the patient to see whether the patient’s interest in accessing voluntary assisted dying is still enduring and whether they still have decision-making capacity. It may even necessitate a reassessment, because, clearly, the prognosis was wrong, and it may be that the diagnosis was wrong as well. Surely, there must be some point at which there is a need to re-evaluate the situation. I am not suggesting it should happen within the six-month period, but at some point post the six-month period.

Hon STEPHEN DAWSON: I am advised that, again, this issue will be looked at during the implementation phase. However, these people will be at the end of life, so the likelihood is that they will engage with medical practitioners and medical professionals fairly regularly. Some of the medication could expire. Should this occur, it will be proactively managed or picked up by the authorised supplier.

Hon ADELE FARINA: It seems strange that this is not included in the bill, particularly if we are looking at the possibility of requiring that the drug be returned. One would think that a head-of-power provision would be required in the bill to enable that to happen. I do not see how that can be done simply by way of directions. I am not sure what is being contemplated during the implementation period. Surely we need a head-of-power provision in the bill. I cannot find one. I would like clarification about what is proposed and what is being considered for the return of the substance.

Also, I agree with the point that the minister made that the person will be at end of life and therefore likely to be in contact with medical practitioners. But the medical practitioners with whom a patient is in contact may not be the coordinating practitioner because the bill provides for doctor shopping. The minister needs to accept the fact that it may not be the same doctor. Certainly once my dad was being looked after by palliative care services at home, his GPs never visited him. He was basically attended to by Silver Chain nurses. We managed to persuade Silver Chain to bring its palliative care doctor to visit him on a couple of occasions, but that is fairly rare. For a long time during his final period, he was not attended to directly by a doctor; it was done by Silver Chain nurses. So my question stands: how will the government make this work?

Hon STEPHEN DAWSON: As I indicated, we will work out the details during the implementation phase. Clause 66 identifies the role of the contact person, and states —

(1) The contact person for the patient is authorised to —

(d) give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer as required by section 104.

Hon ADELE FARINA: Clause 66 authorises the patient’s contact person to do certain things—receive the prescribed substance, possess the prescribed substance for the purposes of delivering it to the patient and supply the prescribed substance to the patient. Paragraph (d) states —

give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer as required by section 104.

Clause 104 applies only if the patient revokes a self-administration decision or when the patient, having made a self-administration decision, dies without taking the drug. I do not know whether that provision covers the situation I am raising, because I am raising a situation in which the prognosis may have been very wrong and beyond six months the patient is still alive and perhaps 12 months later the patient is still alive. Is there a mechanism by which the substance can be brought back to the dispenser or is there a requirement for a further assessment about the prognosis at that time? As I said, I am not talking about the first six months. I agree that we do not want the patient to feel they have to take the substance. However, if the patient is still alive a year later or sometime between six months and a year later, something has gone very wrong with the process. Obviously, there needs to be a mechanism in the bill for intervention and I cannot see any.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: There are no requirements for further assessment in the bill.

Hon ADELE FARINA: I will leave that because I am obviously not going to get anywhere.

Yesterday I asked some questions about the storage of the VAD substance by an aged-care facility and the minister referred me to the Medicines and Poisons Regulations and the guiding principles, none of which was of great help with the concerns I had. Is there anything in the bill that would prevent an aged-care facility from telling its patients or having a rule that if the patient wants to access voluntary assisted dying, they need to do so by medical practitioner administration so that there is no requirement for the aged-care facility to have to store the VAD drug on its premises?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: I had understood from the minister that there would be responses to questions I had asked under clause 1. Obviously, I have effectively finished my questions on clause 1. But I think the minister will understand that I would like answers to the ones that have been taken on notice.

Hon STEPHEN DAWSON: We have just checked. I understand that there was an answer to a question asked by Hon Nick Goiran about the additional 61 full-time staff that this initiative will bring. I mentioned that there will be an extra 61 full-time staff and the honourable member asked over what time frame that is expected to be delivered. The WA Country Health Service has advised that the phased planned resource increase is aiming for 40 per cent expansion in the first year, an additional 20 per cent in the second year, an additional 15 per cent in the third year, and the final 25 per cent in the fourth year. In answer to the question about when the extra 61 FTEs are expected to be delivered and how many of the 61 FTEs are in place, I am told that the planned increase for the first year equates to 24.4 FTE; recruitment is underway and 1.5 FTE are already engaged. There was a further question about how many nurse practitioners are employed, and the answer is that five palliative care nurse practitioners are employed in WA.

Hon NICK GOIRAN: The minister indicated that WACHS has advised him that the rollout will be 40 per cent, 20 per cent, 15 per cent and 25 per cent. Has this information only just come to light?

Hon STEPHEN DAWSON: To me, yes.

Hon NICK GOIRAN: There are also 1.5 FTE currently in place out of the 61?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: The context is that the government has said that it has a plan or has funding to roll out 61 extra FTE across Western Australia, but there are only 1.5 in place at the moment. This goes to the questions that were asked by Hon Martin Aldridge as far back as 8 August about whether the government had a defined plan, to which the parliamentary secretary said no. Now we know, at the end of October, that it has 1.5 FTE out of 61. These are the reasons I will vote against clause 1 of the bill. On Wednesday night last week, the government finally admitted that it had drafted some amendments. The big concern for me is that it said it was discussing them with interested members, but it would not release them to all members. My view, and I know that this will upset the minister, is that this is no time for trickery by government. It promised gold transparency, yet it does the exact opposite.

The reason I asked the question earlier about whether the government had had sufficient time to consider supplementary notice paper issue 4 is that I quite readily realised it had only an hour to consider it over the dinner break. The point I would make is that at least it had an hour and it knows what the amendments are. The reason I asked the question earlier about whether the government had had sufficient time to consider supplementary notice paper issue 4 is that I quite readily realised it had only an hour to consider it over the dinner break. The point I would make is that at least it had an hour and it knows what the amendments are. The rest of us do not know what the amendments are that the government will propose. It is the exact opposite of gold transparency. This is supposed to be a conscience vote, but the government is acting unconscionably. Parliamentarians and the people of Western Australia have a right to know the areas that the government concedes were of sufficient concern for it to invest taxpayers’ funds in drafting amendments. That is what happened on Wednesday last week when we examined clause 1. The following day, on Thursday last week, the government was unable to confirm whether telehealth will be able to be used for its voluntary euthanasia scheme, or voluntary assisted dying, as it is called. Several regional members have quite rightly raised their concerns about why we are debating this bill at this time, when the government has not resolved this impasse with federal law. It was interesting that during our examination of clause 1, the government conceded that it was something that the joint select committee report did not deal with. The committee did not deal with that, despite the fact it was part of its terms of reference. The ministerial expert panel did not do it. My question is: what was the point of creating a so-called ministerial expert panel if the experts have not sorted out whether telehealth will be able to be used?

Worst of all is the government’s refusal to guarantee that it will fund a palliative care specialist and an interpreter to go to regional Western Australia but that it will guarantee funding for up to eight people to go and execute the voluntary assisted dying process in the same location. That is reprehensible. Yesterday, it became clear that the government intends to allow social workers to become care navigators, but to simply leave them to be self-regulated. What could possibly go wrong with having expert steereers who are self-regulated? Meanwhile, although the government has announced extra funding for palliative care, it has confirmed that it does not have a plan on how to allocate that funding.

Extracted from finalised Hansard
Alarmingly, the government has also refused to table correspondence between the Department of Health and the commonwealth Attorney-General’s Department. It also refused to table any information about the concerns raised by the Director of Public Prosecutions and the coroner. I asked about those things, but the government will not tell us what the Director of Public Prosecutions or the coroner had to say. Why should we be concerned in this environment?

In a remarkable revelation, the government cannot tell us what the Chief Psychiatrist advised the ministerial expert panel when he was invited to attend as a subject matter expert, because the ministerial expert panel did not keep any minutes. That is despite the fact that the panel charged taxpayers up to half a million dollars. Finally, the government conceded yesterday that, in some cases, patients will have a gap payment to make. The government cannot tell us how much the scheme will cost because it has not done the work. In fact, we know that it has not even consulted with private health insurers or Medicare. How, in all those circumstances, it would be appropriate for us to move on to other clauses is beyond me. It is for those reasons that I will vote against clause 1.

Hon ADELE FARINA: The bill places quite onerous duties on the control person, including that the control person needs to return any unused substance to the authorised disposer within 14 days. There may be circumstances in which that is not possible. Is there a defence contained somewhere within this bill to protect a control person from prosecution in the event that they have a genuine reason for not being able to return the unused substance within the 14 days?

Hon STEPHEN DAWSON: Can I clarify that the honourable member is referring to the contact person? She said “control person” numerous times.

Hon Adele Farina: I apologise; yes.

Hon STEPHEN DAWSON: So it is the contact person. I am advised that the decision is at the prosecutorial discretion of the CEO of the Department of Health.

Hon ADELE FARINA: What will happen in a situation in which the contact person refuses to continue in the role, which is permitted under the bill, but they do so after the voluntary assisted dying substance has been dispensed to the patient and another contact person is not appointed?

Hon STEPHEN DAWSON: Clause 67 refers to a contact person and states —

(1) The contact person for a patient may refuse to continue to perform the role of contact person.

(2) If the contact person for a patient refuses to continue to perform the role —

(a) the person must inform the patient of the refusal; and

(b) the person ceases to be the contact person for the patient on informing the patient under paragraph (a); and

(c) the patient must make another appointment under section 64(1).

Hon ADELE FARINA: I thank the minister for that. I do understand that provision in the bill. This is a person who is at the end of life. Very onerous obligations have been placed on the contact person. I, for one, would not want to volunteer to be a contact person. What would happen if the substance has been dispensed, and the contact person says they want to cease being the contact person, and the patient does not have another person whom they can appoint to be the contact person?

Hon STEPHEN DAWSON: In that case, the bill allows for the coordinating practitioner to take on that role.

Division

Clause put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the ayes, with the following result —

Ayes (25)

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

Noes (9)

Hon Peter Collier Hon Rick Mazza Hon Charles Smith
Hon Donna Faragher Hon Michael Mischin Hon Colin Tinkney
Hon Nick Goiran Hon Simon O’Brien Hon Ken Baston (Teller)

Clause thus passed.
Clause 2: Commencement —

The DEPUTY CHAIR (Hon Dr Steve Thomas): The Leader of the House is taking over for a moment.

Hon NICK GOIRAN: Clause 2(a) provides that part 1, other than divisions 2 to 4, will come into operation on the day on which the act receives royal assent. Why does the operation of clause 4, “Principles”, in division 2 need to be delayed until a day fixed by proclamation?

Hon SUE ELLERY: As I understood the honourable member’s question, it was: why does that second part under clause 2 need to come into operation at a later date? It is anticipated that the proclamation date will be 18 months from the date of passage of the bill so that health services and the community can prepare for the changes. The minister handling the bill has already flagged the implementation period on a number of occasions. It will require a suite of new procedures to be established to enable the scheme to be implemented properly, including the establishment of the board that has been referred to earlier in the debate. The ministerial expert panel recommended 18 months, and our counterparts in Victoria have anecdotally advised that 18 months is a suitable period.

Hon NICK GOIRAN: I ask the returning minister to look at division 2, “Principles”. The question that I asked his substitute a moment ago was: why does the operation of clause 4, “Principles”, in division 2 need to be delayed until a date fixed by proclamation? The answer that came back was that the government has received advice from Victoria that 18 months is a good implementation period because new procedures need to be developed and the board needs to be established. That does not answer the question about why the operation of clause 4, “Principles”, in division 2 needs to be delayed until a day fixed by proclamation.

Hon STEPHEN DAWSON: My advice is that there is no point in just having principles; we want the principles and the rest of the bill. Therefore, the proclamation date is set at a later stage.

Hon NICK GOIRAN: Unless it is necessary to wait for proclamation for a particular clause, the normal process is that that would come into operation on the day after the bill receives royal assent. That would be the normal process. The government has taken a deliberate decision, presumably—or an accidental one—that clause 4, “Principles”, needs to wait for proclamation. That is irregular; that is not customary. I am simply asking for a comprehensive explanation about what is in the principles that needs to wait 18 months for proclamation. It has nothing to do with the establishment of the board, which was the response given by the Leader of the House. Apparently, there needs to be new procedures. Maybe this will assist us: what new procedures need to be developed by government in order to give effect to the principles?

Hon STEPHEN DAWSON: I am advised that voluntary assisted dying will require a suite of new procedures to be established to enable the scheme to be implemented properly, including the establishment of the Voluntary Assisted Dying Board. There is also the establishment of the statewide pharmacy, operational procedures around care navigators and medical protocols. Further, my colleague the Leader of the House, when she answered the previous question, referred to the 18-month period that was recommended by the ministerial expert panel. Of course she also referred anecdotally to the period it took in Victoria. For those reasons, we wish the proclamation of the remainder of the bill to happen at the same time at a period in the future, and not happen in dribs and drabs.

Hon NICK GOIRAN: The principles set out at clause 4 indicate the types of things that a person exercising a power or performing a function under the act must have regard to. That is at clause 4(1). Subsection (2) states — In subsection (1), the reference to a person exercising a power or performing a function under this Act includes the Tribunal exercising its review jurisdiction in relation to a decision made under this Act. Clearly, the provision is to do with the establishment of the tribunal. As the minister indicated, that needs to be dealt with via proclamation and they are in different clauses in the bill. But they have nothing to do with why the principles at clause 4 cannot commence on the day after royal assent. The explanation provided, which was a vague response about 18 months to implement, makes no sense with regard to the principles. I go back to my earlier question, and maybe those advising can take note of the actual question: what are the new procedures that the government needs to prepare in order to give effect to the principles?

Hon STEPHEN DAWSON: The answer to that question is none. In relation to part 1, divisions 2 to 4, I am advised that they relate to the substantive provisions of the bill. There will be no point in them coming into operation at an earlier date because they would have nothing to operate on. That is the advice given to me by the advisers.

Hon NICK GOIRAN: That happens all the time.

Hon Stephen Dawson: That’s the answer I’ve given you, honourable member. That is the advice provided.

Hon NICK GOIRAN: Why is the government taking a new approach in this bill and not using the same process it uses in other bills? In a debate earlier today, the Leader of the House endeavoured to boast about how many bills the government had passed. If an analysis were done of those bills and this bill, I think it would be found that the government’s approach to this bill is irregular. The normal approach is that part 1, particularly the commencement and the short title, commences on the day the act receives royal assent. That has been done in this instance. Other sections that do not need to wait for proclamation commence on the day after the act receives royal assent. Only the provisions that need to wait for proclamation are dealt with at a later stage. That is something that is routinely

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considered by the Standing Committee on Legislation, which otherwise would have considered this issue. It is quite normal and has to do with parliamentary sovereignty. If the Parliament decides when a section commences, that is when it will commence. Parliament does not delegate that authority to the government unreasonably, and that is happening here. In clause 2(a) the government has made a conscious decision that part 1 will commence on the date the act receives royal assent, but it has decided to carve out divisions 2 to 4. I am trying to ascertain what is so special about division 2 that it cannot commence either on the day that royal assent is given or the day after. Perhaps the minister can provide advice to the chamber about why the government has decided to take a different approach to the commencement provisions of this bill than would ordinarily be taken.

Hon STEPHEN DAWSON: I cannot give the honourable member anything further than I have given him already on that question. I have outlined the reasons that the government has done this. I cannot be sure that this approach has not been taken before in other bills. The member has talked about what is normal, but this could well have been done before. Regardless, it is being done in this bill and it has been suggested that it be done in this bill. I earlier gave the honourable member the reasons that we are doing it. The member may not like them, but they are the reasons that I have outlined.

Hon NICK GOIRAN: If division 2 of part 1 were to commence on the day on which the act receives royal assent, would the legislation be undermined?

Hon STEPHEN DAWSON: We are not saying that it would undermine the legislation. We are saying that we want a holistic proclamation of the act. Our preference is for that proclamation to happen at the same time—in all likelihood, 18 months down the track.

Hon NICK GOIRAN: That is unacceptable. I suspect that most members in this place would be passionate about the principles in this bill. The principles in clause 4 are things that we should all be able to agree with. For example, clause 4(1)(a) states that “every human life has equal value”. The minister’s government wants us to agree to that, and I am happy to agree to that because I also believe that every human life has equal value. The government is asking us to leave that until proclamation. What if the government never proclaims it? What if the government decides to proceed with this legislation but not clause 4? Would that be possible under this arrangement?

Hon STEPHEN DAWSON: That is definitely not the intent. The intention is that, should this bill pass the Parliament—I can tell members that at times I am not so sure that it ever will—the rest of the bill will be proclaimed on a day in the future. Plainly and simply, the intention is to do that.

Hon NICK GOIRAN: Division 3 is also being carved out of part 1. The government does not want the Parliament to exercise its authority and say that division 3 of part 1 should commence immediately. Instead, the government wants to rein that in and keep it as a matter for proclamation. What is in part 1, division 3, that warrants the matter being left to proclamation?

Hon STEPHEN DAWSON: Division 3 has definitions that will apply only if the rest of the bill passes. For that reason, as I have said previously, our preference is that the rest of the bill be proclaimed en bloc.

Hon NICK GOIRAN: That is not quite right, because if we just take a moment to look at division 3, we will see that it contains more than just clause 5, “Terms used”; it also has clauses 6, 7 and 8. My question is: what is so imperative about those particular clauses that they must be left to government to proclaim and cannot possibly commence at the time of royal assent?

Hon STEPHEN DAWSON: Just to clarify, I did say that division 3 includes definitions. With regard to the rest, they set out concepts that only apply to and are contingent upon the rest of the bill.

Hon NICK GOIRAN: Clause 7 states —

(1) The CEO may, in writing, approve a Schedule 4 poison or Schedule 8 poison (as those terms are defined in the Medicines and Poisons Act 2014 section 3) for use under this Act for the purpose of causing a patient’s death.

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

Is it the case that if clause 7 were to commence immediately upon assent, it would need—it would be necessary; it would be essential—clause 5 to also come into operation on that same day? My question is: can clause 7 commence independently of clause 5, or must they both be in operation in order for clause 7 to have effect?

Hon STEPHEN DAWSON: There is a connection, obviously, between clause 5 and clause 7. We are of the view that they should both come into operation at the same time.

Hon NICK GOIRAN: I understand that. I know that that is the view. In fact, the view of the government is that everything from clause 4 onwards should come in at the same time, so I understand that. If the government wants clauses 4 to 184 to come in at all at the same time, it follows that it would want clauses 5 and 7 to come in at the same time. That was not my question. My question was: can clause 7 operate independently of clause 5, or do both clauses need to be operative at the same time for clause 7 to be operative?

Hon STEPHEN DAWSON: The advice is that they would need to come into operation at the same time. Clause 7(2) refers to a voluntary assisted dying substance, which is defined under clause 5 of the bill.

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Hon NICK GOIRAN: That is exactly my point. The definition of “voluntary assisted dying substance” in clause 5 says —

voluntary assisted dying substance has the meaning given in section 7(2);

So they are referring to each other. This is my point: does clause 5 have to be in operation for clause 7 to be operative?

Hon STEPHEN DAWSON: We do not believe that clause 7 can come into operation without clause 5 and vice versa; clause 5 cannot come into operation without clause 7.

Hon NICK GOIRAN: Clause 7 of this bill could come into effect on the day of or the day after royal assent; let us say immediately or the day after—either way—because I am relaxed about either option. Clause 7(1) states —

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.

The minister has indicated that clause 5 would have to also come into operation, so if clause 5 and clause 7 were both in operation on the day of royal assent or the day after, would the CEO be able to approve in writing these schedule 4 and schedule 8 poisons in the absence of the other clauses of the bill coming into operation?

Hon STEPHEN DAWSON: I am told we need the clinical panel to look at the schedule 4 and schedule 8 poisons, and only then will the CEO be able to undertake that action.

Hon NICK GOIRAN: Is the minister saying that clause 7 is an example of a clause that must await implementation so this clinical panel can be put together?

Hon STEPHEN DAWSON: Yes, that is why we are saying we need that 18-month period.

Hon NICK GOIRAN: That makes sense and that is consistent with my view that clause 7 needs to wait for proclamation. Why then does clause 5 need to wait for proclamation?

Hon STEPHEN DAWSON: That is because clause 5 sets out the definitions for the rest of the bill.

Hon NICK GOIRAN: Yes, that is what clause 5 does, minister, but that does not explain why clause 5 can commence only on proclamation and cannot commence on royal assent or the day after. The minister has just provided us with an explanation of why clause 7 can be done only at that point in time—it is because a clinical panel needs to be established and it has to work out the concoction of poisons before the CEO can authorise and approve those things, which makes sense with regard to clause 7. It does not make sense with regard to clause 5. It is not at all clear why clause 5 would need to await anything. Is there some kind of procedure or some other type of panel that needs to be formed? What is it about the definitions section that means it has to wait for proclamation and cannot commence immediately?

Hon STEPHEN DAWSON: As I indicated earlier, honourable member, division 2 to 4 relate to substantive provisions of the bill. There would be no point in them coming into operation at an earlier date because they would have nothing to operate on, so I think that is probably the last answer I can give on this one. We have a view that it should come into operation 18 months down the track. The member obviously has a different view and the member also has an amendment in front of us on the supplementary notice paper, so I do not think the member is going to get any joy out of the answer that I give. Therefore, I think the member should probably consider moving his amendment and putting it to the vote.

Hon NICK GOIRAN: That demonstrates that the minister does not understand the amendment, because the amendment has nothing to do with the questions that I am asking at the moment; they are two entirely different issues. Maybe the minister already has advice on my amendment and he can indicate what the view of the government is on it.

Hon STEPHEN DAWSON: Once the honourable member has moved his amendment, I would normally indicate what the government’s view is, so if the member is in a position to move it, I am happy to indicate what our response is.

Hon NICK GOIRAN: That takes me to my questions around the government’s choice to cut out divisions 2 to 4 of part 1. Thus far, we have identified that clause 7 is the only clause that actually needs to wait for proclamation. Clause 5 does not need to wait for proclamation nor does clause 4. There is no problem whatsoever with clause 4 coming into operation. I think the minister even indicated or conceded that it would not undermine the bill if clause 4 commenced immediately. Would that be the same, minister, for clause 5? If clause 5 were to commence immediately, would that undermine the bill?

Hon STEPHEN DAWSON: I am only going to give one last answer on this, and then I am just not; we are going around in circles here. The provisions in division 3 are part of the substantive voluntary assisted dying scheme. The intent is that all provisions of that scheme come into operation at the same time. That is the intent of government. That is the view and that is certainly what is before us in the legislation. If members have alternative views, they, of course, are absolutely able to vote against the bill as it stands or indeed move amendments. But I have now made it clear a number of times why we have done things the way we have done things, and I do not think I have anything further to add to that conversation.

Hon NICK GOIRAN: One of the reasons the minister said that proclamation of the bill needs to be delayed is for the preparation of new procedures. What are the new procedures that need to be prepared?

Hon STEPHEN DAWSON: I have also indicated that in a previous answer.
Hon NICK GOIRAN: The minister has indicated that. Do you have a list of the new procedures, minister?

Hon STEPHEN DAWSON: I read out what some of the procedures will be. I did not have an exhaustive list, but I mentioned the establishment of the board, the establishment of the statewide pharmacy, care navigators and medical protocols. I have mentioned that issue already and I will not mention it again.

Hon NICK GOIRAN: Let us be clear, the minister said earlier that one of the things that will need to be done is the preparation of new procedures. However, it would not have been apparent to anybody that the establishment of the board was the creation of a new procedure.

Hon Stephen Dawson: It would’ve been because I had said at that point that the creation of procedures —

Hon NICK GOIRAN: Let us be clear, the advice the government has provided at this point is that the establishment of the Voluntary Assisted Dying Board is a new procedure that the government intends to do in the next 18 months. When the minister gave advice to the house earlier this evening, he was listening very closely to the advisers who were telling him to say that. They said to the minister, “Make sure that you respond and say that there are going to be new procedures prepared. One of those new procedures is the establishment of the board.” I want to make sure that that is crystal clear.

Hon Dr SALLY TALBOT: Mr Deputy Chair, I do not want to make a point of order but just a general point. I think that the questioner is sailing awfully close to the wind in implicitly casting aspersions on both the advisers and the minister. I have known Hon Stephen Dawson since he was quite a small boy and I can tell members that nobody puts words in his mouth. In the context of debating this bill, to suggest that advisers are putting words in the minister’s mouth is simply wrong. It is unparliamentary to even make that suggestion. I ask you to ask Hon Nick Goiran to desist in making that imputation.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Hon Dr Sally Talbot, I was listening very carefully to the words of Hon Nick Goiran; I do not think it was offensive. The minister has the capacity not to answer the questions. I will give some unbidden advice to the minister. If the minister says that he is not going to answer questions on a particular topic, the simplest thing to do is not to answer them. He would then have the protection of the Chair. The reality is that the words of Hon Nick Goiran were, in my view, not offensive and should not be considered so.

Hon STEPHEN DAWSON: I thank Hon Dr Sally Talbot for her —

The DEPUTY CHAIR: Defence.

Hon STEPHEN DAWSON: No; for reminding me that I once used to be young. I certainly feel I am ageing at a great pace these days!

Part 9 of the bill refers to the Voluntary Assisted Dying Board and the establishment of the board. Once that board is established, the general procedures that it needs to follow will be done at a later stage. That is one of the procedures that is referred to.

Hon NICK GOIRAN: I thank the minister. It now becomes clear that the procedures the minister referred to are procedures for the board. Is there a need to prepare procedures for anybody other than the board during this 18-month period?

Hon STEPHEN DAWSON: Yes, there is a need. Procedures will probably be needed for the statewide pharmacy, for example. Procedures will be needed for the clinical panel, care navigators and probably around medical protocols. There could be others, but those are certainly some of the procedures.

Hon NICK GOIRAN: The minister mentioned that he had received some advice from Victoria about these things. Does Victoria have procedures with regard to its board or equivalent, and its statewide pharmacy, clinical panel, clinical protocols and care navigators?

Hon STEPHEN DAWSON: I did mention Victoria in relation to clause 2 and the fact that Victoria has anecdotally advised that a minimum of 18 months will be required for the implementation period. That is the context in which I mentioned Victoria. In relation to procedures, I am sure that they do have procedures in operation in Victoria.

Hon NICK GOIRAN: The minister is sure that they have procedures in Victoria. Do they have procedures with regard to care navigators?

Hon STEPHEN DAWSON: They do have care navigators in Victoria and they would have procedures, whatever they are called. I am not sure what name or language they use in Victoria, but I am certain there would be procedures around those care navigators.

Hon NICK GOIRAN: Is it the intention of government to use the Victorian procedures as a template or guide for the preparation of our procedures?

Hon STEPHEN DAWSON: No; but that is not a clause 2 question, honourable member.

Hon Nick Goiran: When would you like me to ask it?

Hon STEPHEN DAWSON: Ask it at a more appropriate time. Perhaps it was a clause 1 question and the member missed his chance there! But certainly in relation to clause 1 —

Hon Nick Goiran: We are in committee.
Hon STEPHEN DAWSON: I think that the honourable member asked it at the wrong time, but I have given the answer.

Hon NICK GOIRAN: The minister indicated that he has received anecdotal evidence from Victoria that an 18-month period is the necessary minimum period for proclamation. What does “anecdotal information” mean? Has somebody actually communicated with someone specifically in Victoria? Has that meant an exchange of correspondence? Is there a copy of that correspondence? Can that correspondence be tabled? The minister mentioned it was a minimum of 18 months. Did they also suggest a maximum period and, indeed, how long did Victoria take?

Hon STEPHEN DAWSON: I am told that there have been ongoing conversations with Victoria and Victoria’s time frame was 18 months.

Hon NICK GOIRAN: There have been some conversations with Victoria, it took 18 months and on the basis of that the minister has indicated that it will be a minimum of 18 months. Is any advice available from government on the criteria under which it may be necessary for there to be a longer period of time? Obviously, there is quite a difference between Victoria and Western Australia, not the least of which is the size and geography of our state. Has any advice been taken by government on that issue and the differences?

Hon STEPHEN DAWSON: No, there has not. But as the member alluded to, Victoria is a different place from Western Australia; it has different topography and it is a different sized state. We are using that 18-month time. I guess that we are suggesting that it will take approximately that amount of time. It could take a little longer, but it depends. Obviously, there are differences between the Victorian bill and our bill. We think that it could take 18 months, but it could take longer.

Hon NICK GOIRAN: In this 18-month implementation period, the time within which the government wants to wait for the bill to commence by way of proclamation, will it be necessary for any regulations to be drafted?

Hon STEPHEN DAWSON: The bill does not require that any regulations be made. It has been drafted as a comprehensive piece of legislation to operate as is. There is a general regulation-making clause as a futureproofing mechanism; however, it is not anticipated that there will be any regulations made under the bill. That is at clause 161. If the member has questions about regulations, he is welcome to ask that question at that stage.

Hon NICK GOIRAN: The minister will see that at clause 162 it talks about the Parliament ordering the minister to conduct a review. Would it be possible under the current draft of clause 2 for that review clause to never be proclaimed?

Hon STEPHEN DAWSON: The intent is to proclaim the rest of the bill on the same day in the future.

Hon NICK GOIRAN: Taking that as an example, what is the fundamental objection of government to a clause, for example, like 162, in which the will of Parliament is that it wants there to be a review of this act at some point in time, and Parliament wants that to commence on the day of royal assent or the day after royal assent? What is the fundamental objection of government to ensuring that that happens? Will that undermine the bill? Will this be another one of the deal-breakers that the Minister for Health previously referred to?

Hon STEPHEN DAWSON: What is the point of starting a review the day after the bill is proclaimed? That was his point. I will not go into the detail of clause 162 because, of course, we will deal with that at a later stage. But that clause states that a review will happen —

... not later than 12 months after the 2nd anniversary or the expiry of the period of 5 years, as the case may be. Obviously, that is an issue for clause 162.

Hon NICK GOIRAN: With respect to the minister, it is not, because the minister is asking us to decide now when all the other clauses are going to commence, include clause 162. There will be no point in me asking the minister questions about commencement at clause 162, because he will pull another one of his tricky moves and tell us, “You should’ve asked that question at clause 2.” That is why I am asking about it now. I draw to the minister’s attention that the terms of clause 2 that the minister wants us to approve say —

(a) Part 1 (other than Divisions 2 to 4) —

Commence —

— on the day on which this Act receives the Royal Assent;

(b) the rest of the Act …

That means all the other clauses. That means clauses 4 to 184, including clause 162. If this chamber says that it wants clause 162 to commence on the day of royal assent or the day after royal assent, and it does not want to delegate to the government proclamation, this chamber is entitled to do that. The only time we can have that debate and that conversation is now on clause 2. With respect, minister, there is no point if every time I provide an example, I am told that those things can be asked at that particular clause. No, they cannot, because the time to discuss the commencement of various clauses is now. Now is the only time that it can be done. That is why I am asking it now.

Clause 162 is a classic example. It disturbs me that the government is asking us to delegate authority to the government to proclaim this clause if and when it wants to in the fullness of time. The minister asked me what would be the point of the review clause commencing immediately. The point is that the Parliament would then know, with absolute certainty, that that review will take place and that it will not be left to a government of the
day to decide that it will proclaim all clauses except clause 162. The minister said that that is not the intent of this government. I accept that. However, the minister is also not the minister who ultimately will be responsible for the proclamation of this bill; he is representing the Minister for Health. There could be another Minister for Health.

I am curious to know the fundamental objection to why these things cannot commence on the day on which the legislation receives royal assent. It seems to me that, in theory, it would be open for the entire bill to come into operation on the day on which it receives royal assent. I think that would be bad practice. It would be highly unusual. It would not be radically unusual for clauses to commence on the day after the legislation receives the royal assent, because the minister has disclosed that there is no intention to prepare any regulations. No clauses are waiting for regulations to be drafted, which is the usual reason that governments of both persuasions give to members. They say, “Please allow us to commence these clauses on a day to be proclaimed, because we need to prepare some regulations and we are not ready yet.” That is the normal reason. It disturbs me that the decision on whether some of these clauses will come into operation, particularly something as fundamental as the principles at clause 4 and the review clause at clause 162, will be left to government discretion. Bills sometimes say, as in paragraph (b) of this clause —

the rest of the Act—on a day fixed by proclamation.

But sometimes additional words are added by parliamentary counsel to say that different sections will be proclaimed or will commence on different dates. Those are not the words used in this bill. Does that mean that clauses 4 through to 184 will have to be proclaimed on one single date, or will it be open to the government to proclaim certain clauses on certain dates and to choose not to proclaim some clauses at all?

Hon STEPHEN DAWSON: The bill operates as a whole scheme and not as a piecemeal scheme. This is reflected in the requirement to proclaim the bill 18 months or thereabouts into the future. The intention is to proclaim the rest of the bill on the same day. Mr Chair, that is all I can give in relation to answering this question. I do not propose to answer any further questions on this.

Hon NICK GOIRAN: The question was a technical question for the minister, on which I was hoping to get a technical response. I know it is the intention of the government to proclaim all the clauses in one package. However, I want to know whether the words before us empower the government to proclaim some clauses on a particular date, other clauses on another date and other clauses not at all. That is the technical question that I want answered pursuant to the drafting in front of us. I know and understand that it is the intention of the government for the whole thing to come in as a package. I am not denying that; I accept that that is what the minister has consistently said this evening. However, is the minister able to take advice on whether it is possible—I know it is not the intention—for the government to proclaim some clauses pursuant to this wording, or would that not be possible because it would require the additional words to say that some sections can come into operation on different days?

Hon Stephen Dawson: I have nothing further to add.

Hon NICK GOIRAN: The minister does not know. We are on clause 2, and we are already at the stage that we cannot get technical advice. That probably goes to the heart of one of the comments that was made by an honourable member earlier this week about one of the difficulties in trying to do this in Committee of the Whole House. This would be not acceptable in the Standing Committee on Legislation; it would be utterly unacceptable. We will continue to pursue this until such time as we extract a response to a technical question. To simply have the chief minister with responsibility for the bill in this chamber tell us that he is not going to provide us with that technical information —

Point of Order

Hon SUE ELLERY: Chair, I seek your guidance. The chamber has already made a decision about whether to refer the bill to a committee. I wonder whether the honourable member is in fact reflecting on a decision of the chamber, which of course would be a breach of standing orders.

The CHAIR: If that were the case, it would be. The member is not reflecting on a decision of the chamber in the sense contemplated by the standing orders. He is referring, as part of a narrative, to what has occurred and what might otherwise have occurred. It is a simple observation. There is no point of order.

However, there is an approaching point of order about repetitious debate. I have not quite reached that stage, but there is a limit to how many times the same point needs to be made. There is no point of order from the Leader of the House, but a near point of order is approaching from me.

Committee Resumed

Hon NICK GOIRAN: I move the amendment standing in my name at 49/2 —

Page 2, after line 8 — To insert —

(aa) Part 1 (other than Division 1) and section 161A — on the day after the day on which this Act receives the Royal Assent;

Hon STEPHEN DAWSON: I indicate that the government does not support the amendment. The amendment seeks to defer proclamation to when the member’s proposed new clause 161A comes into operation. That is a requirement to introduce a system of care navigators by regulation. Therefore, we are not supportive of this amendment.

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Hon ADELE FARINA: My question is really a point of order. The amendment refers to new clause 161A, which the chamber has not yet contemplated. I wonder whether we need to defer consideration of clause 2 until after we have considered new clause 161A. I do not know how we can consider the amendment before we have dealt with new clause 161A. I seek your guidance, Chair.

The CHAIR: The amendment as proposed refers to new clause 161A, which, of course, does not technically exist at this time. However, that does not mean that the amendment to clause 2 cannot be considered at this time. It may. Perhaps the member in moving his amendment might wish to refer to new clause 161A to ensure that the Committee of the Whole House is aware of how the two are interlinked, but there is no necessity for the consideration of clause 2 to be parked. Indeed, it would be undesirable to do so.

Committee Resumed

Hon NICK GOIRAN: Hon Adele Farina has raised a fair question and, ultimately, I am very relaxed about whether we deal with clause 2 now or after the consideration of new clause 161A. If the chamber has an appetite to deal with it now, I am happy to proceed.

The context is that over the course of considering clause 1, the government has been at pains to try to satisfy the concerns of regional members about how this will work in regional Western Australia by telling them that it will be done by way of a care navigation process. Part of the reason that the government has had to invent this care navigation process is that it has not yet worked out whether telehealth can be used. Interestingly, during the clause 1 debate, the government indicated that care navigators might be nurses or social workers. There was a rather startling revelation by the minister during the clause 1 debate that social workers are self-regulated. My concern is that these care navigators are, in my mind, expert steers.

There are concerns about elder abuse in Western Australia. Submissions by the Aboriginal Health Council of Western Australia to the ministerial expert panel contain concerns about the need for special care to be taken. These concerns have been raised. We know that psychological and emotional elder abuse is a real problem in Western Australia and it will take only the smallest of subtle coercions for a person to be navigated to the voluntary assisted dying path instead of the palliative care path. In fact, I find it quite unacceptable that we are prepared to have this government invest taxpayers' funds in creating voluntary assisted dying care navigators, but there is no talk by government about palliative care navigators. The navigators are going to steer people towards voluntary assisted dying. That could include self-regulated social workers and I asked the government whether it had any plans about regulation, but it all became too hard and we were told we were asking too many questions and we did not make any progress. The solution to that is new clause 161A.

I ask members to give new clause 161A serious consideration. What would it do? It would provide that the government could make regulations to govern how these care navigators will operate. Let us remember that care navigators do not exist in Western Australia. That is a new invention of this government. I have asked about whether it is using the Victorian system as a model. Sometimes it says yes, it is referring to Victoria; sometimes it says no. It really depends on the time of day that we ask the question. The point is that they do not exist at the moment. This would allow government to make regulations on how those care navigators will operate. The provisions of new clause 161A require this chamber and the other chamber to approve those regulations. Once we have approved those regulations for care navigators, the bill can commence, but not before. I drew to members' attention that during answers to questions that I have asked on clause 2, the minister has said that we need to defer this for 18 months because we need to deal with the care navigation process. The minister said that the government needed time to prepare new procedures, establish a board, and to deal with care navigators. Proposed section 161A would ensure that if the government wants regulations and it wants care navigators, as it said it does, it will have to prepare the regulations and put them before both houses for approval, and at that point the bill can commence.

Hon AARON STONEHOUSE: I would feel much more comfortable if we deferred debate on clause 2 until we have had a chance to consider proposed section 161A. If we get down in the weeds debating proposed section 161A, we will miss a lot of the context of the bill, especially around the head of power for regulations in proposed section 161. It seems to me it would be a heck of a lot easier to defer consideration of clause 2—only one amendment is proposed for it at this point anyway—and we can come back to it at a later stage when the chamber has considered proposed section 161A. If proposed section 161A is agreed to, we can return to clause 2 and consider the amendment put forward by Hon Nick Goiran.

I am not sure what the attitude around the chamber is, but I would certainly feel much more comfortable being able to discuss both of those proposed amendments in context, together perhaps, rather than being in a situation in which the chamber agreed to the proposed amendment to the question put but later did not agree to proposed section 161A, and we had to return to clause 2 anyway. I do not mean to foreshadow what the will of the chamber might be on individual clauses, but we might end up with a bit of a weird situation and return to clause 2 regardless. I would certainly feel more comfortable if we deferred debate on clause 2 until that stage and proceed to clause 3 now. I put my views out there, Chair. I am interested in whether other members share that sentiment; and, if they do, perhaps we can move in that direction.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: I know the minister’s response to this was to the effect that the government was not supporting it. Can I get an understanding, perhaps a bit more than that, in terms of the reasons the government opposes the recognition and regulation of care navigators within the bill and why it is best placed outside the bill?

Hon STEPHEN DAWSON: This will be an operational system. It is our belief that it is unnecessary to put into regulations. The issue will be worked on, as I have previously indicated, during the implementation phase.

While we are on clause 2, the amendment does refer to clause 161A, which we think is restrictive and it is onerous. We do not support proposed section 161A and we certainly do not support the amendment that is before us, which is that the words to be inserted be inserted.

Hon MARTIN ALDRIDGE: Thanks, minister. With respect to proposed section 161A, which links back to the proposed amendment at 49/2 on the supplementary notice paper, does the minister’s objection centre on the enabling provision that requires the regulations to be passed by an affirmative resolution of both houses as opposed to defining what a care navigator is and the discretionary provision for the making of regulations, or is it both of those issues?

Hon STEPHEN DAWSON: Our concern is a combination of both.

Hon MARTIN ALDRIDGE: I have a question about the operation of proposed new clause 161A, noting that we have had only a short while to consider this amendment. As I read through the logical order of new clause 161A, subclause (1) creates a definition of “care navigator” and subclause (2) states that the Governor “may” make regulations. Subclauses (3), (4) and (5) would apply only if the Governor indeed made regulations. My question—it may be a question to the mover of the amendment—is: if new clause 161A were to pass as constructed, would “care navigator” be defined by subclause (1), but because of the discretion provided by the use of “may” in subclause (2), it does not compel the Governor to make any regulations about care navigators? Therefore, subclauses (3), (4) and (5) would not be relevant.

Hon NICK GOIRAN: I am happy to answer that. The issue is not whether we have the capacity to compel the Governor to make regulations. That is why I have used “may” rather than “must”. But if there is technical advice from the government that it is possible to compel the Governor to make the regulations, I would have no problem with an amendment to the amendment.

Hon AARON STONEHOUSE: To continue the point I was making earlier, this is what I was hoping to avoid. We are now discussing hypotheticals of how proposed new clause 161A might operate. It may be an amendment that many members have not put their minds to yet. The question at the moment is an amendment to clause 2 of the bill. There may be an alternative wording to new clause 161A. I may move an amendment to retain the regulation-making powers but to make them less restrictive. There are infinite hypothetical amendments that could be moved to new clause 161A, and we are discussing these in consideration of clause 2. It is very difficult to engage in this kind of hypothetical debate at this point. So that we can at least move forward and members may have an opportunity to consider new clause 161A at the relevant stage, I would like to move, without notice, that consideration of clause 2 be postponed until after consideration of clause 184, which would be at the end of the bill.

Hon STEPHEN DAWSON: I just want to clarify what the question is before the chamber.

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

To achieve what Hon Aarom Stonehouse is seeking to achieve, we would need a two-part process, if the chamber so wishes—that is, to defer consideration of the amendment and, if that is carried, to defer consideration of clause 2. That would be the process. In that way, we could then consider it after new clause 161A had been considered. I think Hon Aaron Stonehouse was half moving along that way. If members wish, we can resolve that one way or the other.

Hon STEPHEN DAWSON: I am not seeking to be difficult, Mr Chairman; I am just trying to understand the issue. Would we not have to put the question before the chamber first, because Hon Nick Goiran has moved his amendment, before the deferral could happen?

The CHAIR: I am advised that procedurally an amendment becomes a second question before the chamber and takes precedence over the first. In effect, we have two questions that we need to deal with. The first one is the question of the amendment. If we want to defer that, we can do that. Then we would have to defer clause 2. Hon Aaron Stonehouse, I think that is what you were moving, was it not?

Hon AARON STONEHOUSE: Yes, and thank you for that clarification, Chair. I move —

That consideration of amendment 49/2 be deferred until a later stage.

The CHAIR: I note that Hon Aaron Stonehouse has moved that consideration of amendment 49/2 be deferred. This is in two parts and I will be moving another motion, but if members wish to defer consideration of clause 2 until after these other matters are resolved, they will support this proposition. If they do not, they will not. The question is that the amendment at 49/2 be postponed.

Hon MARTIN ALDRIDGE: Is the question before the Chair debatable?

The CHAIR: Yes, it is debateable.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: I understand the issue that Hon Aaron Stonehouse is trying to overcome, and I think it was first raised by Hon Adele Farina. But not having had a chance to read all 64 pages of the supplementary notice paper, after a quick flick through, I think there are several other circumstances in which this issue is going to arise, not least of which being when we get to clause 5 and the definitions. I understand that the member may feel this is the best approach for expediting the process, but I suspect that we will end up being repeatedly faced with the same challenge, and it is my view that it may be best to just soldier on and deal with the difficulties that come with managing multiple amendments and linking the multiple amendments on the supplementary notice paper.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of the deferral.

Division

Question put and a division taken, the Chair (Hon Simon O’Brien) casting his vote with the noes, with the following result —

Ayes (3)
Hon Nick Goiran Hon Colin Tincknell Hon Aaron Stonehouse (Teller)

Noes (30)
Hon Martin Aldridge Hon Stephen Dawson Hon Alannah MacTiernan Hon Charles Smith
Hon Ken Baston Hon Colin de Grussa Hon Rick Mazza Hon Matthew Swinbourn
Hon Jacqui Boydell Hon Sue Ellery Hon Kyle McGinn Hon Dr Sally Talbot
Hon Robin Chapple Hon Diane Evers Hon Michael Mischin Hon Darren West
Hon Jim Chown Hon Donna Faragher Hon Simon O’Brien Hon Alison Xamon
Hon Tim Clifford Hon Adele Farina Hon Martin Pritchard Hon Pierre Yang (Teller)
Hon Alanna Clohesy Hon Laurie Graham Hon Samantha Rowe
Hon Peter Collier Hon Colin Holt Hon Robin Scott

Question thus negatived.

Hon MARTIN ALDRIDGE: Before Hon Aaron Stonehouse moved his motion without notice, I was trying to understand the implications if this new clause 161A passes in its current form. I think for the first time we would have reference to a care navigator in the bill, because I asked a question on clause 1 and the government confirmed that there was no reference to a care navigator in the bill. My plain reading of this amendment is that there is a discretion for the Governor to make regulations, but there is a delimitation on the scope or operation of the care navigator in the absence of regulation. I wonder whether the minister could assist the house with some technical advice, with the benefit of the advisers at the table, about whether this amendment will achieve what is intended, which is essentially to regulate care navigators as opposed to providing discretion to the government to regulate them if it so wishes.

The CHAIR: I appreciate the difficulty presented by the situation. The fact of this matter is that we are contemplating clause 2 and not proposed new clause 161A. In any case, looking at the time, I think I need to now interrupt debate and report progress, which will give members time to look at their 64 pages of amendments prior to resuming.

Progress reported and leave granted to sit again, pursuant to standing orders.
Hon STEPHEN DAWSON: Yes, I do. It is not a clause 2 issue, but it is an issue that I undertook to provide a further answer on, so with the Deputy Chair’s indulgence, I will provide it now. Yesterday, there was a question from Hon Nick Goiran in relation to Medicare benefits. He asked whether the minister could clarify what I meant. I referred to a figure of 85 per cent. He asked whether that meant that Medicare would cover up to 85 per cent of the fee of a nurse practitioner and how the figure of 85 per cent related to the gap that will be required to be paid by a patient who wishes to access voluntary assisted dying. The Medicare benefits schedule sets a scheduled fee for the nurse practitioner item number, and the benefit it pays is 85 per cent of that scheduled fee. Nurse practitioners may charge the scheduled fee; however, the amount they charge is at their discretion. Whether there is a gap to be paid by the patient will depend on the fee of the nurse practitioner involved. Although that is not strictly on the question that is before the chamber, Mr Deputy Chair, I had given Hon Nick Goiran an undertaking that I would provide an answer to that question, and, obviously, we can delve into it at a later stage.

With regard to the question that is before us, I previously indicated that the government was not supportive of Hon Nick Goiran’s amendment.

Hon NICK GOIRAN: We left things yesterday evening in consideration of my amendment to clause 2, specifically at page 2, after line 8, to insert —

(aa) Part 1 (other than Division 1) and section 161A — on the day after the day on which this Act receives the Royal Assent;

This amendment would simply ensure that part 1 in total would start either on the day of royal assent or the day after royal assent. More importantly, it would ensure that proposed section 161A would definitely start on the day after the legislation received royal assent. It is important to mention that, irrespective of the decision of the chamber with regard to this amendment, it is my intention to move the amendment standing in my name for a proposed section 161A, because the difference would simply be whether that provision would be guaranteed to start on the day after royal assent or left to government to proclaim in the fullness of time. That is the purpose of this particular amendment—to make sure that, no matter what, proposed section 161A, if agreed to, would come into force and have effect and commencement on the day after royal assent.

After some of the debate that took place yesterday, particularly after some of the questions from Hon Aaron Stonehouse and Hon Martin Aldridge, I contemplated what effect would be given in the event that this amendment was passed and, at a later stage, proposed section 161A was not passed. It struck me that it would make no difference. It would not undermine the bill in any way because, clearly, a non-existent proposed section 161A would not come into force because it would not exist. Perhaps it may even be something that can be dealt with by clerical amendment, but in any case, whether it is or is not, it would cause no disruption to the bill whatsoever if this particular amendment were to be passed, so I encourage it to be supported.

As I said earlier, the purpose of proposed section 161A is to make sure that there is some regulation around the activities of care navigators. The government previously indicated that one of its suggested solutions for providing voluntary assisted dying to people in the regions—because it has not yet worked out whether telehealth can be provided—is to create care navigators. It seems to me that if it is good enough for us to regulate the activities of health practitioners, surely it must be good enough for us to regulate the activities of the newly invented care navigators. I think it would be simply dangerous to have these individuals, under the guise of care navigation, running around Western Australia without any regulation. In fact, the minister conceded in an earlier part of the debate that they would be self-regulated if they were social workers. That is plainly dangerous. If the government is serious about care navigators, there should be no problem with regulations being made and then definitely coming into effect on the day after the legislation receives royal assent. I encourage support for the amendment.

Division

Amendment put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the noes, with the following result —

Ayes (9)
Hon Jim Chown  Hon Nick Goiran  Hon Charles Smith
Hon Donna Faragher  Hon Rick Mazza  Hon Colin Tincknell
Hon Adele Farina  Hon Simon O’Brien  Hon Ken Baston (Teller)

Noes (25)
Hon Martin Aldridge  Hon Colin de Grussa  Hon Michael Mischin  Hon Dr Steve Thomas
Hon Jacqui Boydell  Hon Sue Ellery  Hon Martin Pritchard  Hon Darren West
Hon Robin Chapple  Hon Diane Evers  Hon Samantha Rowe  Hon Alison Xamon
Hon Tim Clifford  Hon Laurie Graham  Hon Tjorn Srema  Hon Pierre Yang (Teller)
Hon Alanna Clohosy  Hon Colin Holt  Hon Aaron Stonehouse
Hon Peter Collier  Hon Alannah MacTiernan  Hon Matthew Swinbourne
Hon Stephen Dawson  Hon Kyle McGinn  Hon Dr Sally Talbot

Amendment thus negatived.
Hon NICK GOIRAN: The effect of that last amendment, which was 49/2 on issue 5 of supplementary notice paper 139, being unsuccessful is simply that if in due course my proposed section 161A is agreed to by the chamber, it will now be left to the government to decide when it will come into operation by way of proclamation.

The next amendment I have in my name is 50/2. It is about a related but different issue. I move —

Page 2, after line 9 — To insert —

(2) The day fixed under subsection (1)(b) cannot be earlier than the day on which the first regulations made under section 161A have all come into operation.

Clause 2(b) of the bill before us says that the rest of the act will come in on a day fixed by proclamation. This amendment would indicate that that date fixed by proclamation should not be any earlier than the day on which the first regulations are made—that is, the care navigator regulations. In other words, for those of the view that these care navigators should be regulated, that the government should in due course prepare regulations to regulate their activities and that there should be some kind of standards that these care navigators adhere to rather than mere self-regulation, this amendment would ensure that those things happen before the operative provisions of the bill come into effect. That is the reason I have moved this amendment. It is my view that it would be unsafe to have the care navigation system unregulated, not having been brought before the chamber and not in place prior to the operative provisions being enforced. That is the purpose of this amendment and I encourage support.

Hon SIMON O'BRIEN: In a spirit not of engaging in debate, but trying to facilitate the chamber dealing with this proposed legislation, it would seem to me that this matter should not be considered until the matter of proposed section 161A is dealt with. A similar question arose on the last day’s sitting and it was dealt with in a certain way, but this proposed amendment is far more clear-cut. It refers to proposed section 161A. We do not know whether that will come into existence. The government or the proponents of the bill might well say that they are not even going to entertain that proposed section in due course either, so this amendment can be dealt with and voted down. I suggest, with respect, that the most expeditious way to deal with this amendment is to entertain a motion, if it is the government’s wish, to defer consideration of this amendment and of clause 2 until after the issue of proposed section 161A has been resolved.

The DEPUTY CHAIR: Hon Simon O'Brien, were you then moving a motion or suggesting a motion be moved?

Hon SIMON O'BRIEN: I was purely suggesting it. The minister might want to proceed with dispatch to go down that path, and I think it might find general agreement. Conversely, the government might want to go some other way, but I am just offering this to help.

Hon AARON STONEHOUSE: I would like to echo the comments made by Hon Simon O'Brien. Of course, I made this case last night when we considered a previous amendment. It is not just about the difficulty of having to deal with questions about proposed section 161A, but that other new sections may be proposed, moved and agreed to in the course of debate as we progress through the clauses of the bill. If that is the case, there may be a need to revisit clause 2 at a later stage to look at the commencement of those new sections, where they fit and whether they should be proclaimed or come into operation on some fixed date. I think it would be a lot clearer, easier and cleaner and it would help expedite the fate of this bill if we deferred or put off consideration of this amendment and clause 2 until a later time. I will wait to hear what the minister has to say on that matter.

Hon STEPHEN DAWSON: Can I say that I appreciate the helpful nature in which Hon Simon O'Brien has made his suggestion. However, I indicate again that the government does not support the amendment moved by Hon Nick Goiran. I indicated last night that the government is also not supportive of new clause 161A that is proposed to be moved by Hon Nick Goiran at a later stage. I also indicate to the chamber that the government does not support the deferral of clause 2.

The DEPUTY CHAIR (Hon Dr Steve Thomas): I do not propose to allow debate on a postponement unless somebody actually moves a motion of postponement. I have given a little bit of leeway because it is a debate in which leeway is required, but if I do not hear a motion of postponement, we will simply progress to the question that is before the chamber currently—that is, that the words to be inserted be inserted.

Hon ADELE FARINA: I have some concerns about this amendment in that proposed new clause 161A does not deal with any time limits to process the regulations, whereas section 42 of the Interpretation Act sets out time frames for dealing with the regulations. My concern is that if some time frames are not incorporated within proposed new clause 161A, it could drag on forever. Some time frames probably need to be included so that I can, at least from my point of view, give it serious consideration, because it could drag on for quite some time.

Hon NICK GOIRAN: To deal with that issue, I certainly have no objection to what Hon Adele Farina has proposed. If there were to be an amendment to proposed new clause 161A to implement some time limits, I indicate in advance that that type of amendment would receive my support, whether it was drafted by a member of this place or by the government. I have no difficulty whatsoever with that. I think a good point has been made. Nevertheless, I encourage support for the current amendment before the chamber.

Extracted from finalised Hansard
Hon ADELE FARINA: Herein lies our problem. We are being asked to make a decision on an amendment to clause 2 without knowing what proposed new clause 161A will look like and whether there will be further amendments to address my concern, which leaves me in a position to then vote down this amendment to clause 2. That is not a very good way for this place to be making decisions. I really think some consideration needs to be given to how to progress this, because we are being asked to make decisions based on future clauses but we do not know what they will look like. It is problematic.

Hon MARTIN ALDRIDGE: I want to express a similar view to Hon Adele Farina on this clause. I, obviously, did not support the first clause 2 amendment, and I find myself in a difficult position on this one as well. I opposed the motion moved by Hon Aaron Stonehouse last evening because I felt that if we postpone clauses whilst we deal with other clauses, we would end up with some sort of jigsaw puzzle that would need to be put back together at the end. The other way to deal with the bill would be for the Chair to provide some leeway when dealing with interconnecting amendments on the supplementary notice paper so that we could have a proper debate. Obviously, that was not permitted last evening when I sought some understanding from the government about its intention with regard to care navigators and, indeed, how it intends to regulate or guide, or restrict or control, such care navigators. Given that I am not able to have that debate, I find it very difficult to make an informed view on this clause 2 amendment. We may find ourselves in another situation when we get to new clause 161A when we dive deep into the policy of that particular proposed new clause. If the chamber agrees that new clause 161A should stand in either its current or an amended form, we may have to recommit the bill to reconsider other interconnecting clauses that we will have passed. I am just pointing out some level of frustration about the debate on the second clause of the bill, and that perhaps, in hindsight, a more reasonable option than perhaps I expressed last evening would have been to postpone it. However, I think that presents some challenges and we would probably only be kicking it down the road a bit further.

Division

Amendment put and a division taken, the Deputy Chair (Hon Robin Chapple) casting his vote with the noes, with the following result —

Ayes (11)
Hon Jim Chown, Hon Rick Mazza, Hon Charles Smith, Hon Colin Tincknell
Hon Donna Faragher, Hon Simon O’Brien, Hon Aaron Stonehouse, Hon Dr Steve Thomas
Hon Nick Goiran, Hon Martin Petchard

Noes (23)
Hon Martin Aldridge, Hon Stephen Dawson, Hon Colin Holt, Hon Matthew Swinbourn
Hon Jacqui Boydell, Hon Colin de Grussa, Hon Alannah MacTiernan, Hon Dr Sally Talbot
Hon Robin Chapple, Hon Sue Ellery, Hon Kyle McGinn, Hon Darren West
Hon Tim Clifford, Hon Diane Evers, Hon Michael Mischin, Hon Alison Xamon
Hon Alanna Clohesey, Hon Adele Farina, Hon Samantha Rowe, Hon Pierre Yang (Teller)
Hon Peter Collier, Hon Laurie Graham, Hon Tjorn Sibma

Amendment thus negatived.

Hon NICK GOIRAN: It is a shame that those amendments were not passed. They would have ensured that the care navigation regulations, in the event that they are approved by the chamber, would come into operation first before the rest of the bill. But we respect the will of the chamber and if it is to be the case that care navigation regulations will come into effect simply at the same time as the rest of the bill, that is what will happen.

As an alternative—perhaps this will satisfy those members who are concerned about time frames and the like—it seems to me that it is possible to look at another way of dealing with this in clause 2, which deals with the proclamation period. I propose to move an amendment and I will give my reasons in a moment. I move —

Page 2, after line 9 — To insert —

(2) The day fixed under subsection (1)(b) cannot be earlier than the 5th anniversary of the day on which this Act receives the Royal Assent.

Hon Dr SALLY TALBOT: I would like to make a procedural point. Can I ask you, Mr Deputy Chair, to check the supplementary notice paper documents that are being sent around the chamber. We received one today that has some helpful annotations on it so that we can see what is changing. The latest one that was sent around does not have those on it. Can you clarify for the benefit of all members what the arrangements are going to be?

The DEPUTY CHAIR: Member, by way of advice, there will be a comparison. The latest SNP has just come through as is, but a comparison will be made, which requires some work to be done by the clerks.

Hon NICK GOIRAN: By way of explanation, this amendment will allow the government time to implement palliative care service delivery, particularly in regional and remote areas of Western Australia, through the WA Country Health Service as part of its commitment to increase palliative care funding in the regions. It was obvious from the second
reading debate that a number of members from various parties were concerned about palliative care delivery in the regions, which at the moment is inequitable. This government has made a commitment to send out some money to try to address that. This amendment will ensure that the government has time to do more than just make a commitment and indicate that it will spend some money. It will give the government five years in which to make sure that palliative care is available in regional Western Australia.

The other reason that members might be interested in supporting this amendment is that it will allow us to give further consideration to the Victorian experience of voluntary assisted dying and the lessons learnt in that jurisdiction. What we know of the Victorian experience so far is that the Victorian Voluntary Assisted Dying Review Board put out its first official report titled “Report of Operations 2018–19”. A few small parts of it will be of particular interest to members and explain why we would benefit from learning from the Victorian experience over the next five years. The report states —

This report is the first from the independent Voluntary Assisted Dying Review Board.

Members will remember that the government also proposes to have a similar review board in Western Australia. The report details, amongst other things, activity under the Voluntary Assisted Dying Act from 19 to 30 June 2019. This is very important because the Victorian experience is based on only 11 days of activity. Now it is 31 October, but this report from the review board was based on that 11-day period from 19 to 30 June. The review board in Victoria has said that it will continue to report openly and transparently, which will assist us in Western Australia. If the board reports openly and transparently, we will have that five years of information at our disposal. The report states —

In our first public report, we have covered our largely administrative activities over the past 12 months. Covering only 11 days of the operation of the Act, we are not able to report on any activity other than the number of doctors trained in our portal.

According to the official Victorian review board, it is only able to tell us in its portal about the number of doctors trained. In terms of the data that the board has collected—information that will be of benefit for us in Western Australia over the next five years—the report states —

The Board receives information about the disease, illness or medical condition of persons who met the requirements of the eligibility criteria, demographic information, and other insights.

The Board will report more of this information in the future.

We cannot yet publish detailed data, as numbers are small and the information could be used to identify patients, doctors and other participants.

At the end of the report, referring to recommendations, it states —

Under the Act, the Board may make recommendations to improve the operation of the voluntary assisted dying law.

In this reporting period, the board has not made any recommendations.

LOOKING AHEAD

The Board will report again by February 2020. We anticipate we will be able to report more detailed data, depending on the volume of cases we see.

We may also be able to include outcomes of the Board’s review process, including compliance with the act, referrals made to other agencies, quality and safety issues, and insights regarding the voluntary assisted dying process.

Only one report is available in Victoria. The Victorian Voluntary Assisted Dying Review Board is reporting on an 11-day time frame. It has been unable to provide very much information other than the number of doctors trained in the portal. But over the next five years, members, there will be four more reports from the board that will provide us with information on improvements to the Victorian system. So the purpose of the amendment is to do two things. First, it will allow the government to roll out palliative care services in the regions, which it has committed to do. Second, it will allow all of us to be better informed about the Victorian experience because, unfortunately, at the moment, we really do not know much at all about the Victorian experience as we can see from Victoria’s panel board. Interestingly, we know from page 27 of Go Gentle Australia’s “A Guide to the Debate Ahead: Voluntary Assisted Dying in Western Australia” that at least one person in Victoria made a verbal first request to a coordinating doctor on 19 June 2019, which was during the 11-day time frame. The coordinating doctor completed their assessment of that patient for access to voluntary assisted dying on the same day. This information was provided by Go Gentle. I am indebted to Go Gentle for releasing information that the Victorian Voluntary Assisted Dying Review Board was not able to provide. It is curious, is it not, that Go Gentle was able to disclose information—in fact, it disclosed the name of the person, Kerry Robertson—about the one person in Victoria in the 11-day time frame but the official board in Victoria has been unable to provide any information. As I read earlier, the board that said that it will continue to report openly and transparently. I am looking forward to its next four reports so that we can see how to improve the VAD system in Western Australia. The data is not found in the Voluntary Assisted Dying Review Board.
Dying Review Board’s 2018–19 report because, as is stated at page 5 of its report, it cannot publish detailed data because the numbers are small and the information could be used to identify patients, doctors and other participants. Of course, it does not need to worry about that because Go Gentle has blown that out of the water. The board will report more information in the future. We need time to consider this information and to determine whether the Victorian act, which, according to Betty King, a former Supreme Court justice and the chairperson of the Victorian Voluntary Assisted Dying Review Board, has been designed to be the safest in the world. We will have a five-year time frame to ensure that the Victorian model is in fact the safest in the world and, if that is the case, that would be the appropriate template for us to consider at that time.

I conclude by noting that the Victorian board states at page 6 of its report that its next report is due in February 2020. I would think—it is not far away—that we would benefit from seeing that report in February 2020. In my view, we need time to consider the outcomes of the Victorian board’s review process, including compliance with the act, referrals made to other agencies, quality and safety issues and insights into the voluntary assisted dying process. For those reasons, I encourage members to support this amendment to give the government a five-year time frame in which it can roll out palliative care in Western Australia, particularly in regional areas, and to give us more of an opportunity to obtain information from the Victorians, who have had the opportunity to provide only one report so far and, unfortunately, it is for only the 11-day period and it has been unable to provide us with any data.

Hon STEPHEN DAWSON: It is blatantly very clear—it has been from the outset—that Hon Nick Goiran does not support the bill before us—plain and simple. He has taken every opportunity to frustrate the bill. The government does not support the amendment. We do not support delaying the bill for five years. I make the point that the government is learning from all jurisdictions with similar legislation, not just Victoria. I have made that point numerous times as have numerous other honourable members during their contributions to the debate thus far, including in their second reading contributions. This amendment would frustrate the will of the Western Australian community—plain and simple. From my perspective, the honourable member’s attempt to delay the bill by five years is objectionable. As I indicated earlier in my comments on clause 2, it is the government’s intention to proclaim the rest of the bill in 18 months’ time, having learnt from Victoria and the time it took that state to proclaim the remainder of its bill, notwithstanding that we are learning from jurisdictions around the world with similar legislation. Certainly, we will not support the amendment.

Hon NICK GOIRAN: In response to the minister’s intemperate remarks, I remind members that the government itself said that VAD will not start for 18 months. I am saying that instead of 18 months, make it five years so that it has more time to roll out palliative care and receive more information about the Victorian system. There is a difference between 18 months and five years. I also remind members that the minister said yesterday in the chamber that it would be a minimum of 18 months. It may well be five years—I do not know—but I am simply saying that we should put a parameter around it because there is no parameter in the bill whatsoever.

Hon RICK MAZZA: I have made it very clear that I do not support the bill, but I support the will of the chamber through this process. I am hopeful of meaningful amendments along the way to change some of the operations of the bill, but to effectively have a five-year moratorium that spans two terms of government—the rest of this term and almost all of the next term—does not serve any purpose if, at the end of the day, this bill passes. I will not be supporting the amendment.

Amendment put and negatived.

Clause put and passed.

Clause 3: Act binds Crown —

Hon STEPHEN DAWSON: I am advised that as it is a standard clause, parliamentary counsel provided the advice.

Clause put and passed.

Clause 4: Principles —

The DEPUTY CHAIR: Do we have a number of amendments on clause 4?

Hon MARTIN PRITCHARD: I think there is one in my name.

The DEPUTY CHAIR: Would you like to move the amendment standing in your name?

Hon MARTIN PRITCHARD: If I get the call from yourself, Deputy Chair, I certainly will.

The DEPUTY CHAIR: You have the call.

Extracted from finalised Hansard
Hon MARTIN PRITCHARD: I have an amendment standing in my name. It is a fairly simple amendment. It is a matter of adding the word “coercion” on page 3, line 18. It reads —

Page 3, line 18 — To delete “abuse;” and substitute —

abuse or coercion;

I am seeking to have the words “abuse or coercion” inserted. I do that because the minister’s second reading speech states —

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

I am seeking to have “coercion” included in the principles. I understand that it is dealt also within the body of the bill, but I think it is important to be in the principles as well. I urge members to support the amendment.

Hon NICK GOIRAN: I am not sure that the amendment has been moved at this point. While I have the call, I indicate to the honourable member that in the fullness of time when the amendment is moved, I will obviously support it, because, as the member will see, I have an amendment on the supplementary notice paper immediately underneath his. However, I seek to add the words “duress and undue influence”. Perhaps we can get to that in a moment. I have a general question on clause 4. Were the principles in clause 4 modelled on the principles section of the legislation of another jurisdiction?

Point of Order

Hon MARTIN PRITCHARD: Are we discussing the clause? The member quite rightly said that I have not moved my amendment, so are we currently discussing my amendment or the clause?

The DEPUTY CHAIR (Hon Robin Chapple): I was under the impression that the member had moved his amendment.

Hon MARTIN PRITCHARD: It was my endeavour to do so. I am happy to move the amendment standing in my name on the supplementary notice paper.

Committee Resumed

The DEPUTY CHAIR: Hon Martin Pritchard has moved on page 3, line 18, to delete “abuse;” and insert “abuse or coercion;”. The question is that the words to be inserted be inserted.

Point of Order

Hon AARON STONEHOUSE: Deputy Chair, I am a little confused. The question was not put for the amendment. The amendment was not moved. Hon Martin Pritchard sought your advice in a point of order, which then resulted in the amendment being moved in the point of order, which seems to be perhaps out of order, so I am a little confused.

Hon Alannah MacTiernan: No; he got a response on the point of order and then he subsequently moved it.

Hon AARON STONEHOUSE: The honourable member did not move the amendment after that. If the Deputy Chair clarified the situation, the member should then have moved the amendment and we could then proceed with the amendment if that was the case. Otherwise, we are back considering the substantive clause.

Hon MARTIN PRITCHARD: I was seeking clarification from the Deputy Chair. It was my belief that I had moved the amendment. I sought your clarification, Deputy Chair. My understanding is that you clarified that I had moved the amendment.

The DEPUTY CHAIR (Hon Robin Chapple): The member is correct. If the member would seek to move it again, we could have this formalised. But he did actually move it.

Hon MICHAEL MISCHIN: I am getting rather confused. We now have the sixth iteration of supplementary notice paper 139. We have just got on to clause 4. A raft of amendments are proposed to clause 4. One of them is an amendment that deals with an earlier part of clause 4 than the amendment of Hon Martin Pritchard. I accept that we will get on to that. With respect, it may be that he has jumped the gun. I wonder whether we can deal with the amendments in some order, because it seems to me that some of what Hon Martin Pritchard is proposing would be incorporated in other amendments. I just feel that we are getting a little out of order in an already difficult and confusing bill.

The DEPUTY CHAIR: I thank the member for his point of order. I think the member has expressed a good position. Is Hon Martin Pritchard prepared to allow the other amendments that precede his to be dealt with first?

Hon MARTIN PRITCHARD: Deputy Chair, I am more than happy for that to be the case. My confusion was that nobody stood to speak to the bill or move an amendment, so the clause would have been put without discussion. I am happy to take the view of the Deputy Chair.

Extracted from finalised Hansard
The DEPUTY CHAIR: Members, we now go back to clause 4. There are some amendments to clause 4. The first one of those is in the name of Hon Nick Goiran. Would Hon Nick Goiran like to move his amendment or does he want to talk to the clause first?

Hon NICK GOIRAN: I want to talk on clause 4 first. We will get to the amendments. There is no danger of me not moving the amendments in my name on clause 4. I think it is appropriate to discuss clause 4 as it currently sits before we embark on any amendments. My question to the minister was whether the current version of clause 4 was modelled on the principles section of the legislation of another jurisdiction.

Hon STEPHEN DAWSON: I am very pleased that we were able to get that earlier conversation worked out; I am very happy to answer questions on clause 4.

I am advised that the ministerial expert panel considered Victoria’s recommended principles to government. That is stated on page 15 of the ministerial expert panel’s discussion paper. The principles that are in the bill took into consideration Victoria’s principles and the recommendations of the ministerial expert panel. Although they were taken into consideration, what we have before us in the bill is where we have landed.

Hon NICK GOIRAN: Has the government deviated in any way from what the ministerial expert panel recommended? Just while the minister is getting advice on that, I have a further question. I think the minister referred me to page 15 of the report by the ministerial expert panel.

Hon Stephen Dawson: Sorry, the discussion paper.

Hon NICK GOIRAN: It is the discussion paper.

Hon STEPHEN DAWSON: The answer to the member’s question is yes.

Hon NICK GOIRAN: I understand that to mean that, yes, the government has deviated from what was recommended by the ministerial expert panel. To what extent does what is in the bill differ from what the ministerial expert panel recommended?

Hon STEPHEN DAWSON: I refer to page xi of the final report of the ministerial expert panel, where it states —

The following Guiding Principles should be included in the legislation to help guide interpretation:

The first guiding principle is that every human life has intrinsic value. The bill refers to every human life having equal value. The second guiding principle recommended by the ministerial expert panel is that a person’s autonomy should be respected, whereas the bill states —

a person’s autonomy, including autonomy in respect of end of life choices, should be respected;

The report of the ministerial expert panel further states —

- People have the right to be supported in making informed decisions about their medical treatment, and should be given, in a manner they understand and is culturally appropriate, information about medical treatment options, including comfort and palliative care.

The principle in the bill in front of us reads —

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;

There are some further ones. The ministerial expert panel said —

- People should be encouraged to openly discuss death and dying, and their preferences and values should be encouraged and promoted.

The bill reads —

a person should be encouraged to openly discuss death and dying, and the person’s preferences and values regarding their care, treatment and end of life should be encouraged and promoted;

The ministerial expert panel recommends the guiding principle —

- People are entitled to genuine choices regarding their treatment and care; this should be regardless of their geographic location and take into account their ability as well as individual cultural and linguistic needs.

The bill states —

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;

Extracted from finalised Hansard
The ministerial expert panel report states —

- People should be supported in their right to privacy and confidentiality regarding their choices about treatment and care preferences.

There is not a corresponding principle, but I note the prohibition on the recording, use or disclosure of information in clause 105.

The ministerial expert panel’s recommended guiding principles also include —

- People who may be vulnerable to coercion and abuse in relation to end of life choices and decisions should be protected.

The bill before us states —

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

The final principle of the ministerial expert panel is —

- All people, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

The bill before us states —

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

We can see that there are some differences.

**Hon MICHAEL MISCHIN**: I have a couple of general questions on division 2. Clause 4 sets out a number of principles to govern how a person exercising a power or performing a function under the legislation should behave. However, the bill does not have an objectives clause setting out what it is hoping to achieve and to which those principles can be applied. As a matter of statutory interpretation, it would be of assistance to people to know what it is meant to achieve, rather than having to glean it from the structure of the legislation. The principles need to be applied to some kind of objective. The long title of the bill is not much assistance to us because all it says, in part, is —

- to provide for and regulate access to voluntary assisted dying; and

It does not have, for example, some general statement of objective to provide a compassionate and measured means by which people would be able to choose how their lives ought to be ended in the case of terminal illnesses and the like, which I understood was the objectives of the ministerial expert panel and emerged out of the select committee’s recommendations. Why was it not thought useful and advisable to include an objectives section, as well as a statement of general principles, to which those principles can be applied?

**Hon STEPHEN DAWSON**: I am advised that the government did not feel that it was necessary because the object of the bill is to enable someone to access voluntary assisted dying.

**Hon MICHAEL MISCHIN**: That might be right, but only under certain circumstances—not at large. We are told that this is not suicide or euthanasia, but we do not have a statement of the objectives that the bill is trying to achieve by which we can judge, let us say, actions and how these principles are to be applied to that. When the minister says that the government did not think it was necessary, is he saying that the government turned its mind to it and made a positive decision that it was inadvisable to do so or simply that the government had not thought about it?

**Hon STEPHEN DAWSON**: It was considered, but it was considered unnecessary because it is our belief that the principles are more than adequate. The bill sets out the voluntary assisted dying process, so to have a set of objectives, we believe, may well have been redundant. It was considered, and it was decided not to include them.

**Hon MICHAEL MISCHIN**: I will turn to a couple of the principles and the manner in which they are framed. Clause 4(1)(c) provides —

- 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;

Unless I am wrong, “palliative care” is not defined in the bill.

**Hon STEPHEN DAWSON**: No, it is not.

**Hon MICHAEL MISCHIN**: “Treatment” is not defined in the bill. Are “palliative care” and “treatment” meant to be read conjunctively or disjunctively?

**Hon STEPHEN DAWSON**: I am advised that it is conjunctively.

**Hon MICHAEL MISCHIN**: In terms of the exercise of the functions under the bill, bearing in mind that no clear objective has been stated, a person is declared to have the right to be supported in making informed decisions about their medical treatment and has the right to be given information on medical treatment options—presumably, avenues of potential cure or arresting of a condition generally. Those options are specifically to include comfort
and palliative care and palliative treatment, rather than treatment, for their condition. It is limited only to palliative care and palliative treatment, since they are being read conjunctively. Why is it not “treatment” generally—“comfort”, “treatment” and “palliative care and treatment”?

Hon STEPHEN DAWSON: The member has kind of stumped us a little bit; we are just trying to get to the bottom of what the member has actually asked.

Hon MICHAEL MISCHIN: We have some principles, and one of those principles is stated as being that the person has the right to be provided with certain information about medical treatment and their options. The emphasis is that it includes comfort—presumably comfort in the condition they are suffering—and palliative care. The minister has told us that “palliative care” and “treatment” are to be read conjunctively, and that it is palliative care and palliative treatment. Why not “treatment” as a separate entitlement, so that people can be told how they may be cured rather than how they may be palliated towards their death?

Hon STEPHEN DAWSON: I am not actually sure what the honourable member is getting to, but certainly medical treatment is mentioned numerous times in the principle. Medical treatment is mentioned previously, and palliative care treatment is a different form of treatment, but both are captured in this principle, so I think the member’s concern is probably unfounded.

Hon MICHAEL MISCHIN: All right. Is there a difference between palliative care and palliative treatment? If so, what is it?

Hon STEPHEN DAWSON: We are told there is probably little difference, although I am further advised that palliative treatment is a subset of palliative care.

Hon MICHAEL MISCHIN: I will move on from there to the principle under clause 4(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;

My first question is about “a person approaching the end of life”. We are all approaching the end of life. Is the minister talking about a dying person?

Hon STEPHEN DAWSON: The risk of using “dying” is that people could understand that as somebody being in the last couple of days of their life. That is not the case with this bill; it is longer than that, so the term “end of life” was chosen to use under the principles.

Hon MICHAEL MISCHIN: That is where an objectives clause might have been helpful. It is the Voluntary Assisted Dying Bill 2019, to provide for and regulate access to voluntary assisted dying, and we have the Voluntary Assisted Dying Board, yet we cannot use the term under the principles that govern how a person exercises a power or performs a function. There is also “maximise the person’s quality of life”. Is that meant to be a subjective or objective assessment?

Hon STEPHEN DAWSON: It would, of course, be a subjective thing, given that it is different for every person.

Hon MICHAEL MISCHIN: All right, so maximising a person’s subjective quality of life is meant to be one of the principles governing the exercise of a power or the performance of a function under the legislation. Everyone’s idea of quality of life is different; okay. Paragraph (f) states —

a person should be encouraged to openly discuss death and dying, and the person’s preferences and values regarding their care, treatment and end of life should be encouraged and promoted;

Why not “care, treatment and death”? What is the difference between that and “end of life”?

Hon STEPHEN DAWSON: Death is the culmination of end of life; end of life can be a broader period. Honourable member, this is obviously an issue of semantics. If the member has issues with the words that have been used in the principles, it is of course open to him to move amendments. But, certainly, this issue has been considered by government and the words that are before us now have been landed on because we think they encapsulate what we are trying to achieve through this bill. We could probably have a great deal of toing and froing this afternoon in relation to what the member’s belief is, or what he thinks would be better words to use, but these are the words we have landed on, so I am not sure that either of us would get too much joy. Perhaps the member might get some joy out of that process, but if he has the view that other words should have been used, perhaps he might want to consider amending the words before us.

Hon MICHAEL MISCHIN: I do not get any joy out of the process. I am not doing this for my amusement. I have other things I could be doing that would give me far more pleasure and would be far more enlightening. I have a problem with the bill—I have already said so—and I have a problem with the process by which it was crafted. I am trying to understand whether the government has given some thought to these things, because this is pretty important stuff. It is not a question of word games. After all, we have reframed the definition of suicide to suit the government and we have reframed the definition of euthanasia to suit the government. We talk about openly discussing death and dying, but then say that the person’s preferences and values regarding their care, treatment and end of life should be encouraged and promoted. Is the government saying the way in which people end their

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lives should be encouraged and promoted? We need to remember that these are principles that someone is supposed to have regard to in the exercise of their functions under the legislation. Medical practitioners will have to have regard to these things, and their own ethics in dealing with their patients, so some level of precision is necessary. Are we saying “regarding their care, treatment and how they end their life should be encouraged and promoted”? Is that what the government really means by that?

Hon STEPHEN DAWSON: This really is an issue of semantics. I can assure the honourable member that the government has given the words in these principles due consideration. I remind the member of the information I provided to Hon Nick Goiran in response to his question about the differences between the principles that are before us in the bill and those that were in the Ministerial Expert Panel on Voluntary Assisted Dying’s final report. Words were provided by the ministerial expert panel and different words have been landed on.

Sitting suspended from 1.00 to 2.00 pm

The DEPUTY CHAIR (Hon Martin Aldridge): Members, we are dealing with the Voluntary Assisted Dying Bill 2019 in Committee of the Whole House and we are on clause 4. I draw to members’ attention the latest supplementary notice paper 139, issue 6, dated Thursday, 31 October 2019.

Hon NICK GOIRAN: I noticed a couple of well-crafted amendments by Hon Martin Aldridge appear on issue 6 of the supplementary notice paper.

With regard to clause 4, the explanatory memorandum states —

The principles will serve as a guide in interpreting and applying the Bill but do not create any new obligations.

For which interpreters is it intended to be a guide?

Hon STEPHEN DAWSON: I am advised that that refers to anybody reading the bill.

Hon NICK GOIRAN: For which appliers is it intended to be a guide?

Hon STEPHEN DAWSON: That refers to people who have a role under the bill.

Hon NICK GOIRAN: Who has a role under the bill and will be then guided by these principles?

Hon STEPHEN DAWSON: I am advised that it is registered health practitioners, the State Administrative Tribunal, the Voluntary Assisted Dying Board or anyone who has a role subsequent to the bill or arising from processes coming out of the bill.

Hon NICK GOIRAN: I understand the registered health practitioners, the State Administrative Tribunal and the Voluntary Assisted Dying Board, but who are these people to whom the minister referred who will have a role after the bill?

Hon STEPHEN DAWSON: Although this is not an exhaustive list, honourable member, it would include healthcare workers, staff assisting the board and people helping the patient, including the contact person, family and public servants.

Hon NICK GOIRAN: Is there an exhaustive list of people who will be expected to use these principles as a guide as they apply the bill?

Hon STEPHEN DAWSON: No, there is not an exhaustive list.

Hon NICK GOIRAN: The minister mentioned earlier that the Victorian legislation also has a principles provision. Who in Victoria uses those principles to apply the bill there? One would like to think that they would probably be similar people to those in Western Australia. The minister mentioned registered health practitioners; the State Administrative Tribunal, of which there would be an equivalent in Victoria; and the VAD board, of which there is obviously an equivalent there. Which individuals, agencies or groups in Victoria apply the principles there?

Hon STEPHEN DAWSON: I am told that the Victorian act is written in the same way, so I imagine it is the same people, honourable member. That is certainly my understanding, but we are straying now into the Victorian principles, and obviously the Victorian principles are not those under consideration today; in fact, it is the principles in this bill in front of us. I do not have exhaustive information about the Victorian bill, if that is the path the honourable member was going down. Certainly, our explanatory memorandum does set out Western Australia’s intent.

Hon NICK GOIRAN: What remedy is available in the event that a person exercising a power or performing a function under this legislation does so without having regard to the principles in clause 4?

Hon STEPHEN DAWSON: I am advised that the principles are guiding tools by which the provisions of the legislation are considered. They are not binding, but set the proper pathway for how the other provisions are applied.

Hon NICK GOIRAN: Does that mean that no remedy is available?

Hon STEPHEN DAWSON: I am advised that there is no remedy in relation to the breaching of the principles; they are something that we have regard to. They would likely aid interpretation in legal proceedings in a court or the State Administrative Tribunal, for example.

Hon NICK GOIRAN: If a person is able to exercise a power or perform a function under this legislation without having regard to the principles, knowing that no remedy is available, what is the point of them?
Hon STEPHEN DAWSON: The principles make clear that the intent of the bill is to respect individuals, their autonomy, decisions and beliefs, rather than imposing one person’s values onto another or questioning the value of a person’s life. Voluntary assisted dying is about recognising an inevitable death and giving people genuine choice about the timing and manner of their death. It is not about questioning or comparing the value of an individual’s life. The principles also recognise the importance of providing people with all the potential options and information at the end of their life to enable them to make informed decisions and a genuine choice. The principles will serve as a guide in interpreting and applying the bill, but they do not create any new obligations.

Hon NICK GOIRAN: Clause 4(2) refers to —

… the Tribunal exercising its review jurisdiction in relation to a decision made under this Act.

What decisions made under this legislation will be able to be reviewed by the tribunal?

Hon STEPHEN DAWSON: The issues that can be determined or can go before the tribunal will include decision-making capacity, residence in Western Australia and whether somebody is acting voluntarily and without coercion.

Hon NICK GOIRAN: Does the requirement under clause 4(1) for a person exercising a power or performing a function under this act to have regard to the principles listed in paragraphs (a) to (j) also apply to a person hearing any appeal from a decision made by the tribunal?

Hon STEPHEN DAWSON: I am advised that the court or the State Administrative Tribunal must have regard to the principles of the act in a judicial or administrative review of an administrative decision under the act.

Hon NICK GOIRAN: This time, the minister used the word “must”—that the court or SAT must have regard to that. I note that clause 4(2) states —

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

There is no mention of the court; it refers only to “the Tribunal”, which I take to be the State Administrative Tribunal. On what basis does the minister now include the court in that, and why would the court then have to have regard to that, in circumstances in which the minister previously indicated there are no obligations?

Hon STEPHEN DAWSON: I am advised that when the court is determining a matter under its jurisdiction regarding legislation, the court must have regard to the act in its entirety, including any principles in the legislation. That is standard judicial interpretation. Is that what the member was asking? Yes.

Hon NICK GOIRAN: Would it be possible for a person to appeal a decision from the tribunal on the basis that the tribunal has not had regard to the principles?

Hon STEPHEN DAWSON: A decision to appeal to the Supreme Court may in some circumstances be an appeal on a question of law, and in other circumstances may be on a question of law and fact. In this case, it seems that the honourable member is asking about a question of law. There is a right of appeal to the Court of Appeal under section 105 of the State Administrative Tribunal Act.

Hon NICK GOIRAN: I want to be clear. The minister has told the chamber that a person can appeal from the Supreme Court, on the basis that the tribunal did not have regard for the principles set out in clause 4, which the minister indicated it must have regard for.

Hon STEPHEN DAWSON: My advice is yes; they can make an appeal.

Hon NICK GOIRAN: If that is the case, these principles all of a sudden start to take on a whole new meaning and significance. It was a little unfair earlier, before the adjournment, when the minister suggested to the shadow Attorney General that he was playing semantics with the words. We now realise that this could come before the Supreme Court, and the Supreme Court could decide whether an appeal will be upheld, solely on the basis of whether the tribunal had had regard to these principles. Therefore, it sounds to me as though these principles have now risen to a quite high standard. Not only will the tribunal have to have regard for these principles, but also, in fact, the Supreme Court will have to have regard for them. I have no difficulty with that. I am not criticising that. I am just making sure that we are all aware of the significance of the principles, which were almost suggested beforehand to have limited significance, because in fact there was a suggestion from the minister that there would be no remedy. I asked whether there would be a remedy, and eventually the answer was no, there would not be a remedy.
Actually, of course there would be a remedy, because a person can make an application to the tribunal, and, on top of that, they can appeal to the Supreme Court. Those are pretty significant avenues for a person in the event that they think that the tribunal has not performed its power or function having regard to the principles.

The minister mentioned that the State Administrative Tribunal could make a number of decisions. I am going to refer to them as “categories” of decision. I understood the minister to refer to three categories—again, my words—of decision. The first is about decision-making capacity, the second is about residency in Western Australia and the third is about whether things are done on a voluntary or coerced basis. To what extent would the principles be applicable to a decision by the tribunal about a person’s residency in Western Australia?

Hon STEPHEN DAWSON: First of all, I make the point that every clause in this bill is significant, not just clause 4. Every clause in the bill has been put in due to its significance and due to our view that it needs to be in the bill.

In relation to the question of “ordinarily resident”, clause 15(1)(b) provides that the person must meet the following requirements —

the person —

(i) is an Australian citizen or permanent resident; and
(ii) at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;

The member is asking, I think, how SAT would make a decision on this issue. SAT would make a decision on this issue taking into consideration the principles. Clause 4(1)(h) provides —

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 …

It says “regardless of where the person lives in Western Australia”. We are identifying that the person needs to live in Western Australia. Clause 15(1)(b) of the bill also refers to the need for residency in Western Australia.

I am told that the broad principles will apply in any proceedings. SAT, whilst holding its hearings, must demonstrate a respect for the person—for example, the principle that there is a need to protect persons who may be subject to abuse. Clause 4(1)(j) is also useful in that regard.

Hon NICK GOIRAN: Minister, when an application is before SAT to determine whether the person meets the residency requirements, it is not clear that any of these principles would assist SAT in any way. SAT must have regard to these principles. I will give the minister a practical example. Clause 4(1)(a) provides —

every human life has equal value;

When SAT makes a decision about whether a person is resident in Western Australia, that principle is of no relevance to that decision. The reason I am asking this particular line of questions is that it seems to me that of the different categories of decision that SAT can make, some of the principles would have some bearing or some weight or provide some assistance to SAT, and others would be immaterial because they are simple matters of fact. That is what I am seeking to clarify.

Hon STEPHEN DAWSON: SAT must have regard to the principles. But it is not a case of SAT needing to tick off on each of the principles.

Hon NICK GOIRAN: I agree, minister. The context is that the minister has indicated that it is possible for a person to appeal to the Supreme Court if SAT has not had regard to the principles. The minister indicated that SAT must have regard to the principles. I am trying to establish what type of application a person will be able to take to the Supreme Court on the basis that SAT has not had regard to the principles.

It seems to me to be an absurd outcome if somebody can appeal to the Supreme Court on a residency application—a decision about whether the person is ordinarily resident in Western Australia—because SAT did not have regard to the principle at clause 4(1)(a). It would be intolerable if that were the case. If I assume for a moment that we are of one mind on that—that that would not be an intended outcome—what type of applications would be before SAT that then would become appealable to the Supreme Court, and the person would have a right to do so because SAT did not have regard to the principles? If it is not the residency in WA type of application, is it because of the voluntary or coercive nature of the decision? Is it the decision-making capacity? What categories of applications would go before SAT in which these principles would be so crucial that a person could appeal to the Supreme Court?

Hon STEPHEN DAWSON: My apologies; we were getting advice from all over the place, honourable member, but I want to make sure that we give an appropriate answer. I draw the member’s attention to the fact that he has said “Supreme Court” numerous times; it is the Court of Appeal in particular. I just wanted to bring that to his attention.

The member posed a hypothetical question about principles. The response related to judicial interpretation and the right of appeal. It may be the case that a person comes before the tribunal and is treated with disrespect and disregard for their autonomy. The person may be aggrieved and institute appeal proceedings on the basis that they were not treated by the tribunal with proper regard under the relevant principles. It may be the case that a person

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required additional support during the proceedings and this was denied to them by the tribunal. If aggrieved, they could institute an appeal on the basis that the tribunal failed to have regard to the principle at clause 4(1)(c), for example. SAT has regard to the principles generally in performing its review functions, and specifically when a principle is relevant to a decision being reviewed; for example, the need to protect persons who may be subject to abuse when considering whether a person is acting voluntarily or without coercion.

**Hon NICK GOIRAN:** I will move on to a different topic, but I will make the observation that none of that explains how the principles would be used as a mechanism to appeal to the Court of Appeal on an application dealing with the factual issue of residency. A person has to demonstrate residency in Western Australia—that seems to me to be a matter of fact. Whether one of the principles has or has not been considered by the tribunal, I do not think should be a basis upon which somebody would be able to launch an appeal to the Court of Appeal; that is not apparent to me. Nevertheless, given the nature of these appeals that the minister indicates can be launched to the Court of Appeal, would it be possible for the State Administrative Tribunal, having regard to the principles in clauses 4(1)(d) or (h), to order that palliative care must be provided to a patient living in the Kimberley, for example, before a voluntary assisted dying request can proceed?

**Hon STEPHEN DAWSON:** My advisers tell me no.

**Hon NICK GOIRAN:** Minister, if we have a look at the principle in clause 4(1)(h), it states —

- 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;

If that is a principle that we are saying the tribunal must have regard for, why can it not order that palliative care be provided to that patient living in the Kimberley before a voluntary assisted dying request can proceed, if that is the patient’s choice?

**Hon STEPHEN DAWSON:** I do not think that example would happen, honourable member, because if the patient wanted palliative care but did not want to access voluntary assisted dying, they would not be before the tribunal in the first place.

**Hon NICK GOIRAN:** Could a person want to make a request for voluntary assisted dying and make an application for that—I understand that there is also the possibility of self-administration under this bill, so they could even have the substance in their own home in the Kimberley—because they want to make sure that they are doing all that in the context of the principle in clause 4(1)(h), which is that they have genuine choices, and they may say, “Before I take this final substance, I want to have access to palliative care”? Would it not be possible for the tribunal to order that to happen?

**Hon STEPHEN DAWSON:** No. The tribunal’s jurisdiction is established in proposed section 83 and it is limited to three things.

**Hon NICK GOIRAN:** If every Western Australian is to have equal access to voluntary assisted dying but not every Western Australian hasequal access to palliative care, does it not mean that the principle in clause 4(1)(h) is not being followed in practice?

**Hon STEPHEN DAWSON:** With the greatest of respect, honourable member, this issue was canvassed previously in the debate, so I do not think it is appropriate that we go over it again.

**Hon NICK GOIRAN:** Minister, I note in the debate in the other place that the Leader of the Opposition, the member for Scarborough, had concerns about the use of the term “genuine choices”. What is meant by the phrase “genuine choices” as found in clause 4(1)(h)?

**Hon STEPHEN DAWSON:** This refers to people having a genuine choice about the type of treatment that they would like to access. Quite simply, they should be able to choose whether they want to have such things as palliative care or other treatments at the end of their life, and that is a choice that they can make themselves.

**Hon NICK GOIRAN:** If the tribunal has an application before it and it has to have regard to the principles, is it open to the tribunal to say that a person does not currently have a genuine choice in regional Western Australia, because to have a genuine choice, they would need to have access to palliative care, and because they do not have access to palliative care, they do not have a genuine choice, and so the application cannot proceed. Would that be open to the tribunal, given that it has to have regard to the principles?

**Hon STEPHEN DAWSON:** Again, I draw the honourable member’s attention to proposed section 83 of the bill and the limited jurisdiction that the tribunal has. The genuine choice is that a person can choose to access palliative care or voluntary assisted dying or, indeed, both. This is not about the provision of the services. In regional Western Australia, palliative care is available and will become more available through the significant investment that the government has made over the past year, which we have spoken about previously, and it will continue to be rolled out over the next few years.

**Hon NICK GOIRAN:** One of the applications that the minister has drawn to our attention that can be made to the tribunal is whether the person is acting voluntarily and without coercion. Would it be open to the tribunal to determine that a person is not acting voluntarily because they do not have a genuine choice in regional Western Australia because they do not have access to palliative care?

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Hon STEPHEN DAWSON: I think we have a difference of opinion here, honourable member. People do have access to palliative care in regional Western Australia, and, in some cases, that access may be over the phone and it may involve visits, whether it is monthly or regularly. Therefore, I would contend that people in regional Western Australia have access to palliative care already and that access will become more accessible—if I can use that word—as the rollout of the extra investment in palliative care made by this government continues.

The DEPUTY CHAIR: Members, before I give the call to Hon Nick Goiran, I am receiving indications from members in the chamber that they are having difficulty hearing the debate, so if there are unnecessary conversations that can be taken outside the chamber, that would be appreciated.

Hon NICK GOIRAN: I am not sure whether that is true, because earlier in the debate we identified that the government is prepared to guarantee that up to eight people will be flown to regional Western Australia for the voluntary assisted dying process. The minister might recall that when I asked whether the government would guarantee that a specialist would go out with an interpreter, he indicated that he could not guarantee that. There is no criticism from me at this point; I am just refreshing our memory on the sequence of events.

When the minister said that Western Australians living in regional areas have access to palliative care, yes, some Western Australians in regional areas do, but I am talking about a situation in which a person in regional Western Australia is before the board and the board says, “Look, this person doesn’t have a genuine choice because the government has said that it will fly out only the eight-person team; it will not fly out the two-person team.” Is it within the power of the tribunal to say, “This person is not acting voluntarily, and the basis upon which we make a decision is the principles that are set out in clause 4”?

Hon STEPHEN DAWSON: SAT will consider whether someone is acting of their own volition and not whether health service options are available.

Hon NICK GOIRAN: The availability of health services is not part of the consideration of whether a person is exercising or has access to genuine choices about their care treatment and end of life?

Hon STEPHEN DAWSON: I think the honourable member is confusing the principles with the review jurisdiction of SAT. I think he is conflating two issues.

Hon NICK GOIRAN: If I am, it is because the minister indicated that SAT must have regard to the principles. The minister said that the review jurisdiction of the tribunal, which is SAT, must have regard to the principles, so clearly they should be conflated. The bill conflates them. The minister indicated that they must be conflated.

Hon STEPHEN DAWSON: Again, I would say that SAT will consider whether someone is acting of their own volition. It will not consider whether health services are available where someone is located.

Hon NICK GOIRAN: The principle set out in clause 4(1)(b) states —

a person’s autonomy, including autonomy in respect of end of life choices, should be respected;

If a person expresses their end-of-life choices by way of an advance health directive, should they be respected?

Hon STEPHEN DAWSON: Obviously, advance health directives do not appear in the bill before us.

Hon NICK GOIRAN: I know that. That is not the question. The minister wants everybody who is performing a power or a function under this act to have regard to these principles. One of the principles is a person’s autonomy, including autonomy in respect of end-of-life choices and the decision that this should be respected. If a person expresses their end-of-life choice by way of an advance health directive, should it be respected?

Hon STEPHEN DAWSON: It should be respected, but it does not mean that it will be a legally available option with voluntary assisted dying.

Hon NICK GOIRAN: Are there other ways in which the bill before us constrains a person’s individual autonomy?

Hon STEPHEN DAWSON: As with other legislation, the bill creates obligations, but it seeks to balance individual choice with respecting the needs of a patient.

Hon NICK GOIRAN: Yes, minister, but there are 184 clauses in the bill before us and we are on clause 4. I am interested to know which clauses in this bill constrain a person’s autonomy. At the moment, clause 4 indicates that autonomy is a very important principle to be respected; in fact, it specifically says that a person’s autonomy, including autonomy in respect of end-of-life choices, should be respected. The minister has already indicated that if somebody wants to record their choice in an advance health directive, that process of autonomy should be respected but it will not be legal; in other words, our law will disrespect that regard. I want to know in what other ways this bill constrains a person’s autonomy. I am trying to make sure that the bill is consistent with the principle set out in it.

Hon STEPHEN DAWSON: Just because a law is contrary to someone’s belief, it does not mean that they are disrespected.

Hon Dr SALLY TALBOT: Mr Deputy Chair, I make not a point of order, but I will make a few comments and draw your attention to something that happened yesterday. Hon Nick Goiran has asked more than 30 questions

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about the principles in clause 4, and he is quite entitled to do that, but the minister has responded more than 30 times in a way that makes it crystal clear that the minister and the government have a very clear idea about how these principles are supposed to operate. It is completely clear. I would be amazed if it was not completely clear to anybody in this chamber that the set of principles clearly relates to legal options that are available to governments, tribunals and individuals. That is perfectly obvious and that is what the minister has affirmed now more than 30 times in his responses to Hon Nick Goiran. Yesterday, the Chair of Committees introduced us to what, for me, is a slightly nuanced concept of a point of order. He signalled that he was aware of an approaching point of order. I ask you, Mr Deputy Chair, whether you are also aware of an approaching point of order about relevance and repetition.

The DEPUTY CHAIR (Hon Martin Aldridge): Hon Dr Sally Talbot, no point of order has been made and the Chair does not have the discretion to make comments otherwise from the chair, but I will let you know when I feel that the debate is becoming repetitious. Thank you for your point.

Hon NICK GOIRAN: I expect nothing less from Hon Dr Sally Talbot, having served with the part-time member for a year on the Joint Select Committee on End of Life Choices. I thought it would have been pretty obvious to those following the debate that what the minister indicated earlier was that the ministerial expert panel provided certain recommendations about principles and the government decided to deviate from those principles. I thought it would be obvious to the pretty experienced member that it is okay for members to ascertain the extent to which there has been deviation from the ministerial expert panel’s recommendation in the bill before us, considering that taxpayers have paid half a million dollars for the work of the ministerial expert panel. Hon Dr Sally Talbot might forgive me if I have a few more questions about the principles, which, I remind the member, we have just learnt will be a reason for appeal to the Court of Appeal if the tribunal does not have regard to the principles set out in the bill. I ask the member to follow the debate more closely rather than make pointless contributions.

I would like to consider another one of the principles before us. In particular, I would like to turn to the matter that deals with coercion, duress and the like. There is an amendment standing in my name. I take it, Mr Deputy Chair, that it is not necessary for us to move the amendments precisely in the order they appear on the supplementary notice paper. The next amendment on the supplementary notice paper is amendment 52/4, which I intend to move, but given the discussion we have been having with the minister, it seems to me that it might be better if I move amendment 55/4 standing in my name. I want to check with you that that can be done and that, irrespective of the outcome of that, we can go back to other amendments that are listed under clause 4.

The DEPUTY CHAIR: Members, Hon Nick Goiran has signalled his intention to move amendment 55/4 on the supplementary notice paper. The advice I have received—this is probably going to come up again during the debate—is that ordinarily on each clause, we would move chronologically through the amendments listed on the supplementary notice paper, or at least invite those members with amendments standing in their name to move that amendment as we move through the supplementary notice paper from top to bottom. The other option is that I seek the agreement of the chamber, through no objection, for us to move to a different amendment other than the first amendment standing under clause 4.

Hon MARTIN PRITCHARD: If it may assist, I have a very similar amendment to the same part of the bill and I have no concern. It seems to me that if the honourable member’s amendment is accepted, it will make mine redundant. I have no concern with that particular amendment being dealt with before mine, if that assists the chamber.

Hon NICK GOIRAN: Further to this, I am happy to move that amendment, but I do not want to move that amendment and then be precluded from moving amendment 52/4, which is the first one listed on the supplementary notice paper under clause 4. If, by custom and practice or under standing orders, that amendment has to be moved first, I am happy to do that, but it seems that it would be better to move amendment 55/4 at this point in the debate.

The DEPUTY CHAIR: Hon Nick Goiran, you will not be precluded from moving that amendment later, but if you wish to move amendment 55/4 now, I will seek a decision from the chamber by asking whether there is any objection; and, if there is no objection, we will proceed with that question. The question now is that clause 4 stand as printed.

Hon STEPHEN DAWSON: I am not trying to be unhelpful, but I think it would make the debate a little more chaotic if we did not deal with the amendments in the order that they are listed on the supplementary notice paper. I think everybody, including Hon Nick Goiran, would agree with me that this is a complex piece of legislation. The easier we allow the debate to flow, the better it will be for us all so that we can follow what is going on. It is certainly my preference that the amendments be dealt with in the order that they appear on the supplementary notice paper as opposed to going back and forth.

Hon ALANNAH MacTIERNAN: I support the minister in that comment and note that this issue came up earlier when Hon Martin Pritchard sought to move his amendment. It was considered that because Hon Nick Goiran had several amendments on the supplementary notice paper, it would not be appropriate to deal with that amendment. As the minister has said, this is going to be immensely complex for people to manage. I think that we should stick with the principle that we deal with these amendments in order.

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Hon NICK GOIRAN: I am very relaxed about that. I am very happy to move the amendment standing in my name at 52/4. I move —

Page 2, line 28 to page 3, line 1 — To delete “treatment, including palliative care and treatment,” and substitute —

treatment (including palliative care and treatment, psycho-oncology treatment and consultation-liaison psychiatric treatment)

By way of explanation, we are dealing with clause 4(1)(d), which reads —

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 imagine that all members would agree to that principle. I seek to try to improve that principle ever so slightly. The amendment I propose looks to add to clause 4 (1)(d) so that it would read —

a person approaching the end of life should be provided with high quality care and treatment (including palliative care and treatment, psycho-oncology treatment and consultation-liaison psychiatric treatment) to minimise the person’s suffering and maximise the person’s quality of life;

The Department of Health’s WA Cancer and Palliative Care Network 2008 “Psycho-Oncology Model of Care” states —

Psycho-Oncology is concerned with the psychological, social, behavioural, and ethical aspects of cancer. This sub-speciality addresses the two major psychological dimensions of cancer: the psychological responses of patients to cancer at all stages of the disease (and that of their families and caretakers); and the psychological, behavioural and social factors that may influence the disease process.

Consultation-liaison psychiatric is a little-known sub-specialty of psychiatry that deals with mental illness associated with general illness in a hospital setting. Consultation-liaison psychiatrists act as consultants called in to help manage patients on the general medical or surgical wards who have psychological or mental health problems associated with medical ones. Members may be interested to look at the article “Doctors of Mind and Body” published in the Medical Journal of Australia of December 2010.

The transcript of evidence of Dr Lisa Miller, who is a consultant-liaison psychiatrist, to the Joint Select Committee on End of Life Choices reads —

General data around liaison psychiatry would suggest that around 40 per cent of people in a general hospital setting may be experiencing some degree of significant mental health comorbidity along with their physical health morbidity.

That evidence was given at one of the many hearings I attended. In fact, I was the only member of the committee who attended all the meetings and hearings. That hearing took place on 13 December 2017.

We know from overseas experience that undiagnosed depression remains an issue amongst those who request and are offered voluntary assisted dying, including patients in Oregon. I refer members to the 2019 article on that point by Peisah, Sheehan and White.

An article from 2017 illustrates the impact of the failure to identify psychiatric comorbidity in terminal patients. The author, Professor Greg Crawford, states —

One of the motivators was that I looked after a 15-year-old girl who had a malignancy who looked like she was dying. I was working as the clinical head of palliative care at a hospital in Adelaide, and she was referred to us on the basis that she only had weeks to live. She had difficult pain to manage and other symptoms that led to her becoming more and more withdrawn.

I was slow to recognise that she was depressed and I found it hard to find advice and support about to manage it.

I looked in the literature and talked to psychiatrists and other colleagues. I ended up changing her antidepressants and she made a miraculous improvement, both physically and psychologically. She improved and lived for another 12 months. She had serious, progressive disease but her physical function and her ability to interact and live improved. She went off on a holiday, achieved some other things on her wish list and made lots of other nice memories for her family.

She died at home, supported by our palliative care service and her GP, and we had support from the paediatric palliative care service.

It showed me that sometimes the symptoms of impending death and the symptoms of advanced depression can look very much the same. I felt a bit like I had failed, having taken so long to recognise her depression and then act on it, which made me determined to learn more about depression in this context. It drove me to try and understand more about psychological illness.
There has been a large amount of research in this area, but it is still very difficult to really determine what is a normal reaction to what is happening, like sadness, and what is an abnormal reaction, like a major depressive illness.

Professor Greg Crawford goes on to say —

The implications of not diagnosing are that patients have increasing suffering and may not be getting the best treatment. They may be losing an opportunity to have more time or meaningful interaction with people around them. For their families, this can be a very large trauma; to not understand why somebody has turned their back on them or why they might be rejecting relationships, being overwhelmingly sad, or wanting to die precipitously. When triggered by depression, those responses can be quite challenging.

After me reading that the implications of not diagnosing psychiatric comorbidities are that patients have increased suffering and may not be getting the best treatment, I would hope all members would support my amendment to clause 4(1)(d). At its core, the intention of the amendment is to ensure that all Western Australians approaching end of life are getting the best treatment, and their suffering is minimised and their quality of life is maximised. I believe that this amendment to clause 4 recognises the link between physical and mental comorbidities in patients and strengthens the principle in clause 4(1)(d) by explicitly recognising the best care that can be offered to patients approaching the end of life to minimise that person’s suffering and maximise their quality of life.

Hon STEPHEN DAWSON: I indicate that we do not accept the honourable member’s amendment. We cannot accept the additional words after “treatment”. The honourable member is attempting to insert subspecialties that are ordinarily not required for the vast majority of people at end of life. In fact, the term “treatment” already includes the subspecialties of psycho-oncology and consultant-liaison psychiatric treatment, and it is therefore unnecessary to include the proposed words. The honourable member is requiring these persons, who under the legislation must have regard to the principles, to have regard to treatment involving practitioners who are not commonly available and, in any event, whose care is rarely appropriate for most people who are dying.

Hon NICK GOIRAN: I want to make one observation. If the government’s view is that psycho-oncology treatment and consultation-liaison psychiatric treatment are a subset of palliative care and treatment, what is its objection to including it? I would remind members, as the co-chair of the Parliamentary Friends of Palliative Care, we had a briefing from Dr Lisa Miller and we have had many briefings from specialists in palliative care, recognising that this is a very important area that remains under-resourced in Western Australia. If we are setting principles and aspirations to agree to, it seems to me that there is no difficulty in including these subsets that the minister indicates are part of palliative care and treatment anyway. It certainly does not undermine the bill in any way; all it does is enhance and strengthen the existing clause.

Hon COLIN HOLT: If we accept the amendment put by Hon Nick Goiran and go to a subset as described in the amendment, and, as an example, a person who is suffering from motor neurone disease at the end of their life applies for the scheme under the bill, is there a risk that that person will fall outside the scope of the principles of the bill?

Hon STEPHEN DAWSON: It will not legally narrow it, but it will focus on narrow subcategories that do not necessarily reflect those who wish to access voluntary assisted dying. Palliative care or treatment is wider terminology that is more commonly applicable to those at the end of their life.

Progress reported and leave granted to sit again at a later stage of the sitting, on motion by Hon Stephen Dawson (Minister for Environment).

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Division

Amendment put and a division taken, the Chair (Hon Simon O’Brien) casting his vote with the ayes, with the following result —

Ayes (10)

Hon Peter Collier
Hon Donna Faragher
Hon Nick Goiran
Hon Rick Mazza
Hon Charles Smith
Hon Aaron Stonehouse
Hon Colin Tincknell
(Teller)

Noes (23)

Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Tim Clifford
Hon Alanna Clohesy
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Adele Farina
Hon Alannah MacTiernan
Hon Martin Pritchard
Hon Samantha Rowe
Hon Luke Hartsuyker
Hon Matthew Swinbourn
Hon Kyle McGinn
Hon Martin Boydell
Hon Dr Sally Talbot
Hon Kyle McGinn
Hon Darren West
Hon Alison Xamon
Hon Vic Frazer
Hon Robin Scott
Hon Linda Reynolds
Hon Adele Farina
Hon Samantha Rowe
Hon Robin Scott
Hon Pierre Yang (Teller)

Amendment thus negatived.

Hon NICK GOIRAN: I move —

Page 3, line 4 — To insert after “person’s” —

registered

By way of explanation, this amendment to include the term “registered” in clause 4(1)(e) addresses a drafting error in the bill. This amendment will bring clause 4(1)(e) in line with clause 5, in which the term “registered health practitioner” is used. It may be worth noting, members, that the term “health practitioner” is not defined in the bill. This amendment will make it clear for those persons exercising a power or performing a function under the bill that a therapeutic relationship between the individual and their registered health practitioner should be maintained and supported.

Hon STEPHEN DAWSON: I indicate that we do not accept and will not support Hon Nick Goiran’s amendment to insert the word “registered”. Healthcare workers such as Aboriginal health workers, speech pathologists, social workers and dieticians also have therapeutic relationships with patients, and they are not registered. Specialist palliative care teams often include social workers, with Aboriginal health workers increasingly being included in healthcare teams in Western Australia. We are not in a position to support the amendment that Hon Nick Goiran has moved.

Hon MICHAEL MISCHIN: What does that have to do with health practitioners, which is where the amendment is focused? As I understand it, the proposed amendment, which is at page 3, line 4, seeks to amend clause 4(1)(e), which states —

a therapeutic relationship between a person and the person’s health practitioner should, wherever possible, be supported and maintained;

What does that have to do with health workers, support people and the like? Are we talking about a doctor as a health practitioner or is it something broader that has not been explained to us?

Hon STEPHEN DAWSON: It includes doctors, but a health practitioner could also include an Aboriginal health worker and other positions, such as a speech pathologist, which I have also mentioned, but they are not registered. Hon Nick Goiran has moved an amendment to insert the word “registered”. If that was included in the bill, it would exclude some healthcare workers, and we do not support that.

Hon ALISON XAMON: I have some sympathy for the policy intent behind why the honourable member may have moved this amendment. As I understand it, the honourable member is trying to ensure that people who hold themselves out to be health practitioners are indeed health practitioners and not merely people claiming that title. My concern is that we have to think about this legislation within the parameters of our health system. The reality is that despite the urging of a number of health practitioner groups, we do not have registration schemes for a range of recognised health practitioners within the health system. As such, it is very difficult to support this amendment simply because our health regime does not support what I think would be the policy intent behind what the honourable member is trying to achieve, which, as I said, I have significant sympathy for. It is important for members to be aware that because we have not kept pace with those registration schemes, this amendment could have the unintended consequence of excluding important health relationships that a patient may already have.

Hon NICK GOIRAN: The question I have for the minister is: why does the bill not define “health practitioner”, but it does define “registered health practitioner”?

The CHAIR: Members, noting the time, and at this cliffhanger moment, I must report progress.

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

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Committee

Clause 4: Principles —

Progress was reported on the following amendment moved by Hon Nick Goiran —

Page 3, line 4 — To insert after “person’s” — registered

Hon NICK GOIRAN: When we last sat, we were considering an amendment to clause 4. Specifically, we were looking at the principle set out in clause 4(1)(e), which is the fifth principle that the government has indicated should guide the legislation that is before us. On the last occasion we learnt that, according to the government, these principles are very important because anybody who has a power or a function under this act will be mandated to give consideration to these principles. It was revealed during the last debate that that could include an appeal being lodged to the Court of Appeal on the basis that the State Administrative Tribunal or any other person might not have given adequate consideration to the principles before us. We are considering the fifth of these principles at the moment. To refresh the memory of members, the amendment before the chamber relates to the insertion of the word “registered” prior to the words “health practitioner”. I moved that amendment because in every other instance in this bill, the government refers to a “registered health practitioner”. Clause 4 is the only instance in this bill where we suddenly see the words “health practitioner”. I understood that this was a simple drafting error, so it should be easy to facilitate this amendment and insert the word “registered”.

The last time we sat, the minister gave an explanation on behalf of the government. The government indicated that it would not be supporting the amendment. Part of the reason given in the explanation provided by the minister was that it was deliberate on the part of the government—that this should be a wider group of individuals than just registered health practitioners. For that reason, it purposely did not include the word “registered” prior to “health practitioners”. We were just starting to get to the bottom of that before we adjourned at the end of the sitting. I indicate that when we last sat, I had some sympathy for the position that the minister was putting. The government was seeking to capture a larger group of individuals than registered health practitioners. My concern is that the types of individuals whom he listed on the last occasion would not be captured by the term “health practitioner”. Has any consideration been given by the government since we last sat to an alternative form of words? I would even be amenable to seeking leave to withdraw my amendment and not have the words “registered health practitioner” if I could be satisfied that we were incorporating a different form of words that met the government’s intention. Has any consideration been given to that?

Hon STEPHEN DAWSON: Further consideration has been given, but the point that I made the last time we sat remains the same; that is, we are not in a position to support the member’s amendment.

Hon NICK GOIRAN: In the absence of a definition of the term “health practitioner” in this bill and because the term “registered health practitioner” is defined in the bill, how will it be interpreted?

Hon STEPHEN DAWSON: I am told that “health practitioner” is a commonly used term that those engaged in health professions are familiar with. Further to the point about the member’s amendment, I am also told that it is unnecessary to define “health practitioner” in the bill as, unlike registered health practitioners, who have a defined role under the bill, such as in clauses 25(2) and 36(2), health practitioners do not.

Hon NICK GOIRAN: Is the term “health practitioner” defined in any other Western Australian statute?

Hon STEPHEN DAWSON: No, not to my knowledge. My advisers tell me no.

Hon NICK GOIRAN: In the absence of a definition in this bill and, according to the minister and the advice he is obtaining, in any other Western Australian legislation, from what will the courts seek guidance when they interpret the term “health practitioner”, which he has indicated is a fundamental aspect of this bill? The principles need to be considered by the Court of Appeal, the State Administrative Tribunal and any person who exercises a power or performs a function under this legislation. Where will they seek to interpret the term “health practitioner” in the absence of a definition in this bill or in any other statute in Western Australia?

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Hon STEPHEN DAWSON: I am advised that if it came to it, they could look under the umbrella of the Australian Health Practitioner Regulation Agency, which identifies anybody engaged as a health practitioner to be a health professional.

Hon NICK GOIRAN: I did not quite understand that answer. The minister said that any person who is a health practitioner is to be regarded as a health professional, but my question was: how are people to interpret what “health practitioner” means in this bill in the absence of a definition in this bill or, as I understand it from the minister, in any other statute in Western Australia?

Hon STEPHEN DAWSON: I said that anyone engaged in a health profession would be recognised as a health practitioner. That was the Australian Health Practitioner Regulation Agency. I have also been told that it is a matter of perhaps common sense that anyone providing a patient with care of some kind to do with health would be recognised as a health professional, so it is intentionally broad.

Hon RICK MAZZA: I have been listening to the debate very carefully and I have to say that I am inclined to support the amendment put forward by Hon Nick Goiran. I am a little concerned about what is a health practitioner. Further on in the bill, the term “medical practitioner” is defined, but what is a health practitioner? In this day and age, a quick Google search will show that it could be anything from an aromatherapist to a fitness instructor. The term “health practitioner” has a very wide scope. Is the intention of this bill to provide for a health practitioner, such as a dietician or whatever the case may be, to assist somebody in the late stage of their life? I would like to hear from the government a bit more about why it thinks it does not need to be a registered health practitioner. I think the Australian Health Practitioner Regulation Agency registers health practitioners. Is it the government’s intention to open this up to a very wide scope of interpretation of “health practitioner”, whether that be those who provide some counselling assistance or dietary assistance—the whole range of what is termed “health practitioner” these days?

Hon STEPHEN DAWSON: I am told that in the context of the principles, we want a wider scope than “registered health practitioner”, so we have used the term “health practitioner”. I have indicated previously that we are not in a position to support Hon Nick Goiran’s amendment. I do not have too much further to say other than we are dealing with the principles of the bill and we want to have a wide scope.

Hon MARTIN ALDRIDGE: I think I heard the minister say the last time we sat, and I think he reiterated it today, that it was the government’s intent to have a broader application of the term “health practitioner”. I must admit that when I read this clause, particularly subclause (1)(e), which refers to a therapeutic relationship between a person and the person’s health practitioner—that is singular, not plural—I immediately thought that it was between a person and their doctor. Paragraph (g) refers to health practitioners—in the plural sense—family and carers. The minister mentioned a moment ago, I think in response to Hon Nick Goiran, that the interpretation might refer to the Australian Health Practitioner Regulation Agency. Is the minister in a position to tell us which health professionals it regulates so that we can understand the definition of “health practitioner” in this context?

Hon STEPHEN DAWSON: The list may include Aboriginal and/or Torres Strait Islander health practitioners; chiropractors; dental practitioners, including dentists, dental hygienists, dental prosthetists, dental therapists and oral therapists; medical practitioners; medical radiation practitioners; nurses and midwives; occupational therapists; optometrists and opticians; osteopaths; paramedics; pharmacists and pharmaceutical chemists; physiotherapists and physical therapists; podiatrists and chiropodists; and psychologists.

Hon MARTIN ALDRIDGE: Is there any explanation of why paragraph (e) refers to health practitioner in the singular, but paragraph (g) refers to health practitioners in the plural?

Hon STEPHEN DAWSON: I am told that in drafting, the singular includes the plural, so it can be either one of those. It can be more than one.

Hon NICK GOIRAN: The minister kindly provided a list to Hon Martin Aldridge of the classes of persons regulated by the Australian Health Practitioner Regulation Agency. It included chiropractors, dentists, nurses, occupational therapists, pharmacists and the like. Are any of those given in the list not regarded as registered health practitioners?

Hon STEPHEN DAWSON: I might have to ask the honourable member to ask that question again, because all those that I identified are health professionals that AHPRA would register. What was the honourable member’s particular question?

Hon NICK GOIRAN: The context of my question was that the minister indicated to Hon Martin Aldridge that these were all the classes of people—again, I am paraphrasing—whom AHPRA regulates. When the minister was listing them, they sounded to me to be people who would be described as registered health practitioners. If those people would be captured by my amendment, it is not clear to me whom we are trying to capture that my amendment would not capture.

Hon STEPHEN DAWSON: I am told they will be captured only if the individual were registered. In some cases, an individual has to be eligible to be registered, but does not have to register.

Extracted from finalised Hansard
Hon NICK GOIRAN: By way of an analogy, in the legal profession there can be people who are registered and people who are not practising. I imagine the minister is referring to the same kind of situation. For instance, a medical practitioner might be registered, but there may be medical practitioners who are not registered. However, I draw the minister’s attention to the principle in paragraph (e), which states —

a therapeutic relationship between a person and the person’s health practitioner should, wherever possible, be supported and maintained;

I cannot imagine that it is the intention of the government to support and maintain a therapeutic relationship between a non-registered or non-practising health practitioner and the person. That seems to me to be a rather dangerous mechanism. I cannot imagine that that is the intention. Perhaps a better way to ask the question and elicit a response is to ask: what are the classes of persons who would not be registered health practitioners, but would have a therapeutic relationship with a person?

Hon STEPHEN DAWSON: The professions are, potentially, social workers or Aboriginal health workers. This is about a therapeutic relationship. I make the point again that some health services do not require the health practitioner to register. They must be eligible to register and perform health services and/or provide health care. I am not sure that we will land in a place —

Hon Nick Goiran: I think we’re close.

Hon STEPHEN DAWSON: I am not sure that we are going to land in a place where Hon Nick Goiran will be comfortable with the answers I give him on this. By all means, if the member has a couple more questions, he can ask them, but the member has moved his amendment, and we are not going to land in that place, so let us put the amendment before the chamber.

Hon NICK GOIRAN: Thanks, minister. I understand that, but we have to take a moment because, as we have already identified, there is no definition of “health practitioner” in this bill and the minister has advised the chamber that there is no definition of “health practitioner” under any Western Australian statute whatsoever. In the absence of anything else, the courts will have to take guidance from our dialogue right now. I would like to make sure that we get it right. If I understand the minister correctly, one of the classes of persons the government would like to capture by this principle is social workers. Has the government received advice that a court would interpret a social worker as being a health practitioner?

Hon STEPHEN DAWSON: No, we have not received that advice.

Hon NICK GOIRAN: With the greatest of respect, can I suggest to the minister that, in the absence of that advice, I cannot conceive that there is a credible court in the land of Australia that is going to interpret “health practitioner” to include a social worker. It is incomprehensible to me. If the government has advice to the contrary, I invite that to be put on the record so this can be put without a shadow of a doubt.

Hon STEPHEN DAWSON: No, I do not have advice to the contrary at the moment.

Hon NICK GOIRAN: I reiterate what I said at the outset. I have some sympathy for the position that the government has sought to put forward, which is that it wants to capture a class of persons greater than registered health practitioners. I have no problem with that. For that reason, I would be willing to seek leave to withdraw my amendment, but I can do that only if we get an alternative from the government. The phrase “health practitioner” will not cover the situation the government wants it to. I accept that it would like to have social workers included. I think we both agree that they are not captured by the term “health practitioner”, so would the government be minded to move an amendment of its own choosing, which may say “health worker” or “health or social worker” or words to that effect? Would the government be prepared to consider that?

Hon STEPHEN DAWSON: No, I am not in a position to accept the honourable member’s suggestion. I have received further advice that the Health Practitioner Regulation National Law (WA) Act 2010 contains a definition of “health practitioner”; that is the national law that Western Australia adopts. I am sorry, that information has just come to hand now.

Hon NICK GOIRAN: What is that definition?

Hon STEPHEN DAWSON: The definition states —

health practitioner means an individual who practises a health profession;

Hon NICK GOIRAN: I know that the minister has competent advice at his disposal this afternoon, as he has had throughout the course of the debate on this bill. I think that the minister is in a position to agree that that definition does not capture social workers. It is the government’s intention that this principle cover social workers. With that knowledge, surely an amendment is required.

Hon STEPHEN DAWSON: I appreciate the honourable member’s kind words about the advisers I have before me. I have certainly been well looked after in the advice I have been given at the table throughout the debate on this bill. The short answer and the key point is that the government does not want to limit this principle to registered practitioners; therefore, I am not in a position to move an amendment or to accept the proposed amendment that the member has moved before the chamber.

Extracted from finalised Hansard
Hon NICK GOIRAN: In light of the dialogue that we have had today, does the government agree that social workers will not be captured by this principle?

Hon STEPHEN DAWSON: Honourable member, it is our view that a social worker would be captured and the court would recognise that. Specialist palliative care teams often include a social worker. Principles may well come before a court at some stage in the future, but specialist palliative care teams can already include a social worker. We think that, as this clause is written, it would be recognised by a court to include a social worker.

Hon NICK GOIRAN: Minister, that is impossible, for this reason: the minister will appreciate that in the absence of a definition of “health practitioner” in this bill, a court will have to go to another Western Australian statute to determine the definition of a health practitioner. The minister has told us that there is one other statute. Originally, the advice was that there was none, but the more recent updated advice is that there is one statute that defines “health practitioner”. The court will go to that other statute in Western Australia and use those words to determine what “health practitioner” means, and it will go no further. It will not go to the dialogue between the minister and I; it will not go that far. It will stop at that statute in Western Australia. The minister has indicated to us that the other statute does not include the words “social worker”, and the government wants social workers to be included. Any contrary advice to the chamber is wrong advice, and members are going to be misled by wrong advice. I seek for the record to be corrected and for the minister to confirm that it is not possible for a competent court in the circumstances that he has just told us to interpret “health practitioner” to include “social worker”.

Hon STEPHEN DAWSON: I will not attempt to say what a court will or will not do. However, in the absence of a mention in statute, I would not rule out a court going back to look at the parliamentary debate on the bill if it were not satisfied by the Health Practitioner Regulation National Law (WA) Act 2010, which states —

**health practitioner** means an individual who practises a health profession;

**health profession** means the following professions —

The act continues to outline other things.

Hon Nick Goiran: It does not include “social worker”.

Hon STEPHEN DAWSON: I think the court would recognise that, in that case, a social worker providing assistance and service of care to a person would be recognised as a health practitioner.

Hon NICK GOIRAN: Can the minister explain to the chamber how a social worker is engaged in a therapeutic relationship with a person?

Hon STEPHEN DAWSON: I do not propose to answer any more questions on this issue. The honourable member has his proposed amendment before the chamber. I have given an indication from government that we are not in a position to support it. If the member is intent on moving his proposed amendment, then now is probably the right time.

Hon NICK GOIRAN: Mr Chairman, I seek leave to withdraw the amendment currently standing in my name.

Amendment, by leave, withdrawn.

Hon NICK GOIRAN: I move —

Page 3, line 4 — To insert after “practitioner” —

or social worker

I seek the support of members for this amendment, which will facilitate precisely what the government would like to see happen. In response to my last amendment, which I have withdrawn, the government indicated that it sees the scope of individuals to be captured by this principle as greater than registered health practitioners, hence why it has deliberately used the words “health practitioner”. Members who have been following this debate will recall that when I asked earlier whether any other statute in Western Australia defines health practitioner, the minister, on more than one occasion, said no. He subsequently indicated that there is actually one statute in Western Australia that defines “health practitioner”. The minister and his advisers know full well that a court of law will go to that particular statute to define what a health practitioner is. It is clear that that does not include a social worker; it is clear that the government would like social workers to be captured by this particular principle, and my amendment will give effect to that.

Hon ALISON XAMON: I rise to raise a potential issue with the drafting of the amendment in front of us. Because it would read “health practitioner or social worker”, I would hate that to be read as an exclusionary measure. My concern is that multiple relationships may need to be maintained, and as a form of drafting I am concerned that the use of the word “or” might limit the provisions in a way that is not necessarily intended.

Hon STEPHEN DAWSON: I appreciate the spirit in which Hon Nick Goiran is trying to be helpful to the debate this afternoon. I reiterate that we do not think this is necessary. We think that health practitioner, as it stands in the principle at clause 4(1)(e), could include social worker, so we do not see the inclusion of the amendment proposed by Hon Nick Goiran as being necessary. We will not be in a position to support it.
Hon NICK GOIRAN: I take the point raised by Hon Alison Xamon and, subject to the Chair’s guidance, I am happy for my amendment to read “and social worker” rather than “or social worker”. I am happy to hand up a signed amendment to that effect, if that would assist progress.

The CHAIR: I think Hon Nick Goiran sought the advice of the Chair as to how to achieve what he wants to achieve. There are several avenues of recourse you might choose to follow. One of those, if it works, is the easiest way, which is to seek leave to amend the amendment you have moved. That will be very quick, if it works, but if leave is not granted, it will leave you in an awkward position. Another option is to deal with the current amendment, see it defeated, and then move a fresh amendment. The other option is to seek leave to withdraw the current amendment and then move a fresh one, so there is an absolute wealth of options available to you! I can only advise on what they are, never on which one you should pursue.

Hon NICK GOIRAN: Thank you, Mr Chairman. I will take the most expedient option, which is to seek leave so that my amendment will read “and social worker” rather than “or social worker”.

Amendment, by leave, altered.

The CHAIR: The amendment we are now dealing with is —

Page 3, line 4 — To insert after “practitioner” —

and social worker

Hon STEPHEN DAWSON: This gives undue weight to a role that does not necessarily have a primary function in the bill, so we are not in a position to support Hon Nick Goiran’s amendment, as altered.

Hon NICK GOIRAN: I will finish on this point, minister. We have come full circle. The only reason the minister previously gave for opposing the earlier amendment, which was to insert the word “registered” health practitioner so that it was consistent with the entirety of the bill, was that the government was concerned that people such as social workers would not be captured. That was the explanation that was provided, but now when we want to insert “social worker”, the government says they do not really have a primary role, so do not worry about it; it is not necessary. The minister will understand how difficult it is to make efficient progress in this debate when that is what is happening here today. That is not to say anything about the fact that when I asked earlier whether there was any statute in Western Australia that included a definition of “health practitioner”, we were told “no” on multiple occasions, but now we find that the answer is “yes”. I obviously respect the government’s right to do whatever it likes with regard to the amendment, but I seek support for it.

Hon AARON STONEHOUSE: I appreciate the effort to which Hon Nick Goiran has gone in trying to clarify the principle at clause 4(1)(e). However, I am not inclined to support this amendment, despite the fact that it might make clearer the government’s intent to include social workers and to support and maintain the relationship between a person and their social worker and health practitioner. I have a problem with the idea of elevating a therapeutic relationship between a person and their social worker because I am not quite sure there is necessarily a therapeutic relationship in that situation. I could be proven wrong, but the minister declined to answer questions about what the nature of a therapeutic relationship between a person and their social worker might be. I do not necessarily see a therapeutic relationship between a person and a social worker; there may well be a therapeutic relationship between someone and their psychologist or psychiatrist, or some other mental health practitioner. I am therefore not inclined to support this amendment in this case. I think the principle at clause 4(1)(e) reads quite well as it is, even with the somewhat general or vague understanding of what a health practitioner may or may not be. The fact that there is a therapeutic relationship probably provides enough clarity for my comfort in this instance.

Hon ALISON XAMON: I indicate that I have sympathy for what the mover of the amendment is trying to achieve, which is to ensure that ongoing therapeutic relationships are maintained. That is an important principle, and one that needs to be encapsulated. I recognise that very often social workers in certain settings provide therapeutic relationships, although not always; there is a wide range of social work settings, but certainly in the settings that I think are envisaged around this bill, that can be the case. I am also seeking the comfort from government that “health practitioner” will be broad enough to be able to incorporate “social worker”. I understand that for the purposes of the second reading debate, perhaps it could be argued that it is sufficient to put on the record that that is the intent of this bill. That would need to be made unequivocally clear. I think it is important to note that the intent of the amendment is sound. The issue is just whether this chamber believes that it is necessary.

Hon STEPHEN DAWSON: I appreciate Hon Alison Xamon’s comments. We are certainly of the view that this amendment is not needed. My advisers also tell me that if there was any doubt in the future, in the absence of a piece of legislation out there, a court would indeed look at this debate and recognise that the government’s view is that the words “health practitioner” include these other things. So we do not need to include the words “and social worker”.

Hon NICK GOIRAN: I would encourage members to ignore that advice that has just been given by the minister, because it is wrong. There will not be a court that will look at the dialogue between us today. We identified early in this debate, and the minister has said himself, that there is a statute in Western Australia that defines

Extracted from finalised Hansard
“health practitioner”. A court does not go beyond another statute when the words are clear; that is done only in the absence of anything else. That other statute will not confirm that social workers will be included. If the government wants social workers to be included, this amendment will give effect to that.

**Hon Alannah MacTiernan**: It is not going to not include them, either. It is a very general wording that could include social worker.

**Hon NICK GOIRAN**: I missed that. Could the minister please repeat it?

**Hon Alannah MacTiernan**: I said it is a very general wording. The definition that you refer to is a general wording. It would also potentially include social workers. You are saying that they would go to the statute. The statute itself has the capacity to allow social workers to be included.

**Hon NICK GOIRAN**: Is the minister saying that the existing statute in Western Australia that defines the words “health practitioner” includes social workers?

**Hon Alannah MacTiernan**: I am saying that the court will go to that and look at it, and, if the court is unclear about what that means, it will look at this debate. So I do not accept your argument that the discussion here will not be considered because of that other definition.

**Hon NICK GOIRAN**: Sure. Ultimately, it boils down to whether the minister or any other member here wants social workers to be included. Members have two options. They can support my amendment, and then social workers will definitely be included, because there will be clear words from this Parliament and this chamber that they are to be included. Members may or may not agree with that. I hear what Hon Aaron Stonehouse is saying. He does not agree that social workers should be included, and the reason is that he says they do not have a therapeutic relationship. I have a lot of sympathy for what the honourable member has said. However, the point is that the government wants social workers to be included. If the government wants them to be included, this form of words will ensure that that is the case. The second option is that we can just leave it to chance and hope that Hon Alannah MacTiernan or anybody else is right and that a court might look into that statute and somehow wriggle its way around and determine that it includes social workers. That is poor lawmaking, members. We have the opportunity now to make sure that the government’s intention is clear. We could have facilitated this half an hour ago if the government had decided that it wanted to make progress and facilitate the easiest of amendments, but instead it has chosen the hardest way possible. I seek support for the amendment.

**Amendment, as altered, put and negatived.**

**Hon NICK GOIRAN**: We are making our way through the supplementary notice paper. Members will see that there is an amendment standing in my name at 54/4. That amendment refers to page 3, line 11, and particularly deals with the principle at clause 4(1)(g). I would like to ask the minister one question about the principle at clause 4(1)(f). Is this principle a reference to advance care planning?

**Hon STEPHEN DAWSON**: Not necessarily, I am told, but it may include advance care planning.

**Hon NICK GOIRAN**: For the benefit of members, I note that, as I indicated earlier, my amendment that currently sits on the supplementary notice paper at 54/4 deals with the principle at clause 4(1)(g). Although I do not propose to move that amendment standing in my name—the reason being that I had withdrawn the earlier amendment, 53/4, and there would be no purpose in moving this further amendment—I have a series of questions for the minister about the principle at clause 4(1)(g). I note that the next amendment on the supplementary notice paper is in the name of Hon Martin Aldridge, pertaining to a proposed new principle, clause 4(1)(ha). With regard to the principle at clause 4(1)(g), can the minister advise the chamber what is meant by a person having supported conversations with community?

**Hon STEPHEN DAWSON**: The principle at clause 4(1)(g) reads —

a person should be supported in conversations with the … community …

That refers to the people around them.

**Hon MARTIN PRITCHARD**: I have a quick question about the principle at clause 4(1)(g). The minister indicated previously that the singular will also cover the plural when talking about health practitioners. I presume that means that “the person’s health practitioners” will also cover the singular. I am just wondering why this is not constant throughout the bill. I notice that it comes up quite often throughout the bill, and I just wondered why there is not a constant practice to use just singular or plural.

**Hon STEPHEN DAWSON**: It is a good question. It does include both. It is about the reading flow more than anything else. This is how it has been drafted. Certainly, “health practitioner” and/or “practitioners” include each other.

**Hon NICK GOIRAN**: In light of the principle at clause 4(1)(g), how will the legislation facilitate family being made aware of a person’s decision to access voluntary assisted dying?

**Hon STEPHEN DAWSON**: It is the person’s choice. If the person wants to have a conversation with their family about this issue, then it will be supported.

*Extracted from finalised Hansard*
Hon NICK GOIRAN: One of concerns that has been raised with me by the community is that it will be possible under this prospective regime for a person, let us say an 18-year-old, with a terminal illness to access voluntary assisted dying and no family member would be aware of that. Any parent of an adult teenager would understand why some people in the community are concerned that an 18-year-old diagnosed with a terminal illness could access VAD having had no conversations with family whatsoever. I support the principle set out at clause 4(1)(g) —

a person should be supported in conversations with the person’s health practitioners, family and carers and community about treatment and care preferences;

I draw members’ attention to one of the cases from the Northern Territory that highlights the problem here. Members will be aware that for a brief period voluntary euthanasia was available in the Northern Territory. Members will also be familiar with the fact that I authored a minority report dealing with this issue amongst many other things. In particular, I draw members’ attention to finding 73 in the minority report, which reads —

When assisted suicide was legal in the Northern Territory one patient, who had received counselling and anti-depressant medication for several years, was euthanised after a psychiatrist from another State certified that no treatable clinical depression was present, notwithstanding that neither the patient’s adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for assisted suicide.

That was a very disturbing case that arose in the Northern Territory experience and it is for that reason that I would like to see this particular principle broadened to elevate the role of family in those conversations. I accept what the minister has said about it needing to be the individual patient’s choice — no question. But, equally, should there not be some form of safeguards around whether, for example, an 18-year-old who has just been diagnosed with a terminal illness can access voluntary assisted dying without any family member being aware of it? That is the concern I have, particularly from the lived experience in the Northern Territory. This is no longer a theoretical argument; this is what has happened in our own country. Minister, has the government considered the role between the family and the patient who wants to access voluntary assisted dying?

Hon STEPHEN DAWSON: Consideration was given to that, but we cannot discriminate between an 18-year-old and a 58-year-old. An 18-year-old is an adult and 18 years is the age that is set in this bill. We cannot discriminate against one or the other. The bill does not prohibit family or next of kin from providing support for the patient, but the involvement of family or next of kin is dependent upon the patient’s wishes, and that is where we have landed.

Hon NICK GOIRAN: What measures could be put in the bill to ensure that there is facilitation for a conversation between a family member and the patient, perhaps a young patient? I accept that we cannot discriminate on age; nevertheless, if we are mutually concerned about the possibility that a young person could access voluntary assisted dying without any reference to their family, what kind of safeguards could be put in place to address that concern?

Hon STEPHEN DAWSON: Plainly and simply, we do not believe that they are needed. This is a choice. An adult can make a choice to participate in voluntary assisted dying. People in this place might not like it, but the fact is the law will allow for an 18-year-old to make the decision. I guess, in many cases, an 18-year-old could talk to family and friends, but the member is right to identify that in some cases that might not happen. The reality is that this legislation will allow an 18-year-old to go through the process and potentially access voluntary assisted dying. We do not believe anything else needs to be inserted in the bill in relation to this issue.

Hon NICK GOIRAN: To be clear, minister, it is the government’s position that if an 18-year-old with a terminal illness wants to access voluntary assisted dying and they choose never to tell a family member about that, the government supports that choice?

Hon STEPHEN DAWSON: The government respects that choice.

Hon NICK GOIRAN: The principle at clause 4(1)(g) is inherently linked with the principle at clause 4(1)(c); it also refers to supported decision-making. 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;

Are the principles that refer to supported conversations and the like — references to a person’s right to be supported in making informed decisions — intended to be references to supported decision-making?

Hon STEPHEN DAWSON: No, this is not about supported decision-making.

Hon NICK GOIRAN: Is supported decision-making permitted under this regime?

Hon STEPHEN DAWSON: No, it is not, because a person would have to have capacity; supported decision-making is something else.

Hon NICK GOIRAN: I did say “supported decision-making”, not “substitute decision-making”. Is the minister sure that we are talking about the same thing?

Hon Stephen Dawson: The answer remains the same.

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Hon NICK GOIRAN: To be crystal clear, minister, is there no capacity under this legislation for substitute decision-making or supported decision-making?

Hon STEPHEN DAWSON: The member is correct.

Hon NICK GOIRAN: My last question relates to the link between the principles in clause 4(1)(g) and (c) about supported and informed decision-making. Is the reference to the phrase “a manner the person understands” the need for translators and interpreters or is it a reference to a person’s capacity?

Hon STEPHEN DAWSON: One example of this could be an interpreter. It could be that sign language is needed for the person or the document needs to be in plain English or it could be for somebody who needs to use an iPad, for example, to read the document or is voice activated. One of those things.

Hon MARTIN ALDRIDGE: I seek some advice, Deputy Chair. In a moment, I want to move my amendment on the supplementary notice paper. If I do that, will it preclude amendments being made to earlier principles in this clause? If it is the case, I want to make members aware of that. I will take my seat if members have an interest in principles before where I intend to insert words at page 3, after line 16.

The DEPUTY CHAIR (Hon Adele Farina): Honourable member, that is a very good question. Yes, we would need to recommit and go back to earlier principles if members wanted to then consider earlier principles. I think this is a good time for me to alert members who would like to speak to clause 4(1)(a) through to (g) to seek the call now because once Hon Martin Aldridge has moved his amendment, they will be precluded from doing so unless we recommit any of those earlier sections. No-one is seeking the call.

Hon MARTIN ALDRIDGE: Thank you, Madam Deputy Chair. I move —

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;

I gave some thought to this before this bill was introduced into the other place. If I am not mistaken, I made some remarks in my second reading contribution that, in effect, stated that I recognised the overwhelming support in the community for the concept of voluntary assisted dying and the personal choice of somebody being able to end their suffering and end their life. I also said that I thought there was a reasonable, not an unreasonable, expectation that those same people in Western Australia would have access to the regime. I have heard some members, not necessarily through the course of this debate, in other places, express the view that this would be another matter of health care, if you like, that regional and remote Western Australians will have to expect and realise they live in regional and remote places and they will not have the same level of access. To me, that is not an acceptable outcome, particularly in the circumstances in which this bill has been brought to the house, which have been well canvassed. It is about people being able to express a personal and voluntary choice to end their suffering and, in turn, end their life. In these times, it is not unreasonable to expect that a person in Western Australia no matter where they live, no matter their postcode, will be able to express that choice as close to their community, their home, their family or indeed at a location of their choosing and that they will not be discriminated against or disadvantaged by the mere fact that they do not live in a metropolitan area of Western Australia.

We also have to consider the added difficulty of delivering voluntary assisted dying and the restrictions that will be placed on it by provisions of the federal Criminal Code Act. I have said previously during the course of the debate that I sympathise with the government’s position. Hopefully, in time, we will see some change by the commonwealth with the application of the provisions of the Criminal Code Act, which may, at least in the near term, cause some difficulty for the government in delivering the voluntary assisted dying process more easily across Western Australia. There is obviously a range of other aspects, which I do not intend to go into in detail. Obviously, I could refer to the dispensing of the voluntary assisted dying substance as well as the review by the tribunal and a range of other functions in the bill whereby distance, geography and remoteness may well play a factor in one’s ability to have some equity in access to voluntary assisted dying. With those remarks, I hope that I have set it out in a simple way and reinforced the public comments of the Minister for Health and the government about doing whatever it takes to deliver voluntary assisted dying to all Western Australians. We recognise that it would not be an acceptable outcome to have, say, Harry from Halls Creek, who is dying of cancer, which is the example that I have used previously, to have to travel to Broome or Perth to access voluntary assisted dying in Western Australia.

The addition of this principle recognises that a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in the metropolitan region. Obviously, there will be some subsequent or some consequential amendments to clause 5 to define regional resident and metropolitan region and obviously that will be a matter that I consider when and if this amendment standing in my name at clause 4 is supported by this place. I hope that members will find a way to support this amendment. I think it is an important principle that recognises that all Western Australians should have equity in access to voluntary assisted dying.

Hon STEPHEN DAWSON: I indicate the government will support the amendment moved by Hon Martin Aldridge. It reflects the government’s commitment to the accessibility of voluntary assisted dying for all Western Australians,
for the Western Australian community both regional and metropolitan residents. It is also consistent with the government’s commitment to enabling real end-of-life choices to the Western Australian community, so we think this is a good amendment and we are happy to give our support to it.

**Hon ROBIN CHAPPLE**: I want to touch on the amendment. Clause 4(1)(h), which is just above proposed clause 4(1)(ha), refers to —

> 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;

Got it. The amendment contains the word “access”. I am mindful that the government is going to support this amendment, but I would really like to know what access means. Does it mean that somebody living in Tjuntjuntjara can walk out the door and speak to a medical practitioner? What is the level of access? That worries me to a large degree, because if it is how we understand the concept of “access”, it would mean that the government would literally have to provide access to voluntary assisted dying in every small community, whether it has only one or two people. I am actually quite supportive of what Hon Martin Aldridge is saying, but I worry about the word “access” and whether it could be used as a negative at some stage in the future. The minister will, correctly, respond to Hon Martin Aldridge’s amendment, so I note for him that I worry a little about the level of access. I really do want better access everywhere, but to what extent is “access” defined?

**Hon MARTIN ALDRIDGE**: I would like to thank the minister for confirming the government’s support for this amendment. In response to Hon Robin Chapple, I guess what members need to consider is that we are dealing with principles at clause 4. I think a similar argument could be made or a similar question asked about the specificity of the terms used in clause 4(1)(a) to (j). For instance, to what extent should a person be supported? To what extent should a person be encouraged? To what extent should a relationship be supported and maintained? These paragraphs have been drafted in the sense that they are overarching principles. Therefore, the principle I intend to insert through this amendment essentially reflects the intent that a person should not be disadvantaged in their access to voluntary assisted dying. I agree with Hon Robin Chapple that there is a real risk of disadvantage in some communities in terms of access to the provisions of the bill. I have certainly said during the course of this debate that I will consider the amendments through that prism as we work through them on the supplementary notice paper. Obviously, the merit of an amendment is important, but, as a regional member, I also cannot deny the fact that the passage of some amendments might unnecessarily add to the burden or barrier for regional people. As a regional member, they are two key factors that I will use in trying to weigh up whether to support or oppose amendments to the bill.

Coming back to my amendment, it simply reflects the government’s commitment. A person’s ability, naturally, to obtain the same level of access will depend on where a person lives and the circumstances in which they live; therefore, it could mean access to registered practitioners or it could mean access to other services. As I have said, and as I think the Minister for Health has articulated, the state’s intent and commitment is to make sure that those services are provided. Both the minister in this house and the Minister for Health have said that services may need to be provided by mobile teams. A similar approach has been taken in Victoria to ensure that regional Victorians are not disadvantaged through their scheme.

**Hon STEPHEN DAWSON**: I am happy to agree with Hon Martin Aldridge on this one; he has answered the question very eloquently. We are committed to ensuring that regional Western Australians will be able to participate. I think Hon Martin Aldridge answered Hon Robin Chapple’s question as well as I could have done.

**Hon AARON STONEHOUSE**: I certainly appreciate the sentiment behind the amendment that Hon Martin Aldridge has moved and I can appreciate what he is trying to achieve with this amendment, but I am very uncomfortable with the language used, and it might take a little while to unpack and explain why that is. My support for voluntary assisted dying is on the basis that I would like to see restrictions, coercion by the state, removed to allow people to make their own choices about their end of life. I feel rather uncomfortable about the idea of the state moving from merely a regulator of voluntary assisted dying into the space of being a facilitator or, in fact, a service provider of voluntary assisted dying. I think this amendment starts to place upon government an obligation to provide voluntary assisted dying, which I am rather uncomfortable with. There is certainly an aspect of that already in the bill, but look at the language used already in the principles in clause 4(1). Clause 4(1)(c) states —

> a person has the right to be supported in making informed decisions …

Absolutely; I agree with that. There is a right there, but there is not necessarily an obligation on government to provide people with anything. It would seem that there is merely a prohibition on government from interfering with that ability to make informed decisions. Clause 4(1)(e) states —

> a … relationship between a person and the person’s health practitioner should, wherever possible, be supported and maintained;

That is still not so much an obligation on government to provide voluntary assisted dying, but merely an expression of a principle that a relationship between a person and health practitioner should be supported and maintained.

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Similar language is used throughout the principles. It is not until we get to paragraph (h) that the word “entitled” is used, but even then it is only used in a very limited sense. It states —

a person is entitled to genuine choices about the person’s care, treatment and end of life, irrespective of where the person lives …

What is the obligation on government to ensure that a person has genuine choice? When I read that through the classical liberal lens that I look at something like that with, a genuine choice would merely be the absence of coercion; that is, people are free to pursue whatever end-of-life care or end-of-life choices they like in the absence of coercion. In the current status quo there is certainly coercion on the part of the state preventing people from seeking advice and support in accessing voluntary assisted dying. I see this bill as an opportunity to remove that coercion by the state so people will be free to make those choices. The language used by the honourable member in the amendment is —

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;

I could be wrong, and I am happy to have a bit of a back-and-forth dialogue about this, but that seems to place upon government an obligation to at least try to live up to that principle of providing the same level of access for voluntary assisted dying to regional people that metropolitan people may have. How would that be done by the government? It seems it would be done by the government through the provision of these travelling, roaming voluntary assisted dying services, as have been announced in Victoria and which the government here has announced it may look into. I am very uncomfortable with that idea. Removing coercion, providing a regulatory framework with oversight to prevent coercion, is one thing. That is allowing people to make choices. If they want to go to their doctor who is willing to participate in this scheme and they find a pharmacist who is willing to participate in this scheme, that is all voluntary. The state is merely providing oversight to ensure that no inappropriate or accidental deaths and no coercion take place. If we look at the logical conclusion of a principle such as making the state perhaps a provider of last resort, it puts taxpayers in the position of funding a regime of voluntary assisted dying that they may disagree with, and that goes far beyond what I think would otherwise be merely removing restrictions on or the prohibition of voluntary assisted dying, which is what I support in principle.

I would also like to point out what I think might be a missed opportunity here. Proposed new paragraph (ha) states —

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

If we are talking about this idea of trying to correct the limited access to services that regional people experience due to the tyranny and scale of distance—someone living in a remote community of a few hundred or a few thousand people not having access to the same services that someone in Perth enjoys—it is concerning that proposed paragraph (ha) does not include any reference to other forms of end-of-life care such as palliative care. This might merely be an oversight. I do not want to reflect on the intentions of the mover of the amendment. Unless such an amendment is intended to be moved at a later time—I would be interested to hear from the mover if he has that intention or if any other member in the chamber has that intention—it is a little concerning that there should be universal access to voluntary assisted dying, regardless of where someone lives. Even if they live in the middle of nowhere on a cattle station, they should have the same access to voluntary assisted dying. However, that same access to palliative care is not considered in the amendment. I think that is worth highlighting and contemplating.

At this point I am very uncomfortable with the amendment based on my view that the state should act as an impartial regulator of voluntary assisted dying and not as a service provider. This principle would shift the focus of this bill to making the government a service provider. I am a little concerned, and I am interested to hear what members have to say, about the lack of universal provision of palliative care if this amendment is agreed to.

Hon MARTIN ALDRIDGE: I would like to respond to the comments made by Hon Aaron Stonehouse. I understand the position that he holds on my amendment; it is one formed on principle. I will go to his last comment first. I remind members that this is a bill for an act to provide for and regulate access to voluntary assisted dying and to establish the Voluntary Assisted Dying Board and to make consequential amendments to other acts. This is not a bill for an act to provide palliative care. It is not a bill for an act to provide oncologists. It is not a bill for an act to provide general practitioners. It is not a bill for an act to provide the patient assisted travel scheme. I suspect that any amendments moved that go to the provision of those services would likely fall foul of the scope of the bill, which is clearly defined by those three points that I just raised. The opportunity to insist on, regulate or mandate a level of service with respect to every other possible healthcare profession and healthcare service provider is not possible through the opportunity that exists within the Voluntary Assisted Dying Bill 2019.

Hon Aaron Stonehouse has expressed some concern about the involvement of the state in the voluntary assisted dying process. When we read this very lengthy bill, I would argue that the state is involved at just about every turn, whether it be through some regulatory function, through some funding, through review, through the board, through the minister or through the CEO. There is certainly no independence of state in the voluntary assisted dying process.

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I respect Hon Aaron Stonehouse’s position, and also that he represents South Metropolitan Region. The landscape outside the metropolitan area with respect to health service provision and health care is quite different. The reality is that we do not have doctors in many of our communities and the only healthcare workers in many of our communities are those employed by the state—often in the local nursing post or hospital. They are the realities of living outside Perth. Indeed, many regional and remote Western Australians understand those realities. Delivering healthcare services in regional and remote Western Australia is very difficult. We have had many debates about that in this place. We have very thin markets. We have a dispersed population. I think the WA Country Health Service has the largest health jurisdiction in the world. It is simply not possible to have the types of health services that have been described, whether it be oncologists or neurosurgeons, available seven days a week, even in our largest communities outside of Perth.

I think some of the comments made by Hon Aaron Stonehouse do not go to the reality of delivering health care in our regions. I understand that he has some concern that there is not a principle on entitlement to the same level of care such as palliative care, and I have outlined the reasons why that cannot easily be the case in this bill. The next best thing is to make sure that the new scheme that is intended to be created in Western Australia through the Voluntary Assisted Dying Bill 2019 recognises that there should not be an expectation that regional and remote Western Australians should be treated any differently or, indeed, have any difference in access to voluntary assisted dying by the simple nature of where they live. I hope I have addressed the amendment, although I probably have not convinced Hon Aaron Stonehouse to support it. I have identified some of the challenges that I think we all share, and certainly I sympathise with the government on the implementation phase that will occur over the next 18 months or so if this bill passes.

Hon RICK MAZZA: I will support the amendment proposed by Hon Martin Aldridge. Members may recall that in my second reading contribution, I moved a motion to refer the bill to a committee to investigate how this will be delivered to regional Western Australia. We have a very vast state. As Hon Martin Aldridge pointed out, palliative care is very difficult and challenging for the WA Country Health Service to deliver. I can see that voluntary assisted dying will be very similar. Subclause (1)(h) states “irrespective of where the person lives”. Hon Robin Chapple pointed out that it had been covered in paragraph (h), but that the amendment proposed by Hon Martin Aldridge clarifies the fact that regional Western Australia has some challenges and, if we are going to have this legislation, we should make sure that voluntary assisted dying is accessible to all Western Australians across the state. I think the government will have some very big challenges ahead to cover that, but I am pleased that, if this amendment is successful, at least the legislation will state that it is the intention of the government to make sure that all Western Australians have access to voluntary assisted dying regardless of where they live and that the level of care is comparable with that in metropolitan Perth.

Hon NICK GOIRAN: I rise to speak on the amendment moved by Hon Martin Aldridge. I am pleased that the government has indicated its support for the amendment and I congratulate the honourable member for achieving that mighty feat. I move the following amendment to the amendment of Hon Martin Aldridge —

To insert after “dying” —
and palliative care

The DEPUTY CHAIR (Hon Dr Steve Thomas): Honourable members, while that is being distributed, I will summarise the situation. We are on clause 4 and are dealing with amendment 408/4 under the name of Hon Martin Aldridge on issue 7 of supplementary notice paper 139. Hon Nick Goiran has moved to amend the motion of Hon Martin Aldridge to insert “and palliative care” after “dying”.

Hon NICK GOIRAN: It should be self-evident to members that if we a chamber are passionate about the rights of regional Western Australians and their right to access the same level of voluntary assisted dying as a person who lives in the metropolitan area, it follows that we should be equally passionate about their access to palliative care. Throughout the course of the debate, the government has made it very clear that these should not be seen as either/or scenarios and that the government is very passionate about palliative care, as we all are. This is something that I have taken up since the last debate we had in this place on this issue in 2010. With the member for Girrawheen, I established the Parliamentary Friends of Palliative Care. I believe this is something that we can all support on a bipartisan or tripartisan basis. I seek the support of members to insert “and palliative care”, so that as a chamber we make it clear that every Western Australian should have equal access and rights to both voluntary assisted dying and palliative care.

Hon STEPHEN DAWSON: I reiterate the earlier comments of Hon Martin Aldridge. When responding to the words of a previous speaker, he identified that the bill before us is about voluntary assisted dying. He went through page 1 of the bill, which states that this is a bill for —

An Act —

• to provide for and regulate access to voluntary assisted dying; and
• to establish the Voluntary Assisted Dying Board; and
• to make consequential amendments to other Acts.

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This is not a bill about palliative care. In fact, as Hon Nick Goiran outlined, there has been a commitment from this government to addressing issues with access to palliative care around the state. We have made commitments both in this year’s state budget and, indeed, recently about further funding of palliative care around the state. I think this amendment would be outside the scope of the bill. I am certainly not in a position to support it. It is simply not needed. These principles are about the Voluntary Assisted Dying Bill 2019 before us and not about palliative care, which is a very different issue.

Hon NICK GOIRAN: With all due respect, the minister says that the bill is not about palliative care. I draw the minister’s attention to supplementary notice paper issue 8, in which there is an amendment in the minister’s name that seeks to insert a definition of palliative care into the bill. But this bill has nothing to do with palliative care, members!

Hon Aaron Stonehouse: Not to mention, honourable member, clause 4(1)(d).

Hon NICK GOIRAN: Indeed. With all due respect, I do not think that is a satisfactory response, but I do not want to delay progress. I would be keen to seek that members simply support the insertion of “and palliative care” so that we send a message to the community that regional Western Australians have as much right to palliative care and voluntary assisted dying as metro members, and we do not fall into the trap of sending people in regional Western Australia a message that says, “We’ll make sure that you have access to voluntary assisted dying—we’ll definitely make sure that you have access to that—but, sorry, we won’t give you access to palliative care. Only first-class citizens in metropolitan Western Australia can access palliative care—not regional ones.” I am sure that members do not want to send that message, so I seek their support for the proposed amendment.

Hon AARON STONEHOUSE: I thank Hon Martin Aldridge for his comments in response to my remarks. I disagree with what he said about the scope of the bill. As Hon Nick Goiran pointed out, the words “palliative care” appear in this very part of the bill, at clause 4(1). In fact, amendments on the supplementary notice paper consider defining “palliative care”. However, I do heed comments that I am sure will be made that it would be rather impractical to try to ensure universal access to something as complex as palliative care regardless of where someone is in Western Australia. I think it is also rather impractical to try to ensure universal access to voluntary assisted dying regardless of where someone resides in the state. In fact, it is impractical to place an obligation on government to ensure universal access to any service or product regardless of where someone lives. There is obviously a trade-off and a limit to the amount of money that government or policymakers are willing to spend to ensure universal access to a service. It is simply impractical to try to ensure that someone who lives in a caravan 100 kilometres away from the nearest settlement has high-speed fibre broadband. There are obviously scales and issues, which is why there are issues of service provision to regional Western Australia. It is something we should try to address, of course, but the idea of universal access, and the same level of access, to any service regardless of where someone resides in the state is rather impractical and perhaps an aspirational principle rather than something that the government can practically deliver.

Prices change from region to region and town to town. The price of bread or fuel is not the same in any one area. Universal access suggests that we can provide people with the same level of care, whether it be palliative care, voluntary assisted dying, paediatrics or any other kind of care, regardless of the supply of medical practitioners and the cost of shipping resources and supplies, providing electricity or insurance for buildings—all those costs that go into the provision of services. However, if it is the will of Parliament to ensure universal access to one kind of health care—although I still support voluntary assisted dying in principle, I do not really think it is a type of health care. It is an alternative to health care; it is an option out when health care has perhaps failed someone and there is no alternative. If we are to ensure universal access to one type of service, it seems only appropriate to ensure that the alternative to voluntary assisted dying, or perhaps a supplementary form of care—palliative care may be supplementary to other types of treatment—gets the same priority in the principles of this bill.

I am mindful that my concern about turning the state into a service provider for voluntary assisted dying is probably not shared by other members of the chamber, so I am likely to not be successful in convincing members to adopt my position on how the state should act when it comes to voluntary assisted dying. That being the case, I would not want to see the state subsidise and ensure universal access to voluntary assisted dying and not at least try to ensure the same level of access to palliative care for regional Western Australians. That would be inappropriate and rather unfortunate. Although it would represent a further commitment from taxpayers, it would at least be more equitable than subsidising the choice of death and not subsidising the choice of genuine medical care and treatment. On that basis, I am inclined to support Hon Nick Goiran’s amendment to the amendment as perhaps the least uncomfortable option available to me at this time.

Hon STEPHEN DAWSON: I want to make the point that it is not that the bill has nothing to do with palliative care; it is that the bill does not relate to the service provision of palliative care. Hon Martin Aldridge’s amendment is about access to voluntary assisted dying. This principle is not about end-of-life choices or all medical options available; these are wider principles. Today we are dealing with voluntary assisted dying. This amendment is essentially picking one aspect of end-of-life choices. Why not include advance health directives or others? The bill before us is not about the service provision of palliative care; it is about access to voluntary assisted dying, which is a very, very different thing.

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Hon DONNA FARAGHER: I heard what the minister just said, but I also heard his earlier comments. I would like some clarification of how he sees his comments made just now with regard to clause 4(1)(d), which specifically refers to palliative care.

Hon STEPHEN DAWSON: I think I have answered the question already. I will say it again. Hon Martin Aldridge’s amendment on the supplementary notice paper before us is about access to the outcome of this bill. The other principles are more general regarding end-of-life choices. It is not that there are no mentions of palliative care in the bill; there are, but the bill is about voluntary assisted dying. The bill is not about the service provision of palliative care. Palliative care is mentioned, but Hon Martin Aldridge’s amendment is, as I said, about access to the outcome of this bill. Palliative care is something different.

Hon PETER COLLIER: It is very difficult for me not to support this amendment; in fact, I spent an enormous amount of time during my contribution to the second reading debate talking about the lack of palliative care facilities in the regions. The reason I did that was to point out the enormous disparity between what is provided in the metropolitan area compared with that in the regions. I said that we were putting the cart before the horse: we need to get the palliative care facilities right first before we even think about the prospect of moving down the path of voluntary assisted dying. That was the basis of what I said in my contribution to the second reading debate.

I have some sympathy with Hon Nick Goiran’s amendment to Hon Martin Aldridge’s amendment. If the Deputy Chair and the minister will allow me a little self-indulgence here, I will give members an example of exactly why we need palliative care in the regions. When I was 16 years of age in Kalgoorlie, I had everything I ever wanted. I had my family and my friends, and my parents had a corner store. I had my horse, I had my tennis; I had everything I wanted. Just a week before Christmas of that year, Dr King came into our shop, went out the back and into our house next door, and told my mum and dad that my mother had cancer of the uterus, and that they did not have the facilities in Kalgoorlie to deal with her cancer.

Suffice it to say, the whole world came crumbling down. My mum and dad had to then go down to Perth so that my mother could be treated. Had that operation not been successful, she would not have been able to live in Kalgoorlie. However, the operation was successful. She had to have chemotherapy, and so for that she had to make periodic trips to Perth from Kalgoorlie. As a result, they had to sell their shop and I had to take my horse to some friends in Toodyay. I went to live with my sister to do my final year of school.

I am not looking for sympathy here, guys; I am just telling members that these sorts of things happen in the regions every single day. This was in 1975, everyone. This happened 45 years ago. That was a terrible time; I remember it vividly. We had to sell the shop and we had to sell the house within a couple of months. My parents had moved to Perth and three months after that time I went to live with my newly married sister. She got married in August 1975, and in 1976, when I did year 12, my whole stable life was uprooted.

I was relatively resilient, so I was able to get through that, and I got through it. A lot of people would not. I am not saying that I am any champion or anything; all I am saying is that it was a really tough time, and people in the regions have to deal with this on a daily basis. We are moving down a path that changes a fundamental tenet of our society, yet we are still questioning whether we have adequate palliative care in the regions. That was 45 years ago. People who live in Kalgoorlie now still have to come down to Perth to have that operation and still have woeful palliative care facilities in that town, and it is one of the largest regional centres in Western Australia.

I take my mum out each Sunday. She is 86 now, everyone. She survived that and another bout of cancer in 1989 and bypass surgery in 2009. They make them tough in Kalgoorlie, let me tell you. Last Sunday we were sitting out in the courtyard and we always reflect back on times past. We talked about them having to sell the house and the shop et cetera, and she again apologised to me. She feels so sorry and guilt-ridden about leaving me during a period of my life, year 12, when I really needed support mechanisms. It had nothing to do with my mum; she did not want to get cancer. That was one of the things that were thrust upon her with regard to her health. She feels terrible about that because we as a society and a community could not provide those facilities for her. I keep on telling her how much I love her and that it was nothing to do with her and that things turned out all right: “I’ve lived a great life and you’re still here at 86, so, Beryl, you know, the best is yet to come, mate!” I keep telling her that and I give her a big hug. Everything is wonderful; do not get me wrong. The reason I am saying that and giving that personal story is that, guys, we are still not even close to having adequate palliative care in the regions; with all due respect, I cannot work out why we are having an argument over whether we should perhaps include in this bill the same level of palliative care for people in the regions as is enjoyed by people in the metropolitan area. I will support the amendment on the amendment from a personal perspective, but I also think we should support it from a practical perspective.

Hon MARTIN ALDRIDGE: I want to respond to the amendment to the amendment. I also want to add further to some of the comments that I have made about palliative care and the amendment that I have moved. I do not want this debate to become “who can out-palliative care one another”. We have had plenty of those debates. We have had conversations about the government’s investment in palliative care and what that will look like and whether it is enough. I think we are united as a chamber in the view that there is still work to be done on improving palliative care services, as well as other health services, in our regions. It is rather simplistic to draw a direct comparison between access to voluntary assisted dying and access to palliative care. Palliative care is obviously a broad-ranging,

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detailed and specific area of health care. It involves many health professionals across Western Australia, and the models of care are different. If we compare palliative care with voluntary assisted dying, a person who wants to access voluntary assisted dying is principally required to access two registered medical practitioners who are willing to participate in the scheme, over a period that I think can be as short as nine or 10 days. When I talk about entitlement to the same level of access, in the context that I have just described, that is achievable with respect to voluntary assisted dying. The government has made that commitment, and my amendment reflects the commitment of the government. If palliative care were included in my proposed amendment, it would read —

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

I want to say a couple of things about this. One is that we identify palliative care, and therefore exclude every other type of health service that is available. I have already mentioned some of those services. Access to general practitioners is probably the biggest challenge facing regional Western Australia. Why not lob them in; and, while we are at it, let us include oncologists and radiotherapy services? If members reflect on this argument, it does not make sense. I understand people’s passion. However, the way in which the amendment to my amendment has been constructed is just not practical. It is not fair. It does not recognise the complexity and difficulty in delivering health services in regional Western Australia. The models of care are different. They will always be different.

If this amendment to my amendment were to pass, we would essentially be saying that a regional resident is entitled to the same level of access to voluntary assisted dying and palliative care as a person who lives in the metropolitan region, to the exclusion of all other health services, some of which I have just described. The health services that are available in Perth and regional Western Australia are obviously quite different. We need to deliver services differently, as I have said, and the models of care will be different. One example to which I wish to draw members’ attention, as I have previously, I am sure, is the telehealth palliative care service that was designed and implemented in the wheatbelt as a pilot and is now being implemented across other regions in the WA Country Health Service. That is about delivering an increased level of service. However, the model of care is different. It is not practical to have a hospice or palliative care specialist in every town, nor is it practical to have an oncologist in every town. It would not be a good use of public money to fund a palliative care specialist in Halls Creek for Harry, or for the next person after Harry, because the model of care for Harry in Halls Creek will be different. I do not think it is fair to draw a comparison between the delivery of a palliative care system and access to the very specific and defined regime that is voluntary assisted dying, which principally requires access to two registered practitioners willing to participate in the scheme. That is why I will not support the amendment to my amendment in the way in which it has been proposed.

Hon ROBIN CHAPPLE: I really want to agree with the comments made by Hon Martin Aldridge. I think they go to the substance of the matter; that is, we are actually dealing with the Voluntary Assisted Dying Bill, and those issues of whether we have different medical professionals in different places and different services in different places do not have a place in this bill.

Hon MARTIN PRITCHARD: I am concerned with the problems that this amendment on the amendment might cause. It is particularly difficult, being on the government side, because it will cause problems for the government. In my view, the concern is that we are not talking about all patient care. These two issues are joined because we are talking about people in their last months of life having an alternative in the regions. We are not talking about palliative care and to palliative treatment. I again refer the minister and members to clause 4(1), which begins —

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

It then goes through a number of more general principles, and then paragraph (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 —

We are told it should be read disjunctively, so palliative —

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Hon Nick Goiran is proposing simply to reinforce that. Paragraph (d) reads —

a person approaching the end of life —

Or death, we should say; approaching death —

should be provided with high quality care and treatment, including palliative care and —

Since it is to be read disjunctively, palliative —

treatment —

Hon Colin Tincknell: Not if you’re in the country.

Hon MICHAEL MISCHIN: Except, apparently, if a person is living in the country. The paragraph concludes —

… to minimise the person’s suffering and maximise the person’s quality of life;

These are broad statements of principle and entitlements. Then we get on to paragraph (h), which reads —

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;

All that is being proposed here is to reinforce those principles through Hon Martin Aldridge’s amendment, which states, among other things, that a person exercising a power or function under the act must have regard to a person who is a regional resident being entitled to the same level of access to voluntary assisted dying as available to a person who lives in the metropolitan area. There is no question there of resources being a problem for the government. It is quite happy to do that, but now it is cavilling at reflecting genuine choices about how people approach the end of their lives—oh, no; that is too difficult.

This bill has nothing to do with palliative care; it is about directing people and assisting them towards voluntary assisted dying. I find that that is wrong and that it is the government that has defined the terms of this particular debate with these general principles. There is no objects clause, as I have indicated, yet the principles are quite plain that there ought to be genuine end-of-life choices, including palliative care and treatment choices and access to them. I see nothing inconsistent with what Hon Nick Goiran proposes with his amendment to Hon Martin Aldridge’s otherwise worthy amendment. It just reinforces the principles that we heard before, so what is the problem? I just do not get it. Why is it that this bill is suddenly being narrowed in its scope and its operation and people in the regions are being directed to only one choice and access to services? It could be that the proposed amendment could have been framed slightly differently—that is, as a motherhood principle, “people living in the regions should have access to the same level of voluntary assisted dying and palliative care and palliative treatment as people in the metropolitan area”. That would be unobjectionable, too, and it would remove the entitlement aspect and simply leave it as a principle, but I am not going to move any amendments to it. Given the other entitlements stated in clause 4, I see nothing objectionable about what has been proposed. I would be supporting Hon Nick Goiran’s amendment if we were really genuine about having voluntary assisted dying as one of the options for how people will be cared for when they are reaching the end of their life and are suffering.

Hon ADELE FARINA: I think Hon Aaron Stonehouse’s argument about whether the state should be the provider of the VAD service was very interesting and it has certainly given me food for thought. I note that neither Hon Martin Aldridge nor the minister have responded to the point that the member raised, but it certainly caused me to stop and give that some more thought. I suppose the difficulty I am having is that we are talking about options for how people will be cared for when they are reaching the end of their lives—oh, no; that is too difficult.

That clause does not refer to a person living in the metropolitan area; it says “a person”. Arguably, that clause already provides cover for people living in the metropolitan area or in regional WA. In which case, why would anyone object to Hon Nick Goiran’s proposed amendment to Hon Martin Aldridge’s amendment, because it simply endorses what is already stated in paragraph (d)? I do not understand why we are creating a distinction here because paragraph (d) refers to “a person” so that is a person in Western Australia living anywhere in Western Australia and we are already saying that that person should be provided with high quality care and treatment, including palliative care and treatment. Supporting Hon Nick Goiran’s amendment to Hon Martin Aldridge’s amendment does no harm; it is simply endorsing what is already stated in clause 4(1)(d), and I do not see the problem with that. As a member representing regional WA, I will do everything that I can to ensure that the provision of services, medical care and treatment improves in regional WA. If this is one way to achieve that, I fully support it.

Hon STEPHEN DAWSON: I have spoken at length in this place about palliative care. Hon Adele Farina talks about her role as a regional representative in this Parliament and doing all she can to make better the services in regional Western Australia. Can I say that I and, indeed, every single one of us in this place who represents regional Western Australia supports the further expansion of services in Western Australia. On 29 October, in the last sitting
week, I outlined the state government’s significant investment in palliative care in this year’s state budget and the announcements made since then about expanding palliative care services throughout the state, including an additional commitment to a significant number of staff—medical professionals—in the palliative care space.

This is not about the government’s commitment or lack thereof to palliative care. The government is supportive of it. We had a great, long debate about palliative care in this place when we last sat.

I also want to say that I am very grateful to the Leader of the Opposition, and I thank him for being brave and sharing his personal story about his mum and the challenges that his family faced many years ago. The reality is, as Hon Martin Aldridge pointed out, we all face a great many challenges in regional Western Australia in accessing medical services. Hon Martin Aldridge pointed out that we are never going to be able to have oncology services in all our communities; it does not make financial sense to have all those things in those communities. In fact, in some cases now, Western Australian patients have to travel to the eastern states to access certain medical care by virtue of it being new, not available elsewhere, costly or not being rolled out. That happens here and now, so Hon Peter Collier’s story from 45 years ago is transferable to today for some families.

I want to say that clause 4(1)(d) is about the general, but what is before us is specific. The specific amendment moved by Hon Martin Aldridge, which would be paragraph (ha), is about voluntary assisted dying; it is not about general practice or access to general practice in regional Western Australia. It is not about access to advance health directives or other specialist services in regional Western Australia; it is about access to voluntary assisted dying. Hon Martin Aldridge’s amendment is specific. I think that Hon Nick Goiran’s amendment to the amendment detracts from that. Let this not be an argument about the government’s commitment to palliative care, because I can say, as I have said before, we are committed to ensuring that people in regional Western Australia can access palliative care.

Hon Martin Aldridge mentioned the telehealth palliative care service that is available over the phone. That, together with the investment made in the budget this year and, indeed, made since the budget, will ensure that palliative care services are broadened and available to people in regional Western Australia. Members, do not let that be your argument or thought on this issue. The amendment moved by Hon Martin Aldridge is specific and relates to voluntary assisted dying. It 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;

It is not about any other issue; it is simply about this sole issue. I urge members to not support Hon Nick Goiran’s amendment to the amendment, but simply to support the amendment moved by Hon Martin Aldridge today.

Hon JACQUI BOYDELL: Very briefly, I concur with and support the minister’s comments. Hon Martin Aldridge’s amendment is about ensuring regional people have access to voluntary assisted dying. As pointed out by other members, other clauses in the bill cover people’s access to high-quality end-of-life and palliative care services that support their quality of life. At the outset, the amendment moved by Hon Martin Aldridge specifically refers to regional people’s access to the voluntary assisted dying scheme. It should not be diluted by any other type of service, whether that is palliative care or not. This is purely about delineating access for regional people to the scheme. Therefore, I will not be supporting the amendment to the amendment.

Hon RICK MAZZA: The differences of opinion in this debate are very interesting. There are a couple of things to look at here. First of all, there is no doubt that delivering high-quality palliative care in the regions is a conundrum. It is very, very difficult. There cannot be an oncologist on every street corner in every country town along with other specialists. I think everyone gets that. But in clause 4, we are referring to some guiding principles for what we would like to see for voluntary assisted dying. Clause 4(1)(d) refers to high-quality palliative care. They go hand in hand. I expect that in many cases, palliative care would precede voluntary assisted dying. As a principle, to include palliative care in the amendment put forward by Hon Martin Aldridge will do no harm. I think it will give some guidance for what we would like to achieve in the future for palliative care in the regions. It is very difficult for regional people. I do not expect that we could wave a wand and provide perfect palliative care in the regions tomorrow. However, we could work towards improving it all the time. Telehealth has gone a long way towards that. There are many stories about how telehealth has assisted people in regional and remote Western Australia to stay at home during their palliative care time. With that, I will support the amendment to the amendment put forward by Hon Nick Goiran.

Hon ROBIN SCOTT: From living in the regions, no-one I have spoken to expects to have palliative care facilities in every single town. If we pick out, say, six towns in the whole of the Mining and Pastoral Region, such as Kalgoorlie, Meekatharra, Carnarvon, Port Hedland, and maybe Broome and Kununurra, that would service everyone in the regions. Take Kalgoorlie, for example. For people who live in Tjuntjuntjara, which is 700 kilometres east of Kalgoorlie, travelling into Kalgoorlie is like going around a corner to them. It is the same for the people in Warburton, which is 900 kilometres out of Kalgoorlie. They are more than happy to go to Kalgoorlie for palliative care. Unfortunately, it is not there at the moment. The people from Burringurrah near Meekatharra have a choice of whether to go to Carnarvon, which is about 300 kilometres, or to go to Meekatharra, which is 360 kilometres.

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People in these regional remote communities are more than happy to travel to palliative care facilities. It is nothing like the metropolitan area. If those towns had those six major palliative care facilities, we would solve this problem. It would not be too expensive to set up proper palliative care facilities in those six towns.

Hon KYLE McGINN: In response to what the honourable member said, Kalgoorlie does have a palliative care unit. I want to put that on the record. It has three beds. It is correct that Kalgoorlie has a palliative care unit. I understand that Meekatharra is still pushing to have a palliative care unit. I think it is the only region the member mentioned that does not have palliative care.

Hon Robin Scott: There are no palliative care nurses.

Hon KYLE McGINN: Yes, there are in Kalgoorlie. I want to make sure the record is correct. Meekatharra definitely needs to be a focus for that, but the rest of the towns have a palliative care unit.

Hon ADELE FARINA: In relation to the comments made, I need to seek some clarification from the minister. We have been told that it is unreasonable to expect an oncologist to be in every town. Implied in that is the suggestion that the amendment to insert a new paragraph (ha) would provide a VAD team in each town. I do not think anyone is suggesting that is the case, which makes the “we cannot expect to see an oncologist in every town” argument pointless. I am trying to understand: What will proposed paragraph (ha) actually deliver to regional people? Will a mobile VAD team go to the town if that is needed and provide the voluntary assisted dying service? Given that the voluntary assisted dying service requires nine days for completion of those steps, will that team stay in that town to complete that service over that nine days or are we proposing that in regional WA, the nine days will be contracted under exceptional circumstances so that there is no cooling-off period for the patient if they want to reconsider? It then raises questions about that criterion of enduring, which is part of the elements that need to be satisfied to access voluntary assisted dying in the first place. I am a bit unclear about what this amendment to insert paragraph (ha) will actually deliver. What will it mean for people living in regional WA? How are we going to ensure that a regional resident is entitled to the same level of access to VAD as a metropolitan resident? The government is supporting this, so it has obviously given some thought to how it is going to deliver this. I think it is really important for us to put on the record exactly what is intended to ensure that those elements of access to voluntary assisted dying, such as a person having an enduring wish to access voluntary assisted dying, are not diluted in any way.

Hon STEPHEN DAWSON: I do not propose to go into anything that will be dealt with in a later clause, so the level of detail that the honourable member is talking about will be up for further debate later on. I will just remind people that this is in the “Principles” part of the bill. Clause 4(1) reads —

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

We as a government will have regard to these principles. The amendment that Hon Martin Aldridge seeks to put in the bill 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;

This is a principle that we can agree with. People in regional Western Australia should be entitled to the same level of access. What does it deliver practically? This is not about concrete now; this is saying that we believe in the principle that a person who lives in regional Western Australia should have the same level of access. In terms of the detail —

Hon Donna Faragher: Then what’s the problem?

Hon STEPHEN DAWSON: This principle is about voluntary assisted dying. Other issues have been raised, and palliative care is mentioned earlier in the principles, but this is about the specific principle of voluntary assisted dying. This is a specific amendment dealing with a specific issue.

In terms of how it might work, during the implementation phase, the government, together with all stakeholders—WA Country Health Service, WA Primary Health Alliance, Australian College of Rural and Remote Medicine and other stakeholders in regional Western Australia—will work out how, in practice, this will operate in regional Western Australia. But, I say again, this is a principle in the bill, and Hon Martin Aldridge is seeking to include a principle that we can certainly support. People should have equality of access whether they live in regional Western Australia or in the metropolitan area.

Hon MICHAEL MISCHIN: I have a question about that, minister. I refer the minister to clause 4(1)(d). This is one of the principles that the minister says is important and that anyone performing a power or function under the act will have to have regard to it. We are not getting into specifics of detail as to how any of this will be provided. It states —

a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, —
I note that this means “palliative care” and “palliative treatment”, according to what the minister told us the last time we sat —

to minimise the person’s suffering and maximise the person’s quality of life;

Should a distinction be drawn, or is a distinction drawn, in that general principle between whether a person lives in the metropolitan area or a regional area?

**Hon STEPHEN DAWSON:** No.

**Hon MICHAEL MISCHIN:** The government accepts the proposition that a regional resident should be entitled to the same level of access to voluntary assisted dying as a person who lives in the metropolitan area, but it does not want to go so far as to say that a regional resident should be entitled to the same level of access to palliative care as a person who lives in the metropolitan region. Why is that? On the one hand, it is a general principle about there being no discrimination because of where a person lives. The government says that there is a principle on the equal provision of high-quality care and treatment, including palliative care and treatment, to minimise suffering. However, it wants to draw a distinction between the metropolitan region and regional areas in terms of the level of access to palliative care. Why is that? If this is simply a general principle, what is the harm? It simply will be something that a person who exercises a power under the legislation will have to have regard to and try to achieve. However, the government says that we should make a distinction, because this bill is about voluntary assisted dying rather than palliative care. On the one hand, all the principles reinforce equality across the board for every resident of this state, but, in this one case, when we are focusing on access, it is only those who live in the metropolitan region who ought to have that level of access to, and entitlement to access, palliative care. Does that not create a problem with the rest of the general principles stated in subclause (1)?

**Hon STEPHEN DAWSON:** I do not think there are any problems with the principles. I have been asked numerous times now about this issue—the honourable member may have been away from the chamber on urgent parliamentary business—so I do not propose to go around in circles again. I remind members that the substantive amendment was moved by Hon Martin Aldridge. I have indicated that the government is supportive of that amendment and I indicated the reasons behind our support for it. I also indicated that we do not support the amendment to the amendment moved by Hon Nick Goiran, and I also outlined the reasons why we do not support it. I do not think it is appropriate that I keep going around in circles on this issue. These amendments have been moved by other members. In one case, I am supporting the amendment; in the other case, I am not. I have identified the reasons why, and that is probably all I will say about it.

**Hon COLIN TINCKNELL:** Hon Michael Mischin made a very valid point. The principles in paragraphs (a) through to (j) of subclause (1) do not mention “regional”. However, Hon Martin Aldridge has moved an amendment that talks about access to voluntary assisted dying by regional residents. This is the point. That is the difference—the word “regional”—and that is why this debate is taking place. Many members have asked why people in regional areas are not getting the same level of access, whether or not it is about having an oncologist on every corner, but the amendment that has been put up will insert a principle that includes the word “regional”. The amendment to the amendment makes it clear that palliative care should also be available to people in regional areas. That is why this debate is happening in this chamber and that is why it is taking time. This will be the only principle to include the word “regional”. Hon Michael Mischin’s point is very valid. That is the reason this debate is taking place.

**Hon JACQUI BOYDELL:** I am just trying to reiterate why Hon Martin Aldridge moved this amendment. I refer to members’ comments in the second reading debate about how regional people gain access to the voluntary assisted dying scheme. That was a major concern of a lot of members in the house and it was raised by them, quite rightly so. Clause 4(1)(d) and other principles in the bill set out the way in which people’s quality of life, end-of-life choices, palliative care and therapeutic treatments should be supported. Those things are stated in the bill and they are the principles of the bill for the people of Western Australia. The original amendment moved by Hon Martin Aldridge seeks to support the minister’s comments that the government will ensure that there is a legislative regime with in-principle support for regional people having access to the voluntary assisted dying scheme. That is the legislation before us. The original amendment moved by Hon Martin Aldridge seeks to ensure that the legislative principle that the government has supported is set out. It is about ensuring that it is very clear in the principles of the bill that regional people should have equity of access to voluntary assisted dying. Other principles of the bill set out the fact that all Western Australians should be entitled to high-quality end-of-life care et cetera. By moving this amendment we seek to ensure that the principle of regional people having access to voluntary assisted dying is underpinned by parts of the legislation, and it should not be diluted by the addition of “and palliative care”, because the bill is not about palliative care; it is about voluntary assisted dying. Our aim is to ensure that regional people have fair and equitable access to the scheme, should the bill pass the house.

**Hon RICK MAZZA:** The amendment moved by Hon Martin Aldridge really reinforces clause 4(1)(h), which, as you, Deputy Chair (Hon Robin Chapple), mentioned, covers people living in regional Western Australia; it refers to all Western Australians. It is interesting to note that paragraph (h) states —

a person is entitled to genuine choices about the person’s care, treatment and end of life, …

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If we are going to reinforce clause 4(1)(h), then to me care and treatment include palliative care. I think the amendment on the amendment moved by Hon Nick Goiran expands on the original amendment moved by Hon Martin Aldridge to reinforce paragraph (h) for regional Western Australians. That is a reason that I support the amendment to the amendment. The amendment in its original form, and with this amendment to it, talks about access. We are not talking about having oncologists on every street corner; we are talking about access to palliative care and end-of-life choices. How that access is delivered is for the government to work out. I think palliative care is really part of that and it is highlighted in clause 4(1)(h).

Hon MARTIN ALDRIDGE: I hope we can get to a vote on this shortly, but I take on board that a lot of members have expressed the view that they take very seriously the provision of palliative care. I put to the members who support this amendment to my amendment to insert these words that the proper place to have given consideration to this matter is at clause 4(1)(d), which is a specific principle that relates to the provision of high-quality care and treatment, including palliative care and treatment. I would have thought that if members felt compelled to support the amendment before the Chair, that would have been the appropriate place to have supported it. It could have included words similar to those in paragraph (h), which states —

… irrespective of where the person lives in Western Australia and having regard to the person’s culture and language;

It may not have included all those words but certainly the words “irrespective of where the person lives in Western Australia”. That would have been a more appropriate amendment, because high-quality care can mean different things to different people in different places. That better reflects the reality; that is, we do not have a one-size-fits-all approach to the delivery of healthcare services in Western Australia, and we never will. I think it is unfair to include these words and say that we will be able to deliver palliative care in the same way as we deliver palliative care in Perth, or at least deliver the same level of access, excluding all the other medical services.

Hon Adele Farina commented that I had not responded to Hon Aaron Stonehouse and his concern that the inclusion of this principle would create a circumstance in which the state would provide voluntary assisted dying. I think I did respond to Hon Aaron Stonehouse. I do not deny the fact that the state of Western Australia will be intrinsically involved in just about every step of voluntary assisted dying. They may not be the private practitioner who is assessing the patient but they could be the public practitioner who is assessing the patient, the public hospital who is looking after the patient, the State Administrative Tribunal that is reviewing a decision or the CEO of the Department of Health exercising a power under the provisions of this bill, and potentially under this act. I do not deny that the state will be involved in voluntary assisted dying. I think the inclusion of this principle in the form that I propose better reflects the commitment by the government and the reality that we face.

Division

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

Ayes (17)
Hon Jim Chown  Hon Rick Mazza  Hon Tjorn Sibma  Hon Alison Xamon
Hon Peter Collier  Hon Michael Mischin  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Donna Faragher  Hon Simon O’Brien  Hon Aaron Stonehouse
Hon Adele Farina  Hon Martin Pritchard  Hon Dr Steve Thomas
Hon Nick Goiran  Hon Robin Scott  Hon Colin Tincknell

Noes (18)
Hon Martin Aldridge  Hon Stephen Dowson  Hon Colin Holt  Hon Dr Sally Talbot
Hon Jacqui Boydell  Hon Colin de Grussa  Hon Alannah MacTiernan  Hon Darren West
Hon Robin Chapple  Hon Sue Ellery  Hon Kyle McGinn  Hon Pierre Yang (Teller)
Hon Tim Clifford  Hon Diane Evers  Hon Samantha Rowe
Hon Alanna Clohesy  Hon Laurie Graham  Hon Matthew Swinbourn

Amendment on the amendment thus negatived.

The DEPUTY CHAIR: Members, we return to the original amendment 408/4 moved by Hon Martin Aldridge —

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;

Hon AARON STONEHOUSE: Now that we are back to discussing the substantive amendment, it would be a good opportunity to further clarify why I oppose the amendment. It is true that in responding to my comments, Hon Martin Aldridge pointed out that the state will be intimately involved in every aspect of voluntary assisted dying as a result of this bill. That is certainly true, but I feel that putting in place an entitlement to voluntary assisted dying places an obligation on the state that pushes it beyond a level of facilitation of VAD that I am comfortable...
with. It stems from my view that, ultimately, individuals have a right to make choices about their end-of-life care, but then we weigh into issues such as what is a right and what is the state’s obligation for an individual’s rights. It is a weird political science space that we start wandering into.

To try to put it into really simple terms, I will use a couple of analogies to help illustrate to members where I am going with this. People have a right to free speech in a natural justice sense, but also, as interpreted by the High Court, people have a right to political communication. But we will deal with the natural justice sense of a right to free speech, which is recognised in common law and in the broad political consensus that we have in Australia. People have a right to free speech. Some people on certain ends of the political spectrum may place limitations on that, but a person’s right to free speech ensures that the government cannot act to curtail their free speech. It does not mean that the government needs to give them a megaphone, a soapbox to stand upon, a website, a TV show, or a radio station. Their right to free speech simply means that the government cannot interfere with their right to speak freely and communicate with other people.

I am an advocate of the decriminalisation or legalisation of cannabis for recreational use. It is a rather controversial position to some. My belief that the government should not criminalise the consumption or cultivation of cannabis does not mean that I believe the government should provide cannabis to people who wish to use it. Removing criminal penalties for smoking cannabis is very different from the government becoming a cannabis dispensary, getting into the business of producing cannabis and ensuring that every citizen, regardless of where they live and their economic means, has access to cannabis.

I hope members will forgive me if this is a rather controversial topic. I will choose another contentious social issue that has weighty moral and ethical issues at its heart—that is, abortion. To argue that abortion should be decriminalised is very different from arguing that the state should provide abortion services at the expense of the taxpayer. They are very different things. To remove criminal penalties or a constraint on someone seeking to access a service is very different from the state becoming the primary service provider or taking a central role in the provision of that service.

A right to exercise freedom is very different from an obligation on government to provide people with that service. We have the right to buy and own private property. At least, I think everyone except those on the political fringe left believe that people have a right to private property. That does not mean that the government has an obligation to provide people with a house. We have a right to own clothing and to buy food and water, but there is no obligation on the state to provide people with clothing, food or water. We certainly provide welfare and have a social safety net. Some acts and statutes may have in their principles the principle that the state should provide those services. However, if we are talking about the natural justice sense of rights and what government is instituted to protect and provide for citizens, there is a real distinction between what people should be free to pursue on their own terms without unnecessary government interference and what the government has an obligation to provide to them. Regardless of whether members see voluntary assisted dying as I do—as something people should have a right to access if they choose to, but that the government should not be obliged to provide to them as a subsidised service—they should at least recognise a distinction between the two. There is a distinction between the right for citizens to pursue something and an obligation on the state to provide that service.

Taking the classical liberal view that government should be instituted to protect rights such as life, liberty and property, and that people are autonomous, own their own bodies, and have a right to make their own choices about their own life and their own bodies as long as they do not harm anybody else, I am rather uncomfortable with this amendment and I will not be supporting it. Regardless of the fact that I do not think anybody should be blocked from accessing voluntary assisted dying, as long as they are exercising their own conscience and are fully informed and have capacity, putting an obligation on the state to provide voluntary assisted dying to anyone regardless of where they live is a step too far for me.

**Hon NICK GOIRAN:** I rise briefly to indicate that, like Hon Aaron Stonehouse, I will be opposing this amendment that has been moved. I do that for two reasons. One is that I share the reasons he has just articulated. Secondly, if we as a chamber support this now, having defeated the previous amendment, we absolutely send the wrong message to regional Western Australia, and that is something I cannot support.

**Committee interrupted, pursuant to standing orders.**

[page 8986]

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

**Clause 4: Principles —**

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

**Hon MARTIN ALDRIDGE:** I will provide some final remarks. As I said before, I seek the support of the committee on this substantive amendment that we have returned to. I understand that some members have some concerns

*Extracted from finalised Hansard*
around the state being obligated to, or involved in, the service provision of voluntary assisted dying. I am sorry that I cannot help them with that concern. If that is a concern, I think the only course of action for those members is to oppose the bill, because, at the end of the day, this is a state-sanctioned scheme. The state will be involved in the implementation of the voluntary assisted dying scheme in many respects.

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

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

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

Amendment put and passed.

Hon MARTIN PRITCHARD: I move —

Page 3, line 18 — To delete “abuse;” and substitute —

abuse or coercion;

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

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

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

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

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

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

Hon NICK GOIRAN: Clause 4(1) states —

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

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

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

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

Hon STEPHEN DAWSON: I am advised that the principle is aspirational for everyone, but in the context of this bill, a person who is exercising a power or performing a function under the legislation must have regard to the principles.
Hon NICK GOIRAN: Looking ahead to the amendment standing in my name at 55/4, as I indicated, I am probably inclined to move an amendment to the one proposed by Hon Martin Pritchard. I can provide a detailed explanation for the reason for that, but perhaps if we are looking to make some progress, can I get an indication of what the government’s position is on the addition of the words “duress or undue influence”? If we are all on the same page, I am happy to move on.

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

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

- to insert after “coercion” —

  duress or undue influence

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

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

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

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

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

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

“Abuse” is quite a strong term. There are a number of concerns about people’s influence on patients’ decisions, such as coercion, duress, undue influence and the like. A lot of those terms have specific legal meaning, which is not defined by reference to the word “abuse”. I am not aware of any legislative provision in Western Australia or any precedent that defines coercion or duress as abuse. I am simply concerned about where the boundary will be drawn for what constitutes abuse and what is considered bad behaviour that may not necessarily reach the point of being abuse. In asking that question, I seriously ask the minister to contemplate broadening this definition, because, as I said, abuse has quite a high bar to go over to be proven. Alternatively, I suggest an inclusive definition that says something along the lines of “abuse includes duress, coercion and undue influence”. Otherwise, irrespective of whether these are principles or enforceable legislative provisions, we leave this act open to question marks about serious matters that could have strong influence on a person who is contemplating making these sorts of decisions that may not necessarily reach the point of being considered abuse but would still be considered to be having an unfair and undue influence on that individual.

The member for Hillarys went on to say —

We all agree that no-one wants anyone to be subject to abuse, but the point here is that there are levels of pernicious behaviour towards a vulnerable individual that may not necessarily be considered to be abuse; they may be considered to be slightly lower than the benchmark for abuse, but still highly influential and pejoratively influential on an individual. That is the point I am making. I have made it very clear that I do not feel comfortable supporting this legislation, but I still want it to be as safe as humanly possible. I think

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that limiting the types of influences that a person is protected from to abuse is setting the benchmark way too high, because, as I said, I know of no legal jurisdiction that defines duress as being abuse or that defines coercion as being abuse. If it is litigated, there may well be a finding that there needs to be a level of coercion or duress before it is abuse. We are talking about principles here and I would have thought that broader and more inclusive language would have been used to assuage the fears and concerns of people, which I have, that this is highly prescriptive and highly dangerous legislation that does not provide enough protection for vulnerable individuals.

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

(2) A person commits a crime if the person, by dishonesty, undue influence or coercion, induces another person —

(a) to make a request for access to voluntary assisted dying;

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

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

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

Division

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

Ayes (12)
Hon Donna Faragher Hon Rick Mazza Hon Martin Pritchard Hon Colin Tincknell
Hon Adele Farina Hon Michael Mischin Hon Charles Smith Hon Alison Xamon
Hon Nick Goiran Hon Simon O’Brien Hon Aaron Stonehouse Hon Ken Baston (Teller)

Noes (22)
Hon Martin Aldridge Hon Peter Collier Hon Colin Holt Hon Matthew Swinbourn
Hon Jacqui Boydell Hon Stephen Dawson Hon Alannah MacTiernan Hon Dr Sally Talbot
Hon Robin Chapple Hon Colin de Grussa Hon Kyle McGuinness Hon Darren West
Hon Jim Chown Hon Sue Ellery Hon Samantha Rowe Hon Pierre Yang (Teller)
Hon Tim Clifford Hon Diane Evers Hon Robin Scott
Hon Alanna Clohesy Hon Laurie Graham Hon Tjorn Sibma

Amendment on the amendment thus negatived.

Amendment put and passed.

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

Hon STEPHEN DAWSON: Honourable member —

Hon Nick Goiran: It must be complicated!

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

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

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

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

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

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

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

Page 3, lines 19 to 21 — To delete the lines and substitute —

(j) all persons, including health practitioners, and organisations have the right to be shown respect for their personal or organisational culture, religion, beliefs, values and characteristics.

Hon STEPHEN DAWSON: I had indicated that we would not support both parts of the original amendment, but we certainly do not support how it has been moved now, as it still includes the issue of organisations. As many of us would be aware, the culture of an organisation may not be reflected by the individuals within it. This bill is patient centred and reflects the choice of individuals to participate or not participate in the voluntary assisted dying process, from the patient to the medical practitioner, who may be asked to be an assessing practitioner; to a pharmacist, who may be asked to supply the substance; to a nurse practitioner or medical practitioner who administers the substance to the patient. These are actions of individuals. As such, the government will not accept a change to this principle.

The intention of the existing provisions in the bill directed at health practitioners is that corporations, including faith-based institutions, cannot be compelled to participate in the voluntary assisted dying process. They are able to object to participating in the voluntary assisted dying processes for any reason, including but not limited to conscientious objection. The bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of individuals and organisations that do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility.

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

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

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

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

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

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

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Medical assistance in dying —
   … even when their own health care providers object to it.

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

**Division**

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

**Ayes (7)**

Hon Martin Aldridge  
Hon Simon O’Brien  
Hon Aaron Stonehouse  
Hon Ken Baston *(Teller)*

Hon Nick Goiran  
Hon Charles Smith  
Hon Colin Tincknell

**Noes (25)**

Hon Jacqui Boydell  
Hon Robin Chapple  
Hon Jim Chown  
Hon Tim Clifford  
Hon Alanna Clohesy  
Hon Peter Collier  
Hon Stephen Dawson  
Hon Colin de Grussa  
Hon Sue Ellery  
Hon Diane Evers  
Hon Adele Farina  
Hon Laurie Graham  
Hon Colin Holt  
Hon Alannah MacTiernan

Hon Colin de Grussa *(Teller)*  
Hon Rick Mazza  
Hon Kyle McGinn  
Hon Martin Pritchard  
Hon Samantha Rowe  
Hon Robin Scott  
Hon Tjorn Sibma  
Hon Matthew Swinbourn

Amendment thus negatived.

Clause, as amended, put and passed.

**Clause 5: Terms used**

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

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

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

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

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

**Sitting suspended from 6.00 to 7.30 pm**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hon STEPHEN DAWSON: The bill does not contain a specific clause regarding the delegation power of the CEO. The intent is that the CEO will have the final sign-off for any duties under the bill. However, if we do wish the CEO to delegate, as may be an administrative necessity over time, we may rely on section 9 of the Health Legislation Administration Act 1984 as the overarching delegation power. This is because that act applies to the acts, the administration of which is committed by the Governor to the Minister for Health, and the administration of the VAD act will be committed to the Minister for Health.

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

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: At line 20, it states —

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

Clause 50 states —

(1) On receiving a final request made by a patient, the coordinating practitioner for the patient must —

(a) review the following in respect of the patient —

(i) the first assessment report form;

(ii) all consulting assessment report forms;

(iii) the written declaration;

and

(b) complete the approved form ... in respect of the patient.

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

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

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

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


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

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

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

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

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

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

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

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

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

To ensure that the medical practitioners seeking to become co-ordinating or consulting practitioners for the purpose of voluntary assisted dying are only those that are appropriately qualified, skilled and experienced.

To ensure that there is appropriate access to voluntary assisted dying across the geographically diverse state of Western Australia.

To ensure that trainees or junior medical practitioners do not able —

I presume that is supposed to read “are not able” —

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

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

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

In considering the question of medical practitioner qualifications and experience, the Panel was clear that this is not an appropriate task to be undertaken by junior medical practitioners or by medical practitioners.

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in training. Being a co-ordinating or consulting practitioner for a person who has requested voluntary assisted dying is a significant responsibility and poses ethical and clinical practice considerations for these practitioners. This is not an appropriate responsibility to place on learning or inexperienced practitioners.

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

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

**Hon Stephen Dawson:** The answer is yes.

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

**Hon Stephen Dawson:** Yes.

**Hon Nick Goiran:** Yes; okay. This is why the definition of “medical practitioner” is so important. The definition before us at the moment says —

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

Students are carved out of this definition, and I think that is entirely appropriate for the reasons that we have discussed, as also outlined by the ministerial expert panel at pages 58 and 60 that the minister referred us to. However, the ministerial expert panel also said that it would not be appropriate for junior medical practitioners to be involved in this process, yet I understand from the minister that we are still requiring Western Australian junior medical practitioners to have certain duties under this bill. Why is that appropriate?

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

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

**The Deputy Chair (Hon Matthew Swinbourn):** Member, can you bring this back to the clause.

**Hon Nick Goiran:** It requires some elaboration, Mr Deputy Chair.

**The Deputy Chair:** I am giving you that, but I just want you to bring it back.

**Hon Nick Goiran:** I am endeavouring to do so now.

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

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

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

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

Having made those remarks, I have some questions about whether a definition of “simple offence” should be put into the bill. This arises from discussion that took place in the other place. Queries were raised about this, in particular whether it would be appropriate to make it clear that we are referring to a term alleged to be in the Criminal Code. I draw to the minister’s attention this exchange that took place between the member for Hillarys and the Minister for Health. Mr Katsambanis said —

Clause 110 is headed “Who may commence proceedings for simple offence”.

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

Hon NICK GOIRAN: Does the minister want to clarify that?
Hon Stephen Dawson: My advisers tell me that section 67 of the Interpretation Act 1984 sets out that offences are of two types: indictable offences, which are crimes and misdemeanours; and simple offences, which are offences that are not designated as a crime or misdemeanour and are dealt with in the Magistrates Court.

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

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

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

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

He was obviously speaking to the member for Hillarys —

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

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

Hon STEPHEN DAWSON: Yes, and the member is correct.
Hon NICK GOIRAN: I move —

Page 4, line 2 — To delete “substance,” and substitute —

poison,

Notwithstanding the comments I made to members earlier that it is possible to leave an amendment on the supplementary notice paper and deal with a more substantive one later—this is one that could be dealt with in

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

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

The DEPUTY CHAIR: Order, member!

Hon Donna Faragher interjected.

Hon Alannah MacTiernan interjected.

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

Hon NICK GOIRAN: Thanks, Mr Deputy Chairman. It is disappointing to get that interjection from another very experienced parliamentarian, who also knows the difference between a consequential amendment and a primary amendment. Nevertheless, because of the hysteria caused by the Premier and his intertemperate remarks, I think it is best that we deal with this amendment now rather than at the more preferable place, which would be at clause 7. This is a consequential amendment that would flow from the proposed amendment to clause 7 that is on the supplementary notice paper under my name. At clause 7, I seek to substitute “substance” with “poison”. As I have indicated, a great number of consequential amendments flow from the substitution of that term throughout the bill, the first of which is this amendment to delete “substance” and substitute it with “poison” in the definition of “administration” in clause 5.

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

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

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

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

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

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

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

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

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

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

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

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

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

The Deputy Chair: Hon Nick Goiran.

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

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

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

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

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

Hon Stephen Dawson: I thank the honourable member for that. As I was saying, we do not support these amendments. Clause 7 of the bill defines a voluntary assisted dying substance to mean a schedule 4 or schedule 8 poison approved by the CEO for the purpose of causing a person’s death. It is clear that a VAD substance is a poison by reference to clause 7. There is no smokescreen; it is consistent with the Victorian act in that regard.
“Prescribed substance” is defined under clause 5 of the bill to mean a voluntary assisted dying substance, generally, prescribed for a patient by the patient’s coordinating practitioner; and, in relation to a particular patient, the voluntary assisted dying substance specifically prescribed for the patient by the patient’s coordinating practitioner. The Victorian legislation gave some guidance in how it named its voluntary assisted dying substance, but it was not the sole basis for why this terminology is being used in the bill; it was the starting point. Members will note also that the Western Australian legislation is more specific. Once a VAD substance is prescribed to a particular patient, it is called the “prescribed substance”.

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

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

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

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

Hon AARON STONEHOUSE: I have a lot of sympathy for this amendment, given the arguments made by Hon Nick Goiran and the common understanding and definition of the word “poison”. It certainly seems to be a more accurate description of what we are dealing with here than “voluntary assisted dying substance”. It is at least consistent with the Medicines and Poisons Act and regulations in Western Australia, and it seems to address a concern I have had with this legislation. Although I am in support of the right of individuals to make choices about their own body, as I stated earlier this evening, I am concerned about what seems to be an attempt to sanitise or sterilise the way we deal with voluntary assisted dying—to dress it up and make it sound a little prettier than it really is. Ultimately, what we are dealing with here is someone taking a poison to kill themselves. It is suicide, under the most basic understanding of that word; it is somebody taking their own life and, in this case, using a poison to do so. It may be a compound or substance that is mixed with other things that are not necessarily poison, but certainly a poison is involved. The definition of a poison is a substance you take to end a life.

I understand that there are negative connotations around some of these words—poison and suicide—and that they may be upsetting to some people, but we should not water down what will eventually become statute because certain people are sensitive to certain words. Words have meaning, and when we are dealing with statutes, we should use the commonly understood meaning of those words. We should not compromise on language to tiptoe around the sensibilities of certain members of the public. It is, in fact, a poison, and that is the clearest way to understand what we are dealing with, regardless of how offensive that term might be to some people. I am sure that we will deal with this topic again when we start to discuss whether suicide is recorded on a death certificate. In fact, we dealt with this topic in another unrelated piece of legislation when we looked at the Human Reproductive Technology and Surrogacy Legislation Amendment Bill. That legislation tried to insert what I thought was an element of almost social engineering, namely the new made-up term “social infertility”. I had never heard of that before, but a biological man who does not have female reproductive organs and therefore cannot give birth to their own child is now described as socially infertile. It is an act of wordsmithing and manipulation of language —

Hon Simon O’Brien interjected.

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

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

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

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

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

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

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

Hon STEPHEN DAWSON: Clause 72 sets out the requirements.

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

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

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

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

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

Hon STEPHEN DAWSON: That is correct.

Division

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

Ayes (6)
Hon Jim Chown
Hon Simon O’Brien
Hon Aaron Stonehouse
Hon Charles Smith
Hon Ken Baston (Teller)

Noes (26)
Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Tim Clifford
Hon Alanna Clohesy
Hon Peter Collier
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diana Evers
Hon Donna Faragher
Hon Adele Farina
Hon Laurie Graham
Hon Colin Holt
Hon Dr Sally Talbot
Hon Alannah MacTiernan
Hon Rick Mazza
Hon Kyle McGinn
Hon Martin Pritchard
Hon Samantha Rowe
Hon Robin Scott
Hon Dr Sally Talbot
Hon Colin Tincknell
Hon Darren West
Hon Alison Xamon
Hon Pierre Yang (Teller)

Amendment thus negatived.

Hon NICK GOIRAN: I do not propose at this time to move the amendment standing in my name at 127/5. It is my
intention, for the benefit of the hardworking clerks of the chamber, that this amendment remain on the supplementary
notice paper in the event that at a later stage the bill is recommitted for consideration of clause 5. By way of
explanation, this particular amendment is effectively a consequential amendment to a more substantive one that
I have under clause 11. If you like, this is a consequential amendment, as is another one under clause 5, which I will

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refer to later, and the primary amendment is under clause 11. This is something that an experienced parliamentarian like the Premier would know full well, but he continues to mislead the public. Nevertheless, to facilitate progress I do not propose to move that amendment at this time. Should I need to move the amendment at a later stage, I will. Although I do have other amendments under my name on clause 5, I note that other members have amendments in sequence, so I will leave it to them to make their remarks.

Hon RICK MAZZA: Hon Nick Goiran pointed out that there are a number of consequential amendments. In fact, I have some 46 amendments on the supplementary notice paper, but only around five or six of them are actually substantive amendments; the rest are consequential amendments. It would be somewhat of a nonsense to move those amendments at this point, not knowing whether the substantive amendments will pass. I have also consulted with the clerks on this issue and I prefer not to move those amendments now. I will move the substantive amendments when we get to those clauses, and if I have some success on those, we can always recommit the bill.

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

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

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

Page 6, after line 6 — To insert —

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

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

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

Amendment put and passed.

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

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

Hon CHARLES SMITH: That is correct.

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

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

I have some questions about how that will interact with division 2 in part 3 of the bill and the obligation on a medical practitioner to report a request made to them for voluntary assisted dying and, in fact, their obligation to provide a patient with information that is referred to in clause 4(1)(b). I will leave my questions around the steps that a practitioner must take under division 2 until the chamber considers the clauses under that division. I wonder whether the minister can provide a little bit of information about where the definition for “patient” comes from and why it is defined in these terms. When we get to division 2 in part 3, the language changes a little and rather than a “patient” making a request, it refers to a “person” making a request. The distinction between a patient of a medical practitioner and a person merely making a request gets a little confusing. I ask this because I am a little concerned that, for instance, a medical practitioner could be, I do not know, at a function or out at dinner and a random person could approach them and ask them for information about voluntary assisted dying. That may trigger

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the obligations for a medical practitioner under division 2, based on the language used in division 2 where it merely refers to a person. Even the definition here of a patient does not require that a patient, as defined in clause 5, needs to be anyone with any kind of therapeutic relationship with a medical practitioner. Again, by my casual reading, it could be any person who approaches a medical practitioner and requests information about voluntary assisted dying. A patient might approach a pathologist who might be merely handling one aspect of someone’s therapeutic care and the patient could ask them questions about voluntary assisted dying. However, they would be in no way qualified to answer the patient and all of a sudden, obligations under division 2 would be triggered. Without getting perhaps too much into the process under division 2, maybe the minister can give us a little information about the definition of “patient” in clause 5 and how that was determined during the consultation and the drafting of this bill.

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

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

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

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

**The DEPUTY CHAIR:** Your clarification is correct.

**Hon NICK GOIRAN:** I move —

Page 6, after line 10 — To insert —

\[\textit{palliative care and treatment}\] includes a medical, surgical or nursing procedure or other treatment or service that is provided to a person, who has been diagnosed with at least 1 disease, illness or medical condition that is life-limiting, for the purpose of preventing or relieving suffering by means of early identification, assessment and treatment of pain or discomfort, including physical, psychosocial and spiritual distress;

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

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

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

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

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

\[\textit{palliative care}\] has the same meaning as in the \textit{Medical Treatment Planning and Decisions Act 2016};

We can read in the \textit{Hansard} from the other place that the member for Girrawheen had originally intended to move an amendment to insert a similar definition into the bill that is before us that palliative care has the same meaning as found in section 3 of the Guardianship and Administration Act. However, as I read the \textit{Hansard} from the other place, the member for Girrawheen noted that the Minister for Health indicated that this definition was too narrow and outmoded—“outmoded” was the word the minister used, according to the member for Girrawheen on 4 September 2019 at page 6402.
The health minister acknowledged in the other place that the definition of “palliative care” in section 3 of the Guardianship and Administration Act is considered a rather constricted and outdated perspective of what palliative care means. He stated —

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

He was referring to the Guardianship and Administration Act definition —

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

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

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

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

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

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

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

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

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

The committee went on to say at paragraph 3.88 —

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

And at paragraph 3.89 —

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

The committee went on to say at paragraph 3.95 —

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

Extracted from finalised Hansard
The report states at paragraph 3.96 —

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

The committee further stated at paragraph 3.149 —

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

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

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

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

The CHAIR: Hon Nick Goiran.

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

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

The response from the health minister was —

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

The member for Dawesville then said —

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

The health minister said —

I can give the member that assurance.

The minister gave assurance to the member for Dawesville in the other place to keep him quiet, to suppress his voice in the debate, only for us to come into this place and now have a definition provided by the minister. It shows such disrespect to the members of the other place. I feel for those members who had to sit through a debate, including until five o’clock in the morning, to be told that kind of information from the health minister only for them now to find that they were right. Dr Honey was right, Mr Kirkup was right and the member for Girrawheen was right. In the health minister’s response to the member for Dawesville he works from the assumption that the patient will already have a palliative care specialist, yet we know from the inquiry, the so-called “My Life, My Choice” report, that most Western Australians who would benefit from the care and expertise of a palliative care specialist do not
have access to those specialist services. As I mentioned earlier, that report from the committee clearly indicates that health professionals, including specialists, do not recognise the need for palliative care or may not know how to refer their patients into the service. This says nothing of how the same health professionals can then be expected, under the current bill, to inform patients requesting voluntary assisted dying of—to effectively quote clauses 26 and 37—the palliative care and treatment options available to them and the likely outcomes of that care and treatment.

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

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

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

Including this definition —

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Leave denied.

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

Point of Order

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

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

Committee Resumed

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

I would like to know, in order to make up my mind up as to whether I support Hon Nick Goiran’s proposed amendment or the government’s, what the material differences are, as the government sees them, that makes their definition preferable to the broader one that has been proposed. There are some obvious differences. One is that the government’s proposed amendment mentions a “progressive and life-limiting” disease, illness or medical condition. Why “progressive”, for example? What is material about that as opposed to a life-limiting medical condition, disease or illness? Why is it that elements such as “physical, psychosocial and spiritual distress” are being abandoned in place of the vague “quality of life” concept? Quality of life according to whom? We heard earlier under the principles in clause 4 that quality of life is meant to be determined subjectively. How does that fit with something that is an objective exercise of palliative care and treatment—meaning that it is directed towards improving comfort and quality of life in the manner that is proposed in the government definition? What does “quality of life” mean for the purposes of being able to decide that?
I would like to know more about, particularly, the minister’s comment that this is a definition of “palliative care and treatment” as understood in Western Australia. By whom is it understood? We have not had any consultation other than within government. We do not know whether this particular definition is drawn from any other definition that is used anywhere else. I would like to know more about its genesis, how it was formulated and against which touchstones, particularly when one sees the attitude of the government in the other place. The minister has simply dismissed it by saying that the government’s position has evolved. It has “changed”, I presume. If it has evolved, why has it? It was found to be unnecessary in the other place by the Minister for Health, whose bill this is. It was dismissed out of hand when people were talking about it down there. Now, all of a sudden, the government comes up with its own definition and says that its position has evolved. What has caused it to evolve? What are we dealing with here, and why has the government proposed this particular amendment in these words?

Hon Sue Ellery interjected.

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

Hon Stephen Dawson: She can seek the call.

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

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

Hon Michael Mischin: Why?

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

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

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

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

Hon NICK GOIRAN: Again, I foreshadow that I will seek leave to withdraw my amendment. I appreciate the helpful observations made by my colleague. I thank him for it. I might just quickly take this opportunity to put on the record my concern that it does appear to be a far more limited definition. I would have spoken to that earlier, but I did not want to get in the way of the member

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

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

Amendment put and passed.

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

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

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

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

Page 7, after line 20 — To insert —

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

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

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

Amendment put and passed.

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

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

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

Hon NICK GOIRAN: I move —

Page 8, lines 7 to 9 — To delete “administration of a voluntary assisted dying substance and includes steps reasonably related to that administration;” and substitute —

process by which a person is given assistance to die in accordance with this Act, whether by voluntary euthanasia or by assisted suicide;

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

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

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

Progress reported and leave granted to sit again, pursuant to standing orders.
dying being available by way of practitioner administration, have grave concerns about self-administration. I am certainly a member who has grave concerns about self-administration, but we need to be clear that in this bill we are allowing two different forms of voluntary assisted dying—practitioner administration and self-administration. They are not the same, and there are, obviously, significant differences in risk between those two things.

Very different reporting and procedural requirements, including extra levels of assessment, witnessing and certification, are ascribed in this bill to practitioner administration compared with the reporting and procedural requirements around self-administration. Since this bill takes a very different approach to practitioner administration and self-administration, it follows that these very different voluntary assisted dying methods, and the legal framework around them, should be explicitly acknowledged in the bill through the employment of the terms commonly used to describe these methods—voluntary euthanasia and assisted suicide. This amendment should be supported to provide definitive clarity for practitioners and the general public. This amendment would also provide clarity for reporting purposes, both to the Voluntary Assisted Dying Board and also under clause 81 with regard to death certificates.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of the amendment that stands in Hon Nick Goiran’s name. This issue was canvassed previously at clause 1, so I do not propose to go into that detail again. However, I will say that the government is firm on the model of voluntary assisted dying and does not propose to change the model or the terminology—the terms are clearly defined in the bill.

Hon NICK GOIRAN: If my amendment were successful, would it change the model?

Hon STEPHEN DAWSON: I have said generally that we do not propose to change the model or the terminology. I do not want to get into semantics.

Hon Nick Goiran: Just answer the question, then move on.

Hon STEPHEN DAWSON: I have indicated that the government is not supportive of the member’s amendment.

Hon NICK GOIRAN: For the record, in the absence of an explanation by the minister, let it be clear to the people of Western Australia that my amendment would not change the model. I invite the minister to correct the record if he disagrees with that proposition.

Hon AARON STONEHOUSE: I honestly cannot see anything objectionable about the amendment moved by Hon Nick Goiran. As far as I can tell, it does not seem to insert any new language that might be problematic or offensive. It goes back to the point I made last night, which was that I am concerned about a softening, coddling or watering down of language to the point at which words no longer have their proper meaning and we wrap this legislation in cottonwool to prevent causing offence to certain people who are particularly sensitive to certain language. It is certainly not my intention to use language that would cause anyone distress, but it seems to me that a clearly understood definition of “assisted suicide” would aid in understanding exactly what this legislation does. In fact, a clear explanation of what this legislation deals with, which is assisted suicide, really appears only once in this bill. A comprehensive explanation of what the legislation aims to do is strangely absent from the bill. Voluntary assisted dying is described in this bill as —

… the administration of a voluntary assisted dying substance and includes steps reasonably related to that administration;

“Voluntary assisted dying” is defined only as the taking of a substance, but then the substance is not described as a poison, so it is a little hard to follow and understand exactly what voluntary assisted dying is when one reads the terms in the bill. Making that a little clearer to the reader and the public might be of benefit. Without a compelling argument the other way, I cannot see that the inclusion of this new term would diminish the bill in any way or interfere with its operation, but I am happy to be proven wrong on that part. I will be paying close attention to the response by the minister.

Hon STEPHEN DAWSON: Honourable member, I made countless remarks on this point in the debate on clause 1, so I do not propose to raise it again. I have been very clear. I have to say that I am deeply offended by the member’s suggestion that we are trying to pretty things up, which were the words the member used last night, or to coddle people. To suggest such things is utter rubbish. The clause 1 debate was extensive; I was told today it went for 14 hours, and it is the right of this Parliament to ask appropriate questions about clause 1. When this issue was canvassed in the debate on clause 1, I indicated that the government did not support this language, and I outlined why it did not. I remain of that view, and I have indicated that the government is not supporting the amendment standing in Hon Nick Goiran’s name.

Hon SIMON O’BRIEN: While we are talking about these things, I will make good on one of the undertakings I gave in my second reading contribution when I expressed my concern about the Orwellian approach that this government is taking through this proposed legislation, with the government saying that when someone deliberately ingests a poison with the intention of killing themselves, it is not suicide. It is. Yet, the government is proposing to pass a law saying what is, is not. Elsewhere in this bill we are proposing to say that if someone assists a patient who requires the assistance to ingest a poison either orally or intravenously with the express intention of terminating that person’s life, it is not euthanasia. It is. Just because the government passes a law with its numbers through its
caucus phenomenon here, and it disturbs me in a number of ways. I have mentioned that it is Orwellian—this sort of newspeak that the Labor Party seems to like, which it seems determined to thrust upon the rest of society. Fundamentally, I do not like it, because it is wrong. I do not like the fact that there do not seem to be enough members in this place at this time, and particularly in another place, prepared to stand up and say this is just humbug. Hon Aaron Stonehouse is, so the minister can pour scorn on him because he does not like his terminology when he has the temerity to question the minister’s. The reason I am rising at this stage is that the matter currently before us is an attempt by Hon Nick Goiran, and has he not been vilified publicly —

Several members interjected.

**The DEPUTY CHAIR**: Members! We are dealing with the clause before us.

**Hon SIMON O’BRIEN**: I am standing up. I am sorry if it is not fashionable enough for members. I am standing up to support Hon Nick Goiran, because he is calling out the proponents and supporters of this bill over this particular piece of humbug. It is via this amendment, and others related to it, that he is seeking to correct or prevent a wrong from being done on our statute book, and rightly so. That is why he will have my support in this particular matter. I fear that the amendment will not be successful though. That is why I am on my feet—to place on the record that at least some members in this place were prepared to resist this nonsense that when people deliberately kill themselves, it is not suicide; it will be called something else. When we administer poison, do not call it medicine. Medicine is meant to heal. When we administer medicine to a patient to kill them, it is not euthanasia. That is just nonsense.

**Hon Alannah MacTiernan**: Any medicines are on the poisons list. That point has been made.

**Hon SIMON O’BRIEN**: Please do not be disingenuous about such a matter.

**Hon Alannah MacTiernan** interjected.

**The DEPUTY CHAIR**: Member! Order!

**Hon Alannah MacTiernan** interjected.

**Hon SIMON O’BRIEN**: What the heck does that have to do with the price of fish?

**The DEPUTY CHAIR (Hon Robin Chapple)**: Members! When I call order, I want conversation across the chamber to stop. Is that clear? Thank you. In fact, Hon Simon O’Brien is addressing his comments through me to the minister for a response from the minister.

**Hon SIMON O’BRIEN**: Indeed, that is what I am trying to do, Mr Deputy Chair. Thank you for reminding members of that—members who want to mutter away in the background, at the risk of incurring your displeasure by distracting me, and we would not want that.

As it seems to have been raised in the ether, I do understand what the Poisons Act is all about. I was working with it for years before I came into this place, so I thank members via their interjections for their attempts to be helpful but they are not being helpful; they are being disingenuous by deliberately misrepresenting the context in which I am using the term “poison”. The minister ought to know that. If she does not, heaven help her.

I would have concluded my remarks before now but for interjections and but for the fact that I feel constrained to offer the observations that I have in large part because of the demeanour that has been exhibited towards me by members on the benches opposite and other members in this place in connection with this bill. They might not like the fact that their perfect bill is being questioned. That is tough, but that does not give them the right to criticise the processes from within this house or from without. If they choose to do so anyway because they have no respect for established protocols and no respect for plain English, they should not be surprised if they get a dose of their own medicine back at them. I might have to participate a little more in this debate if that is the sort of attitude that they are going to display to those of us who are watching attentively, even if not participating as fulsomely as some.

For now, I place on the record why I support this amendment. I challenge anyone to get up and argue with what I am saying, to gainsay that this government, through its bill, is trying to replace the meaning of well-understood terms with different terms. I do not know if it is trying to get around life insurance premium technicalities or whatever the hell it is trying to do but I object to it and the way it is going about it. It is contemptible.

**Amendment put and negatived.**

**Hon AARON STONEHOUSE**: When we last sat, I asked a question about the definition of the term “patient” in clause 5 at line 11 on page 6 of the bill and how that relates to the obligations of medical practitioners in division 2 of part 3. I pointed out that there was what I thought was inconsistent language used in division 2. Clause 17 says that a person may make a request, but clause 19 refers to a patient making a request. The minister explained to me the difference—at first, a person making a request may not be a patient of a medical practitioner. That is fair enough; it makes sense. I would like to raise with the minister a concern I have, and this may be better addressed on division 2, but I will mention it now in case any aspect of it can be addressed now; otherwise, I am happy to

*Extracted from finalised Hansard*
pick this up again at a later stage. The term “patient” is defined in clause 5 in rather broad terms. As I said, in clauses 19 and 20, rather onerous obligations are put on medical practitioners. Clause 20, “Medical practitioner to record first request and acceptance or refusal”, states —

The medical practitioner must record the following in the patient’s medical record —
(a) the first request;
(b) the practitioner’s decision to accept or refuse the first request;
(c) if the practitioner’s decision is to refuse the first request, the reason for the refusal;
(d) whether the practitioner has given the patient the information referred to in section 19(4)(b).

That sounds rather reasonable if we use the common understanding of “patient” and the therapeutic relationship that a patient and a medical practitioner would have. It is a patient and their regular general practitioner. The medical practitioner knows the patient and they have their identification and their medical record on hand; they know who that person is. However, the definition of the term “patient” in clause 5 states —

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

The term “patient” as defined in clause 5 seems to be almost indistinguishable from the term “person” as is used loosely in clause 17. It could be merely someone who approaches a doctor on the street and says, “Hey, doc, tell me about voluntary assisted dying” or “I want to access voluntary assisted dying.” The medical practitioner may have no relationship with that person or patient, but under clause 20, the medical practitioner has an obligation to record the request in the person’s medical record and submit forms to the board, among other obligations. I see this as potentially being a problem for medical practitioners with their obligation to record certain information when the person makes the request, whether the language used is “person” or “patient”. The medical practitioner may have no relationship with that person; the medical practitioner may not know them, may not be able to identify them and may not be able to identify their medical record. I am happy to talk about this when we get to that division, but I think it is relevant when we are looking at the definition of the term “patient” in clause 5.

Hon STEPHEN DAWSON: I appreciate the honourable member’s comments. This issue will be addressed under division 2 of part 3, so I am happy to have a further conversation with him then.

Hon NICK GOIRAN: The next amendment that stands in my name is at 145/5. I foreshadow, as I did yesterday evening, that this is an example of an amendment that I would like to leave on the supplementary notice paper. It is, effectively, consequential on an amendment to clause 11 that stands in my name at 155/11. I would, potentially, seek to move this amendment in due course if we were to recommit the bill for consideration of clause 5.

Clause, as amended, put and passed.

Clause 6: Decision-making capacity —

Hon NICK GOIRAN: Could the bill continue to operate if clause 6 were defeated?

Hon STEPHEN DAWSON: In our view—no. Decision-making capacity is fundamental, to our view.

Hon NICK GOIRAN: To be clear, the advice the minister is giving the house is that if clause 6 were defeated the entire bill would become inoperable and there would be no ability for anybody to determine what decision-making capacity is. I want to be very clear about the advice the minister is giving to the house so that there is no possibility of us being confused in any way. I am not asking the minister to indicate whether it is the preference of the government for clause 6 to be in the bill. Self-evidently, the answer to that question is yes. That is not the question that is being considered. The question that is being considered is: if clause 6 were defeated, would the bill become inoperable?

Hon STEPHEN DAWSON: I am told that it would not render it inoperable, but it would weaken the safeguard. Decision-making capacity and the determination thereof could be determined. However, it is an essential safeguard and is therefore made explicit in the bill.

Hon NICK GOIRAN: Thank you, minister. That is how we make progress—when we get a straightforward answer to a straightforward legal question. For the benefit of members, it is now clear that if clause 6 were defeated, the bill would not become inoperable. It is open to members to oppose this clause in the bill and the bill will continue to be able to operate. It is open to members to do that. In light of that, the minister has indicated that the preference and desire of the government is for clause 6 to be retained because it is an important safeguard. Can I take the minister 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.

Is that a statement of common law? Would that already be the case irrespective of whether clause 6(3) is included in the bill? In other words, is that reconfirming what would already be the case, irrespective of whether clause 6 is passed?
Hon STEPHEN DAWSON: It is in common law, but we are choosing to have it included in the statute law, which is consistent with the Mental Health Act.

Hon NICK GOIRAN: We have had a clarification that if clause 6(3) is deleted and we strike it out now, it will make no difference whatsoever in Western Australia because, of course, it is already the case that a patient is presumed to have decision-making capacity unless they are shown not to have that capacity. I anticipate that the minister will say that it does no harm to include clause 6(3) and it is the preference of the government; I am not disputing that. I am simply making the point that whether clause 6(3) is included or not makes no difference whatsoever.

That takes us to the heart of clause 6, which is 6(2). The minister has indicated that clause 6 is an important safeguard—that is why the government wants it included. I understand why he says that. Can the minister indicate whether clause 6 is based on any other model—for example, the Victorian legislation?

Hon STEPHEN DAWSON: The definition of “decision-making capacity” in this bill is consistent with the provisions in the Western Australian Mental Health Act 2014, so I am told that medical practitioners are already familiar with the WA definition. The definition that is used in the Victorian legislation reflects the definition in the Victorian Medical Treatment Planning and Decisions Act 2016.

Hon NICK GOIRAN: I have a copy of the Victorian Voluntary Assisted Dying Act in front of me. There is one provision in the Victorian act that is missing from the safeguards that the minister has indicated are very important for Western Australia. The minister said to us this afternoon that the government desires clause 6 to be included because it is an important safeguard, yet there is one provision missing from the Victorian legislation. I draw members’ attention to section 4(b) of the Victorian legislation, which includes the phrase —

 retain that information to the extent necessary to make the decision;

The member for Girrawheen—the minister’s colleague in the other place—moved a proposed amendment to include that provision of the Victorian legislation at clause 6 of the Western Australian legislation. The minister indicated to us earlier this afternoon that clause 6 is very important for the government, despite the fact that, as he confirmed to me, if clause 6 were defeated, the bill would still be operable. As the government is passionate about this safeguard, should we not include the provision at section 4(b) of the Victorian legislation, as proposed by the member for Girrawheen?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: Given that wholly inadequate response by the minister, I move —

Page 8, after line 24 — To insert —

(aa) retain the information or advice to the extent necessary to make the decision; and

Hon MARTIN PRITCHARD: I seek clarification of the amendment. It says, “retain the information or advice to the extent necessary to make the decision”. Is that retained physically or mentally?

Hon NICK GOIRAN: It is a reasonable question and I will explain the basis for my amendment, which will capture what the honourable member just asked. This particular amendment that I have moved will lift clause 6 of the Western Australian legislation to the standard of the Victorian legislation. In other words, it is my proposition to members that clause 6 of our legislation is verifiably less safe than the Victorian legislation. This amendment will bring us up to speed with the Victorian legislation, specifically section 4(1) of its Voluntary Assisted Dying Act 2017. It is word for word the amendment that was moved by the member for Girrawheen in the other place. That amendment was defeated because, as members know, the government’s attitude in the other place was that all amendments be defeated. It is unusual that clause 6(2) before us largely reflects Victorian section 4(1) with this notable absence; however, the requirement that a patient be able to “retain that information to the extent necessary to make the decision” is found in Victorian section 4(1)(b). I quote from Hansard on 4 September this year at page 6431, when the minister in the other place said —

… 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.

The minister in the other place reiterated not only the enduring nature of the patient’s request or decision to access voluntary assisted dying, but also the enduring nature of the person’s capacity. This amendment to include the words “retain the information or advice to the extent necessary to make the decision” supports the principle that the patient’s decision-making capacity must be enduring or ongoing. If the patient cannot retain the information to the extent necessary to make the decision, surely that patient does not have decision-making capacity for the purposes of making a voluntary assisted dying request. This should be mandated in clause 6, as it is in the Victorian legislation.

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I note the comment made by Dr Mike Nahan, the member for Riverton, in the other place regarding the relevance of the amendment given the government’s assurance that voluntary assisted dying will not be available for people suffering from dementia and Alzheimer’s disease. I quote from Hansard on 4 September this year at page 6465, when the following remarks were made —

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.

The minister in the other place indicated that the words employed in clause 6 are consistent with the provisions of the WA Mental Health Act 2014. That is, in fact, what the minister in this chamber said to us this afternoon. That is true. Clause 6(2) reflects section 15(1) of the Mental Health Act 2014, but what the minister has not told us this afternoon, and has chosen not to tell us, is that clause 6 does not include the wording of section 15(2) of the Mental Health Act 2014. Section 15(2) states —

(2) For the purposes of this Act, a decision made by a person about a matter relating to himself or herself must be made freely and voluntarily.

This government just picks and chooses the ways in which clause (6) is consistent with section 15 of the Mental Health Act 2014. Surely, members, in a decision the consequence of which will be that the patient’s life is ended, it would be better to bring the Western Australian bill’s definition of “decision-making capacity” up to the standard of the Victorian legislation, regardless of whether the words “retain the information or advice to the extent necessary to make the decision” appear in section 15 of the Mental Health Act 2014. The bill itself provides that a minimum of nine days must pass between the patient’s first request and the patient’s final request. If the patient cannot at the very least retain the information to the extent necessary over those nine days, surely the patient cannot be assessed as having decision-making capacity for the purposes of making a voluntary assisted dying decision. I therefore urge members to support this amendment, which, as I say, is word for word the same as the amendment moved by the member for Girrawheen in the other place, and is word for word the same as the legislation in Victoria.

Hon STEPHEN DAWSON: Can I indicate that we do not support the amendment that stands on the supplementary notice paper in the name of Hon Nick Goiran. I had mentioned in my earlier contribution that the definition of “decision-making capacity” in the bill is consistent with the provisions in the WA Mental Health Act 2014. The reference to “retain the information” is a reference to the Victorian legislation and is not reflective of Western Australian legislation. The definition used in the Victorian VAD act reflects the definition in the Victorian Medical Treatment Planning and Decisions Act 2016. The reference in that act to “retain the information” is not reflective of our Western Australian legislation.

Can I also say that medical practitioners are already familiar with the definition of decision-making capacity in the WA Mental Health Act. The bill requires the patient’s decision-making capacity to be assessed at several stages, and, at each stage, the patient’s capacity to understand any information or advice about the voluntary assisted dying decision, the matters involved in the decision, and the effect of the decision, are to be weighed up. If the patient is unable to retain the information whenever they are being assessed, clearly they will not have decision-making capacity.

I also want to make the point that because voluntariness is already built into the bill as an eligibility criterion, it is not necessary to include it twice.

Hon RICK MAZZA: I rise to support the amendment that has been proposed by Hon Nick Goiran at 59/6. To me, clause 6 within this bill is absolutely crucial to its operation. It is fundamental that people have a decision-making capacity in order to be able to access voluntary assisted dying. Retaining the information is supremely important. Clause 6 talks about someone understanding the information and advice, and understanding the effect of a voluntary assisted dying decision. But they have to be able to retain that information. People can—as I suspect this bill provides for—change their mind at any time. If they are unable to retain that information, for whatever reason, because of whatever condition they may have, I would be very, very concerned that something like this would slip through the net. I cannot see any reason why we would not include the amendment that is before us—that a patient is able to retain the information that has been provided to them. With that, I most definitely will be supporting this amendment.

Hon ADELE FARINA: I would like an explanation from the minister as to what harm would be caused if this amendment were adopted.

Hon STEPHEN DAWSON: As the honourable member can see, there has been a bit of conversation about that. My advisers tell me that it is not about harm, but it would be an unnecessary inclusion and it would be a legislative inconsistency.
Hon ADELE FARINA: Can the minister explain what he means by a “legislative inconsistency”?

Hon STEPHEN DAWSON: Earlier, I indicated that this is based on words in the Mental Health Act 2014. The words that we have used in this bill line up with the words used in that act, which is the same as the Victorian legislation. It uses words in its equivalent legislation. I am happy to give the member that name again, but I have placed it on the record. To include it would mean that it would not be consistent with the Mental Health Act.

Hon STEPHEN DAWSON: Before we broke for question time, Hon Aaron Stonehouse had asked a question about memory loss. With regard to memory loss, it is important to recognise that an element of memory loss does not carte blanche mean that a person does not have decision-making capacity. Retention of information to the extent necessary to make the decision is inherent in the elements of decision-making capacity in clause 6. This has been confirmed with the Chief Psychiatrist. In order to be able to understand the information, the matters involved and the effect of the decision, and weigh up these factors, make a decision and then communicate that decision, clearly the person has to be able to retain information to the extent necessary to make the decision. I do not believe the amendment is necessary. It is not included in the Mental Health Act, and I believe it is not required in this bill.

Hon DONNA FARAGHER: Can I just clarify that? The minister is saying that it is not necessary. But would it cause any harm for it to be included and to make it more explicit?

Hon STEPHEN DAWSON: I responded to that part of the question earlier.

Hon Donna Faragher: I do not think you have.

Hon AARON STONEHOUSE: This is getting into something that I was pondering myself—whether the ability to retain information has an impact on capacity. The minister is telling us that that is not necessarily so, or at least that the standard employed currently under the Mental Health Act or according to the Chief Psychiatrist is that the ability to retain information does not necessarily impact capacity. That makes some sense to me, I suppose. A person’s ability to understand what is going on and their capacity to consent in that moment is probably more important than their ability to retain information from some previous session. I suppose, though, that I am not completely convinced one way or the other yet, because I am not sure to what extent retention of
information might have an impact on capacity. I think of the film *Memento*, which is about a person who loses his memory every minute or something. It was written by Christopher Nolan. It is a brilliant film. In a scenario like that, if a person is basically a blank slate every few minutes, surely they would not be able to retain the necessary information, or at least hold all that information in their mind at one time, and be able to assess that information properly internally to come to some kind of decision, whereas if a person is able to retain information perhaps over a longer period of time, that may have less of an impact on their capacity. Can the minister give us some idea of the extent to which the ability to retain information has an impact on capacity? I understand that in some cases, it may not have an impact, but to what extent, and in what instances, and can the minister give us any examples to help clear this up a bit more?

**Hon Nick Goiran:** While the minister is contemplating that question from the honourable member, can I just point out what we have learnt as a result of the responses to this amendment so far. We know from the minister that, according to the Chief Psychiatrist, it is already inherently the case that the words in my amendment would be taken into account in clause 6. In other words, if a person was trying to determine whether a patient has decision-making capacity, the patient would have to retain the information or advice to the extent necessary to make the decision. That is what the Chief Psychiatrist has told the government. Therefore, it is inherently already in clause 6; and, therefore, the government says that the amendment is not necessary, even though it will cause no harm. Can I put to members that we have two choices here. We can either rely on what the government has said by virtue of the Chief Psychiatrist or insert those words ourselves right now to put it beyond doubt, noting that is exactly what has been done in the Victorian legislation. I do not think this is a complicated decision. I am actually disappointed that the government has chosen to take a path of resistance to not simply facilitating this so that we can move on to the next part of the bill. That is really the decision that we have to make. We can leave it, if you like, in a nebulous state, whereby we rely on the fact that, potentially, on this occasion the information that has been provided to us by the minister is correct. Let us remember that, in the context of this debate, so far there have been multiple occasions on which I have asked questions, and the responses have only had to be corrected later. We can either rely on the verbal evidence provided by the minister now or simply enshrine the words in the legislation, as per the amendment in the exact same terms as the Victorian legislation.

**Hon Stephen Dawson:** A person who suffers some memory loss may still understand all the relevant information and make an informed decision, even though he or she may later forget some of the information that was given previously. The impact of memory loss on decision-making capacity is contextual to the individual patient, and it is dependent on multiple factors.

**Hon Martin Pritchard:** I am not going to support this amendment, because what the minister just said rings true to me. If a person continues to make the same decision, given the same facts, I think of the matter as enduring. I have been thinking very hard about this one, because at first I thought it was a good idea to include it, but I think it would possibly knock some people out who have issues with short-term memory loss, but the fact that they would continue to make the same decision, given the same facts, convinces me not to support the amendment.

**Hon Martin Aldridge:** I am a bit like Hon Aaron Stonehouse; I am trying to find my way through on this amendment. I understand from the briefings that I have had that a person who applies to qualify for voluntary assisted dying has to have decision-making capacity and has to maintain decision-making capacity. Despite that, the only two occasions on which, as a minimum, that person is going to be assessed for decision-making capacity is by the consulting and the coordinating practitioners. Keeping in mind that the other requirement is that the person is likely to die within six or 12 months from the disease with which they have been diagnosed, we would then need to consider whether the patient has the capacity to retain the information necessary for the six to 12 months post-qualification. I hope members are following me, and I hope that the minister will be able to correct me if my assumptions are wrong. If somebody has some inability to retain information throughout the course of the six or 12 months, knowing that this bill has no ability to require the patient, once they qualify, to be reassessed for capacity, could it not be the case that that person, through some limitation, or an inability to retain information, could indeed be consuming the voluntary assisted dying substance without having retained the information that was available to that person at the time they qualified for the process?

**Hon Martin Pritchard:** I was just going to make a comment on that. That would be the case if they get through the process. They could still then lose capacity at some further time, but they are not assessed. It is just a matter of timing in my view.

**Hon Nick Goiran:** It will be quicker if I explain it. The clause before us defines “voluntary assisted dying decision” to mean a request for access to voluntary assisted dying or a decision to access voluntary assisted dying. The purpose of this decision-making capacity clause is to say, “What does a doctor have to determine for that patient to have met the criteria for decision-making capacity?” It is these things that are set out here, but it is just in respect of the request for or a decision to access voluntary assisted dying. In other words, if the patient has decision-making capacity at the moment they make the request, for the purpose of what we are discussing with clause 6, it does not matter what their state is down the track. I think that goes to the heart of the member’s question. I think it is a fair point that is probably worthy of consideration, particularly when we
are thinking about self-administration. Should a person be able to self-administer at that point if they do not have decision-making capacity? However, that is a different issue for a different clause. What we are dealing with at this point is that moment of a request or a decision.

Hon COLIN HOLT: This is obviously about a capacity assessment to be undertaken by a medical practitioner at the time of a request to access voluntary assisted dying. I think the minister was earlier talking about the consistency of what doctors consider as they make an assessment of capacity. They do this all the time in a range of situations with patients, including decisions on life and death—for example, “do not resuscitate”. At that point, a patient may have a request saying, “Please do not resuscitate” or “I have an advance health directive saying do not resuscitate.” It is a life-and-death situation. A doctor, in witnessing an advance healthcare directive, would assess the patient’s capacity based on how they have done it and on common law—as I think Hon Nick Goiran mentioned earlier—and in relation to the Mental Health Act. That would all be taken into account, but without the extra step about the retention of the information. Even when doctors and specialists discuss care options with patients—including cancer treatment, potential brain tumour operations, the whole thing—at that time, they have to make a decision on the capacity of the patient to understand the treatment, the options and the potential outcomes, and ask, “Do you understand what I’m putting to you about the risks and my evaluation of the treatment options?” The doctor would have to make a decision then about the patient’s capacity. I find this clause to be completely consistent with that. Our doctors are well trained to make those decisions—does the patient have capacity at the time of making this request? It seems to me that if we include this amendment, we would be asking doctors to consider something beyond what they would normally do. If the clause is amended, the question could then arise for the doctor, “If I have to comply with this legislation, what extra things do I now have to consider to ensure that I assess capacity, even though it will be different from every other time I assess capacity?” That is my simple observation of this amendment.

Hon STEPHEN DAWSON: I thank Colin Holt for his contribution, which I concur with.

Hon Nick Goiran: He just said something different from you, so how can you concur with it?

Hon STEPHEN DAWSON: No. The person is required to have decision-making capacity about the voluntary assisted dying decision. The voluntary assisted dying decision means a request for access to voluntary assisted dying or a decision to access voluntary assisted dying. Decision-making capacity is not about the patient being able to retain all the information presented to them. This is not some sort of school test, for example, that the patient must undergo.

Hon AARON STONEHOUSE: I think we are perhaps getting a little off track. There seem to be two views around the chamber about this amendment. One view seems to be that this is already part of an assessment, in which case the argument may be that there is no harm to include it in the bill. The other view is about whether this amendment is too onerous. It is not part of an assessment currently and to make it a requirement would make it too onerous and cumbersome, and there is no need for someone to have the ability to retain information as one of the decision-making capacity assessment criteria. The problem with that argument is that the amendment moved by Hon Nick Goiran does not refer to retaining all information or a large sum of information. It states —

retain the information or advice to the extent necessary to make the decision;

We are talking only about retaining the information to the extent necessary to make the decision. It seems to me that that would absolutely have to be part of a capacity assessment, whether or not it is in the statute, because if a person cannot retain information to the extent necessary to make the decision, surely they do not have capacity. Therefore, I think we need some further clarification, which I suspect is what Hon Nick Goiran was going to ask for. Is the amendment proposed by Hon Nick Goiran currently part of a capacity assessment according to the Mental Health Act and the Chief Psychiatrist? If it is not, that is a concern to me. If it is, perhaps it is something worth including or perhaps it is not, but then we can at least narrow down what we are actually debating.

Hon NICK GOIRAN: The answer to the question asked by Hon Aaron Stonehouse is yes. Everything that Hon Colin Holt said earlier was correct except for one thing: we are not adding anything new here. The evidence provided earlier by the minister was that the information in my amendment is inherently in clause 6 already. I do not have a problem. If members wanted to vote against this amendment on the basis of saying, “Look, it’s unnecessary because it’s already in clause 6; it’s inherently in there”, they could absolutely hold that view. A view that would be wrong is to say that by putting this in here, we are adding something extra that does not need to be included. That is wrong as a matter of law and that is wrong pursuant to the evidence provided—not by me, but by the minister earlier. Therefore, I think the minister would help members, and we could make some progress, if he could reconfirm for us that the information provided to the government by the Chief Psychiatrist is that amendment 59/6, standing in my name, is inherently already in clause 6.

Hon STEPHEN DAWSON: Thank you. I can confirm that the retention of information to the extent necessary to make the decision is inherent in the elements of decision-making capacity in clause 6. Further, as I have said previously, this amendment would create an inconsistency with other Western Australian legislation, and we do not want to add an additional limb.

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Division

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

Ayes (16)
Hon Martin Aldridge Hon Adele Farina Hon Robin Scott Hon Dr Steve Thomas
Hon Jim Chown Hon Nick Goiran Hon Tjorn Sibma Hon Colin Tincknell
Hon Peter Collier Hon Rick Mazza Hon Charles Smith Hon Alison Xamon
Hon Donna Faragher Hon Simon O’Brien Hon Aaron Stonehouse Hon Ken Baston (Teller)

Noes (18)
Hon Jacqui Boydell Hon Colin de Grussa Hon Alannah MacTiernan Hon Dr Sally Talbot
Hon Robin Chapple Hon Sue Ellery Hon Kyle McGinn Hon Durran West
Hon Tim Clifford Hon Diane Evers Hon Martin Pritchard Hon Pierre Yang (Teller)
Hon Alanna Clohesy Hon Laurie Graham Hon Samantha Rowe
Hon Stephen Dawson Hon Colin Holt Hon Matthew Swinbourn

Amendment thus negatived.

Hon NICK GOIRAN: The minister in the other place said the following on 4 September about this clause — … 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.

Where in the bill does it mandate that the practitioners involved in assessing a patient’s decision-making capacity must consider the patient’s medical records?

Hon STEPHEN DAWSON: It is not in the bill, but I am advised that it is good medical practice.

Hon NICK GOIRAN: That is not what the minister in the other place said. Is this another example of the minister misinforming the other place?

Hon STEPHEN DAWSON: I cannot comment on what the minister said in the other place, but I can comment on the bill before me, and I can certainly answer the questions that the member asks about the bill before me.

Hon NICK GOIRAN: Where in the bill does it mandate that the practitioners involved in assessing the patient’s decision-making capacity must consult with the patient’s other specialists in reaching their own decision?

Hon STEPHEN DAWSON: It does not, but, again, I am advised that it is consistent with good medical practice.

Hon NICK GOIRAN: That is another example of the minister in the other place misinforming members there. Given that these things are not found in the bill, will the government ensure that these instructions are contained in the mandatory training for voluntary assisted dying–eligible practitioners?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: Will the Victorian mandatory training modules be used as a basis for that?

Hon STEPHEN DAWSON: The detail of that has not been worked out yet.

Hon NICK GOIRAN: On 4 September, the minister’s colleague in the other place, the Minister for Health, also said about this matter —

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.

Given the outcome of such a bad decision—in this case, a failure to identify impaired decision-making capacity—why does the government not mandate the best care for patients in Western Australia by requiring assessment by an expert in decision-making capacity such as a psychiatrist or a geriatrician?

Hon STEPHEN DAWSON: I am told that to suggest that only a psychiatrist can assess decision-making capacity mischaracterises the role of a psychiatrist. A psychiatrist treats mental illness. They are not general experts on decision-making. During consultation with the registered health practitioners, including the Office of the Chief

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Psychiatrist, it was made clear that it would not be appropriate or necessary for every patient who requested voluntary assisted dying to undergo psychiatric assessment. I turn to who assesses. Under the legislation, decision-making capacity must be independently assessed by two experienced medical practitioners. If they are unable to make a determination, they are obliged to refer the patient to a health practitioner with appropriate competency to make the assessment. The appropriate health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate; if the concern is decline due to ageing, a geriatrician may be preferable.

Hon NICK GOIRAN: The minister indicated that there had been some consultation with the Office of the Chief Psychiatrist and that as a result of that conversation, it was clear that it would not be necessary for every patient who requested voluntary assisted dying to undergo a psychiatric assessment. I think that is what I heard the minister say. Of course, that is not what I asked. I asked why an expert in decision-making capacity such as a psychiatrist or a geriatrician might not be the best person to make this assessment. It is not necessarily about having a psychiatric assessment. I draw the minister’s attention to an exchange that took place between the Chief Psychiatrist and me during the yearlong inquiry of the Joint Select Committee on End of Life Choices. On 14 December 2017, the Chief Psychiatrist of Western Australia, Dr Gibson, said in evidence to the Joint Select Committee on End of Life Choices —

… if you look at the Mental Health Act, it requires a psychiatrist to determine capacity to make someone involuntary under the Mental Health Act. My feeling would be why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

That was evidence given by the Chief Psychiatrist to the Joint Select Committee on End of Life Choices on 14 December 2017. What was the date of the consultation that the government had with the Chief Psychiatrist that would suggest otherwise?

Hon STEPHEN DAWSON: The last correspondence that the government received from the Chief Psychiatrist, Nathan Gibson, on this matter was dated 14 November 2019.

Hon NICK GOIRAN: Can the minister table that correspondence?

Hon STEPHEN DAWSON: I have quotes from the email, but I do not have the full piece of correspondence, so I cannot table it.

Hon NICK GOIRAN: I will take a bit longer to go through this then. This is a very significant issue.

Hon Sue Ellery interjected.

Hon NICK GOIRAN: The Leader of the House is not paying attention so she should not get too disturbed.

Hon Sue Ellery: How do you know what I’m doing?

Hon NICK GOIRAN: It is pretty obvious. It is self-evident.

Through you, Madam Deputy Chair, evidence has been provided by the Chief Psychiatrist to a joint select committee of the Parliament. It is pretty rare to establish a joint select committee of the Parliament. It took evidence from the Chief Psychiatrist. The Chief Psychiatrist said in that evidence on 14 December —

… why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

That is what the Chief Psychiatrist said in evidence to a parliamentary inquiry. I was present on that day, as I was for every meeting and hearing during that yearlong inquiry. To offset that evidence that was provided—a transcript of that evidence is available—we have an indication from the minister of some correspondence on 14 November 2019 that he says suggests something else, but we are not privy to that piece of correspondence. Can I suggest to members that greater weight needs to be given at this point to the transcript of evidence provided to the joint select committee. Members can read that for themselves to determine whether what I am saying is true. Am I misquoting the Chief Psychiatrist or can we rely on an unseen, untabled letter that the minister says he has in his possession?

Withdrawal of Remark

Hon STEPHEN DAWSON: I take a point of order. I have not said that I have a document in my possession. I ask the honourable member to retract that. He just said that the minister has said that he has a document in his possession. I have not said that. Please withdraw that comment.

Hon NICK GOIRAN: I will not withdraw it.

Hon Stephen Dawson: I said that I was aware of the correspondence. Do not put words in my mouth.

Hon NICK GOIRAN: The minister has a piece of correspondence dated 14 November.

The DEPUTY CHAIR (Hon Adele Farina): Order, members! This not a debatable issue. The minister raised a point of order. Based on my understanding of the conversation, I believe that the minister stated in his answer that
he had extracts from the email or the letter, but he does not have a copy of the letter/email in his possession, so he is not able to table it. It is unclear to me whether Hon Nick Goiran was referring to this minister or the Minister for Health. I am not going to make a ruling, but I want to make it very clear that that is what I heard the minister say.

Committee Resumed

Hon NICK GOIRAN: I concur entirely. For any clarification necessary, it was absolutely the Minister for Health. That is who I understand has possession of a piece of correspondence from the Chief Psychiatrist dated 14 November 2019. Unless anyone wishes to correct the record and suggest that somebody else has it in their possession, I will proceed on that basis.

On 14 December, in evidence given to the Joint Select Committee on End of Life Choices, Dr Gibson said —

... obviously we have said, again in the Mental Health Act, that anyone who is made involuntary has to be seen by a psychiatrist. It is so serious that a psychiatrist must see them to determine capacity, mental illness et cetera. What I would not like to see is a watered down version that would not apply the same rigour to individuals seeking to end their life, notwithstanding that palliative physicians are good at screening for mental illness. Palliative physicians would not call themselves psychiatrists. They would not say that they can, hand on heart, make diagnoses of mental illness in every case. They would screen for it. Except if you are Lisa Miller, you can do both, but most palliative physicians would say that they screen for it but they would ask for specialist advice if it was a complex situation, hence, I am trying to not have a lesser standard for individuals who are seeking to end their life, even in the case of terminal illness, than we apply already within the Mental Health Act.

That was from 14 December 2017. On that same day, Dr Gibson said to the committee —

The issue is around when someone actually wishes to accelerate and end their life actively. Then, I think, there is an ethical and professional requirement to really make sure that we exclude mental illness in that situation.

He further went on to say in evidence to the committee on that same day —

In some jurisdictions, GPs are, obviously, making these decisions with regard to assisted suicide. I am aware of that. It is about the stakes. The question is: are GPs good at doing capacity? That is one question. The answer is that it is extremely variable.

I pause there to remind members that I am quoting from the evidence given by the Chief Psychiatrist in Western Australia, who said to the Joint Select Committee on End of Life Choices —

... are GPs good at doing capacity? That is one question. The answer is that it is extremely variable. The nature of GP practice is that they often do not have the appropriate time to do this, and they will acknowledge that.

The DEPUTY CHAIR: Order, members! The level of noise in the chamber is making it very difficult for me to hear the honourable member on his feet, which would make it very difficult if another point of order were called.

Hon NICK GOIRAN: I continue —

They are the people seeing people in nursing homes. They are seeing lots of individuals who are incapacitous or may have capacity or not. So, they are seeing lots of it but they are not always thinking in that paradigm; they are thinking in more broad, holistic paradigms. In the situation where a GP is treating mental illness, assisting with the palliative care and making potential capacity assessments that are not leading to the potential death of the person, that may be reasonable. But the stakes go up when you are saying that someone is going to die. I do not think it is reasonable to have a GP make that capacity assessment at that point.

That was the evidence given by the Chief Psychiatrist to the Joint Select Committee on End of Life Choices on 14 December 2017. In contrast to that, the minister said that there is this infamous correspondence of 14 November 2019 in the possession of somebody that we cannot see. The suggestion—the implication—from the minister is that it is going to tell us something different or something new that the Chief Psychiatrist is going to inform us of that is very important. The minister has said that clause 6 is fundamental to the bill; he has said that decision-making capacity is crucial. If the Chief Psychiatrist has changed his view from the evidence he gave in that hearing that I attended on 14 December when he said that GPs are not the ones who should be doing that, I would like to know that, and I suspect that other members in this place would like to know that. Without having seen this correspondence from 14 November, I would not be surprised if the correspondence to the government says that the Chief Psychiatrist says that it is not necessary for every person who wants to access voluntary assisted dying to have a psychiatric assessment. He probably has said that, but is that the same as the Chief Psychiatrist saying that an expert in decision-making capacity, such as a psychiatrist, palliative care specialist or a geriatrician, should be involved? They are two different and distinct things. That is why I am pursuing this letter that the minister has said states something different. He may table it in due course later today. It may well demonstrate

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that the Chief Psychiatrist’s view on this has evolved, which is the current language we are using when people change their mind—it has evolved. It may say that, but I would like to test it. I would like to be satisfied on that piece of correspondence to give that greater weight than the evidence that was given to the Joint Select Committee on End of Life Choices. During that hearing on 14 December 2017 this interaction between me and the Chief Psychiatrist occurred —

**Hon NICK GOIRAN**: I notice that you distinguish between GPs and psychiatrists on the basis that the stakes are higher. Would you agree that the stakes are higher than a decision about whether to involuntarily detain a patient?

**Dr GIBSON**: Yes.

**Hon NICK GOIRAN**: In the process for determining capacity with regard to involuntary detention at the moment, is it the assessment of one psychiatrist?

**Dr GIBSON**: It is the assessment of one psychiatrist, that is right, but there is a check and balance in the sense that you have the Mental Health Tribunal, which has a psychiatrist on it, as well as a lawyer, as well as a community member, who automatically must—so, it is mandatory—review that decision. You automatically have a mandatory check.

I hope that when we, in due course, adjourn proceedings, that there will be an opportunity during that one-hour adjournment for this piece of correspondence of 14 November 2019 to be located and that when we return, the minister will be able to table that correspondence. From the recent debate that we have had it is clear that a lot of members are interested in decision-making capacity. I think there is, at least, agreement between the government and the majority of members that this is a crucial issue that needs to be determined. I am not satisfied to rely on the oral evidence that has been provided in the absence of a document that is available and in the possession of the government. In contrast to that, we have evidence given—sworn testimony—to a Parliamentary inquiry. I am going to continue to give greater weight to that evidence by the Chief Psychiatrist from 2017 than what has been related to us in what is, frankly, a hearsay fashion today. I will insist on the letter being tabled.

**Hon STEPHEN DAWSON**: The honourable member can, of course, place whatever weight he likes on whatever document he wants. I have made the point that correspondence was received from the Chief Psychiatrist that suggests that his opinion has evolved. I can quote from it and I will certainly give an undertaking that I will seek to access a copy of the email correspondence during the tea break. If I can provide it, I certainly will. I have a quote from it that states —

- Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

I also draw to members’ attention that the Royal Australian and New Zealand College of Psychiatrists made clear that although the practitioner’s assessing capacity needs relevant expertise, they do not need to be a specialist, and that capacity assessment is not solely in the domain of psychiatrists. Psychiatrists are rarely the most appropriate clinician to do capacity assessments.

**Hon NICK GOIRAN**: I move —

Page 9, line 5 — To delete “unless the patient is shown not to have that capacity.” and substitute —

unless —

(a) the patient is shown not to have that capacity; or

(b) the patient has, within the last 7 days, received medical advice relating to their disease, illness or medical condition that contains —

(i) a terminal or life-limiting diagnosis; or

(ii) a poor prognosis.

The genesis of this amendment before us arises from a concern raised by Dr Mike Nahan, the member for Riverton, in the debate in the other place. On 4 September this year, at page 6431 of Hansard, he said —

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?

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The response provided by the Minister for Health is very instructive at this point and has led me to move this amendment. Minister Cook said in response to Dr Nahan —

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.

At page 6459, the minister went on to say —

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.

Anecdotal evidence from Victoria tells us that some individuals have indeed made their first request for access to voluntary assisted dying on the same day on which they received their diagnosis, including one case in which a person made their first request on the day on which they received their diagnosis of motor neurone disease. There is nothing in this bill, nor in my proposed amendment, that can prevent someone from making their first request on the day on which they receive the prognosis. That is the reality of what the passage of voluntary assisted dying legislation will mean—that individuals will turn to voluntary assisted dying before they have had an opportunity to process their diagnosis and prognosis. This amendment seeks to make it clear to those practitioners who receive a first request under those circumstances that the individual cannot be assessed as having decision-making capacity at that point in time.

The Minister for Health suggested in the other place that the scenario that I suggest should be avoided under this bill simply could not possibly take place. On 4 September 2019, at page 6459 of Hansard, he said —

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.

He continued at page 6460 —

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.

Sitting suspended from 6.00 to 7.00 pm

Hon NICK GOIRAN: Prior to the interval, I was explaining to members the basis behind the amendment we are considering at the moment, which is 75/6 on the supplementary notice paper. I indicate to members that the genesis of the amendment was a dialogue that took place in the other place between Dr Mike Nahan, the member for Riverton, and the Minister for Health, Hon Roger Cook. To paraphrase that debate, the indication from the minister was that at the moment a person receives a diagnosis of a terminal illness, according to the Minister for Health, they do not have decision-making capacity, and it would not be appropriate for them to make that decision at that time. I have a lot of sympathy for what the Minister for Health was saying in the other place, as found in Hansard on 4 September this year. That is the basis for my amendment. I remind members that the suffering requirement

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that a patient, within seven days of receiving medical advice relating to their disease, illness or medical condition that the patient will take time to process and understand the diagnosis that has been given, and may seek further frame. This is not part of the accepted criteria for determining decision-making capacity. Furthermore, it is unlikely that the definition of “decision-making capacity” in the bill is consistent with the WA Mental Health Act 2014. The definition of suffering 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.

The Premier said a little late that day, at page 6584 —

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.

It is clear that the requirement that a person be suffering would be clearly satisfied on the day on which that person receives that diagnosis. In other words, when they receive the diagnosis or the bad news, they would be suffering. It would be wrong to assume that a patient cannot receive a diagnosis when the disease, condition or illness is already advanced as required by clause 15(1)(c)(i) of the bill. A lot of people receive a diagnosis when their disease, condition or illness is already advanced. For example, Associate Professor Kelvin Kong is concerned that Indigenous people with cancer tend to present late, when their symptoms are well advanced. This quote is found in the article entitled “Indigenous surgeon ‘terrified’ by WA euthanasia provision” published in The Australian —

While Australia’s overall cancer survival rates were among the best in the world, there was a big disparity between the incidence and survival rates of Australians who were non-indigenous and Australians who were Aboriginal and Torres Strait Islander.

“We are jumping to an end-stage conversation when we haven’t got all the pathways in cancer management leading up to palliative care,” he said.

Contrary to the assurances given by the Minister for Health in the other place, some individuals will qualify as eligible, under clause 15, for voluntary assisted dying on the day their diagnosis takes place, but their decision-making capacity being impacted by the news of their diagnosis and poor prognosis will be in play. This amendment seeks to make very clear to practitioners that, as the minister has said in the other place, a person in those circumstances would not have decision-making capacity for the purposes of accessing voluntary assisted dying. In summary, this amendment will give effect to what Minister Cook said in the other place, that at that time a patient would not be demonstrating decision-making capacity. I agree with him and this amendment would ensure that for a period of seven days, a practitioner would not determine that that person has capacity.

Hon STEPHEN DAWSON: The government does not support Hon Nick Goiran’s amendment. As I said previously, the definition of “decision-making capacity” in the bill is consistent with the WA Mental Health Act 2014. The presumption of decision-making capacity, unless shown otherwise, is a fundamental principle. Decision-making capacity cannot be removed on the basis of a person having received a certain diagnosis within a certain time frame. This is not part of the accepted criteria for determining decision-making capacity. Furthermore, it is unlikely that a patient, within seven days of receiving medical advice relating to their disease, illness or medical condition that contains a terminal or life-limiting diagnosis, will seek to access voluntary assisted dying. It is more likely that the patient will take time to process and understand the diagnosis that has been given, and may seek further
medical opinion as part of this process. It is in human nature to do something like that. The government also has a concern about the member’s use of the words “poor prognosis”. A poor prognosis could be absolutely anything that a patient is not happy about. I am told that “poor prognosis” is an ill-defined term and unsuitable for use in this context. A fundamental flaw in the amendment is that the aspects contained in proposed paragraph (b) cannot be a basis for removing someone’s decision-making capacity.

While I have the floor, Mr Chairman, I had undertaken before we broke for dinner to seek access to some correspondence in relation to comments made by Dr Nathan Gibson, the Chief Psychiatrist, on 14 November 2019. I will table that document.

[See paper 3415.]

Hon RICK MAZZA: I am trying to consider whether I will support this amendment. From what I can see, I think the mover of the amendment is concerned that someone might be given bad news and that they would be able to make a rash decision to access voluntary assisted dying in a short period. If someone makes a decision to access voluntary assisted dying, how quickly could that occur for them to be able to end their life?

Hon STEPHEN DAWSON: Typically, the period is nine days, but there is provision under clause 47 for that time frame to be shortened.

Hon NICK GOIRAN: Would it be possible for a patient in Western Australia, under the voluntary assisted dying scheme, to make a request on the same day that they receive a terminal or life-limiting diagnosis or, to use the phrase used by Hon Rick Mazza, on the same day that they receive bad news?

Hon STEPHEN DAWSON: Yes, they could make the request on the same day.

Hon RICK MAZZA: Someone could be diagnosed with a terminal disease, have a very poor prognosis and be emotionally affected by that, and then make a very quick and rash decision to access voluntary assisted dying. To ensure that someone does not access this too quickly, if they have just been given a diagnosis and they drop their bundle somewhat, for want of a better word, and decide that they do not want to go on, what other safeguards are there around somebody having a more rational decision, maybe to slow things down a bit, so they can come to terms with the position that they are in before they access voluntary assisted dying? My concern about the amendment before us is that I would not like to see someone be given a prognosis and make a rash decision and within a week be able to access voluntary assisted dying. I have heard a number of stories of people being given a short time to live. Their initial reaction was to access some sort of voluntary suicide, but once things had slowed down a bit and time had passed, they went on to live for a time and made more rational decisions and maybe enjoyed a bit of time with their family. What are the safeguards around someone making a very quick decision in accessing voluntary assisted dying?

Hon STEPHEN DAWSON: The person would have to go through the assessment process. Obviously, they would have to be assessed by a coordinating practitioner and a consulting practitioner, both of whom would make an assessment of the person’s decision-making capacity. If there is any question, they can refer the person to a specialist. Could this event happen? It is possible. Humans tend to cling to life. More commonly, if we were given that information, we would seek a further opinion and advice from someone else rather than make a rash decision and rush into something. Certainly, the safeguards are the consulting practitioner and coordinating practitioner. Both have to make an assessment and that is the safeguard.

Hon AARON STONEHOUSE: I am considering this amendment carefully. However, in this instance, I am not sure that it is entirely necessary. I can see the desire to put in some kind of, for want of a better term, cooling-off period to ensure that people do not take rash decisions. However, it seems to me that the capacity assessment should provide for that anyway. If we think the capacity assessment does not provide for preventing people from making rash decisions before they are fully informed, we need to go back to the capacity assessment in its earlier stages and address that there, as opposed to having, without meaning to sound insulting to the drafter of the amendment, what seems like a rather arbitrary cooling-off period of seven days. Why not two weeks? Instead of a seven-day cooling-off period, why not have some mandated counselling or something else in place? It seems that a passage of merely seven days may or may not provide for a patient to clear their head and properly assess the situation. For those people that it does not, we rely on the standard capacity assessment. For those people that it does, what is it about seven days that is so special? I am a little unconvinced about the need for this, and I would think that the regular capacity assessment would be sufficient; and, if it is not, we have a serious problem. To begin with, we would probably need to go back and look at the capacity assessment. Therefore, at this point, I am not sure that this is necessary and at this stage, I am unconvinced.

Hon KYLE McGINN: I think it was pretty well covered there. Hon Rick Mazza was saying that people would not get access to carry out voluntary assisted dying on that day; they would still have to run through the process and it would then go back to the Voluntary Assisted Dying Board. The minister covered it pretty well in that there would be a test of their mental state. I was a little confused about whether we were talking about getting access to voluntary assisted dying straightaway or just being able to put in the first referral, but it seems that it was just the first referral.
Hon NICK GOIRAN: In response to Hon Aaron Stonehouse: honourable member, I agree with you entirely. Allow me to explain it this way. My preference is indicated a little later on the supplementary notice paper where I say that there needs to be a mandatory referral to a psychiatrist, and that psychiatrist is obviously then going to be involved to ensure that there is proper decision-making capacity. I say that because of the testimony given by the Chief Psychiatrist in evidence to the Joint Select Committee on End of Life Choices in 2017. Members might remember that before the adjournment, I sought the provision of a document of which we have now been provided. Hopefully, members now have it available to them, and if they do not, I strongly encourage them to get a copy of this document, dated 14 November 2019. Members will be interested to know that this document, which is six days old, originates from an individual titled Malcolm McCusker. I am not too sure what role he has in doing consultation on behalf of government, but this gentleman, Malcolm McCusker, on 14 November 2019, wrote to Dr Gibson. For members who do not know, Dr Gibson is the Chief Psychiatrist in Western Australia. This individual, Mr Malcolm McCusker, writes —

Dear Dr. Gibson,

If you have any time available, I would be grateful if you would call me, to clarify your opinion on whether the assessment of a patient’s capacity to understand and make an informed decision on applying to qualify for VAD may be made by a medical practitioner, who may not have specialist psychiatry qualifications, but who, if uncertain of a patient’s capacity in a particular case, would be obliged to refer the patient to someone with relevant expertise.

Or is it your view that assessment of capacity must always be made by a psychiatrist?

Regards,

Malcolm McCusker

I can only assume that this individual, Malcolm McCusker, must have some expertise in what is called “leading questions” because, as members who are familiar with this bill would know—I invite the minister to correct me if what I am about to say in any way misleads members—there is no obligation to refer the patient to someone with relevant expertise in this bill. There is no obligation to do that. In fact, that goes to the very heart of one of my concerns, and I know a number of members have that concern because there are a number of amendments that address that. This individual who has written to Dr Gibson, the Chief Psychiatrist, has sought to steer him into a situation of answering a question that asks, “Well, look, would it be possible for someone, effectively, other than a psychiatrist, to make a decision on decision-making capacity on the basis that if they are not sure, they would be obliged to refer it to another person?” Of course, there is no obligation in this bill. Nevertheless, members can read the interesting response in the penultimate paragraph from the Chief Psychiatrist, which goes to the heart of my answer to Hon Aaron Stonehouse. He writes —

- Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

There is a lot of material in that for members who want to intellectually engage on this particular issue, not only on this clause, but also into the future. I strongly recommend that members look at the document that was tabled by the minister this evening. I thank Mr Malcolm McCusker for taking the opportunity, presumably in a voluntary capacity on behalf of Western Australians and as a gesture of goodwill, to write to Dr Gibson to get this information.

I note for Hon Aaron Stonehouse that I have an amendment on the supplementary notice paper to amend a later part of the bill to include mandatory referral to a psychiatrist for exactly that reason. That member will appreciate that, at this point in time, I have no confidence that any amendment standing in my name will receive support from this government. I have received no indication whatsoever that that will be the case in terms of the history of this debate so far or from any member of the government that they will support any of my amendments. If I use that as a basis for forecasting into the future, I assume that my amendment to provide for mandatory psychiatric referral will be defeated. Mandatory psychiatric referral would be my preference, but since that is probably not going to happen, the next best thing I can do in terms of a safeguard is to say that we should enshrine into statutory law that a person cannot make this request within the first seven days.

The second point that Hon Aaron Stonehouse raised, which was a very legitimate question, was why I chose a period of seven days. All I can tell Hon Aaron Stonehouse is that I had this dialogue with parliamentary counsel—they also raised it with me—and I had to pick a period of time. I emphasise to the honourable member that this is not my preferred approach. My preferred approach is mandatory psychiatric assessment for the purposes of decision-making capacity, but I have no confidence that that amendment will be supported by this government or the chamber. To use the member’s words, this seven-day cooling-off period seems to me to be appropriate in those circumstances.
Hon STEPHEN DAWSON: First of all, that was a very defeatist attitude, Hon Nick Goiran. I make the point that we will consider each of the amendments on the supplementary notice paper on their merit, whether they are in his name or the name of any other honourable member in this place.

Hon Donna Faragher: Really?

Hon STEPHEN DAWSON: Absolutely. In relation to the correspondence, I should have pointed out that any contact details have been removed—their email address has been removed. I just wanted to be clear on that. In relation to the status of Mr Malcolm McCusker, he is a special adviser to the Minister for Health for the purposes of this bill. His appointment has been through the cabinet process. That is his standing and status.

I want to make the point that I do not think the Chief Psychiatrist is someone who would be steered by anyone. I take issue with anyone suggesting that he was asked leading questions or steered to give this answer. Having served as shadow Minister for Mental Health in a previous Parliament and having had many interactions with the Chief Psychiatrist, whether in briefings or things like estimates, I know that he is not one to be steered by anyone. He tells us what he thinks. He has certainly told people what he thinks in this regard. Furthermore, I believe it is entirely appropriate for the government to ask the Chief Psychiatrist to clarify the position he gave to the Joint Select Committee on End of Life Choices, given that he provided that some time ago. That is what has happened.

Hon ADELE FARINA: I want to make a few comments. I agreed with Hon Aaron Stonehouse’s concern about the reason for having a period of seven days, and I think Hon Nick Goiran has explained that quite clearly. I note the minister’s concerns about the words in paragraph (b)(ii) of the amendment—“a poor prognosis”—being too general. I am just wondering whether the government’s position would change if that were to be amended to read “a prognosis that the illness, disease or medical condition will, on the balance of probabilities, cause death within a period of six months”. That adopts the words used in clause 15 and provides consistency in the wording used. I wonder whether the minister and the government would feel more comfortable if that amendment were to take place. It seems to me that there is merit in a cooling-off period, given what the Minister for Health has said about people often being very distressed when they first get a diagnosis, that they probably do not have decision-making capacity at that time and that it would be highly dangerous to make an assessment about decision-making capacity then. This seems to provide a bit of protection. That change in words should address the concerns raised by the minister.

Members might recall in my second reading contribution that I talked about the situation of my dad having a medical procedure performed on him that he did not consent to. I find it really interesting that in his response to Malcolm McCusker, the Chief Psychiatrist said that psychiatrists and geriatricians were by far the best placed to assess capacity. The person who performed that procedure on my father was a geriatrician. That was the person who spoke to my dad and apparently got informed consent, which my dad never gave. This whole area is really fraught with difficulty, particularly in circumstances in which the person has had very little schooling or for whom English is not their first language. Making these sorts of assessments is extremely difficult. I think we should provide some protections to ensure that this is done properly, with the clear intent that we in this place all want. The intention of the bill is for it to be done properly as well, but I do not think it hurts to have protections in place to help ensure that that is the case. I ask the minister whether that amendment would be more palatable with the change to proposed section 6(3)(b)(ii).

Hon STEPHEN DAWSON: I appreciate the spirit in which Hon Adele Farina seeks to be helpful about the amendment. We would not be any more supportive of the amendment if it was worded in that way. I have said before, but I will say again, that decision-making capacity cannot be removed on the basis of a person having received a certain diagnosis within a certain time frame. This is not part of the accepted criteria for determining decision-making capacity. I also point out, as I have before, that the college of psychiatrists took a different view from the Chief Psychiatrist. It has made clear that although the practitioner assessing capacity needs relevant experience, they do not need to be a specialist in that capacity assessment is not solely in the domain of psychiatrists. Psychiatrists are rarely the most appropriate clinicians to do capacity assessments. Under the training program of the Royal Australian and New Zealand College of Psychiatrists, psychiatrists are well placed to support upskilling colleagues. The WA branch suggests that training be provided to non-psychiatrically trained professionals by psychiatrists with relevant expertise, and that resources be developed to cover screening tools for mental disorders and neuropsychiatric conditions. Another risk factor to look out for is the inclusion of vulnerable populations such as older isolated women, who may seek access to voluntary assisted dying more often. There needs to be guidance on the appropriate use of telehealth, noting its potential to not only increase access but also compromise the integrity of assessments; how to interact with families or carers; and what to do when a patient does not wish to involve their family. The best person to assess decision-making capacity is a person who has been appropriately trained to do so and receives contemporaneous upskilling in this area.

The CHAIR: Members, we seem to be straying somewhat into related but distinct areas that are not covered by clause 6 itself. I remind members that we are dealing with clause 6. The question is that the words proposed to be deleted be deleted.

Extracted from finalised Hansard
Hon NICK GOIRAN: I seek the support of members for the amendment standing in my name. It is all very well for the minister to say that the Royal Australian and New Zealand College of Psychiatrists has recommended that GPs and the like be trained by psychiatrists in decision-making capacity. That statement alone should cause members to pause for a moment and ask why they would need to be trained by psychiatrists. Because they need to be upskilled. Minister—this is a rhetorical question—where in this bill is there a requirement that such people have to be trained by a psychiatrist as recommended by the college? It does not exist; hence why it is rhetorical. The minister will tell me that there are some training requirements but there is nothing in this bill that says that before someone can sign off on decision-making capacity, they must have received training by a psychiatrist as recommended by the college. This safeguard would at least press the pause button for seven days. For every Western Australian who wants to access this, if they receive that news, a pause button will be pressed for seven days. That is all that this will achieve. I think that is a helpful safeguard in the overall scheme of things, and I encourage support for it.

Amendment put and a division taken, the Chair casting his vote with the ayes, with the following result —

Ayes (12)
Hon Jim Chown
Hon Peter Collier
Hon Donna Faragher
Hon Michael Mischin
Hon Simon O’Brien
Hon Charlie Smith
Hon Colin Tincknell
Hon Nick Goiran
Hon Simon O’Brien
Hon Robin Scott
Hon Ken Baston (Teller)

Noes (21)
Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Tim Clifford
Hon Alanna Clohesy
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTieman
Hon Kyle McGinn
Hon Martin Pringle
Hon Samantha Rowe
Hon Aaron Stonehouse
Hon Matthew Swinbourn
Hon Dr Sally Talbot
Hon Darren West
Hon Alison Xamon
Hon Pierre Yang (Teller)

Amendment thus negatived.

The CHAIR: Members, that deals with that amendment. We return to the question that clause 6 do stand as printed.

Hon NICK GOIRAN: At page 6461 of the Hansard of 4 September 2019, the Minister for Health in the other place is reported as saying —

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.

What is this robust, international assessment to which the minister referred?

Hon STEPHEN DAWSON: It would be a best practice clinical assessment, but we are not aware of the international assessment that the minister in the other place referred to.

Hon NICK GOIRAN: I can respect that, but if this minister is not aware and he is representing the Minister for Health, I certainly am not aware and the other 35 members who are trying to cast their conscience vote cannot possibly be aware either. At page 6461 of the Hansard of 4 September, Hon Roger Cook, Minister for Health, a minister of the Crown of the state of Western Australia in the other place, is reported as saying —

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.

A reasonable observation is that the reason the Minister for Health provided that response in the other place was to ensure that some comfort was given to members, but when we ask what the international assessment is, we are told that this minister, who represents the other minister, does not know. That is how we are supposed to cast our conscience vote on clause 6, and the minister has said previously that if it is defeated, the bill would still be operative anyway.

Clause 6(2)(e) requires that a patient communicate a voluntary assisted dying decision in some way. Can the minister indicate what is intended to constitute an acceptable form of communication under this clause? I am particularly interested to know about any non-verbal communication, such as hand gestures and the like.

Hon STEPHEN DAWSON: Examples include sign language, use of a communication board or an iPad communication aid. Such strategies are often established with the person by a speech pathologist.

Hon NICK GOIRAN: My final question about clause 6 is: what safeguard is in the bill to ensure that decision-making capacity remains at the time of self-administration?

Hon STEPHEN DAWSON: With the greatest of respect, I think that is a question for clause 57 of the bill, which deals with self-administration. It would be best asked at that point.

Clause put and passed.
Clause 7: Voluntary assisted dying substance —

Hon NICK GOIRAN: What regard would the CEO have for whether the substance is a therapeutic good on the Australian register of therapeutic goods?

Hon STEPHEN DAWSON: The commonwealth Therapeutic Goods Act 1989—the TGA—provides for the establishment and maintenance of a national regulatory system of controls relating to therapeutic goods that are used in, and exported from, Australia. The TGA also provides a framework for the states and territories to adopt a uniform approach to poisons in Australia. The Standard for the Uniform Scheduling of Medicines and Poisons—the SUSMP—is made under the TGA and classifies medicines and poisons into schedules for inclusion in relevant state and territory legislation. The classification of medicines and poisons into schedules depends on the level of regulatory control required over the substance for the protection of public health and safety—the higher the schedule number, the greater level of regulatory control required. The SUSMP is registered on the Federal Register of Legislation as the Poisons Standard. Hopefully, that answers the member’s question.

Hon NICK GOIRAN: My question was what regard would the CEO have for whether the substance is a therapeutic good registered on the Australian Register of Therapeutic Goods?

Hon STEPHEN DAWSON: He would not have to have regard to that. He would have to have regard to whether it is a schedule 4 or schedule 8 poison.

Hon NICK GOIRAN: Would the CEO be able to approve a poison under clause 7 if it is not registered as a therapeutic good?

Hon STEPHEN DAWSON: Yes, he would. The CEO would just have to have regard to whether it is a schedule 4 or schedule 8 poison.

Hon NICK GOIRAN: For clarification, if a poison is a schedule 4 or schedule 8 poison, is it automatically a registered therapeutic good?

Hon STEPHEN DAWSON: The answer is no.

Hon NICK GOIRAN: A poison can be a schedule 4 or schedule 8 poison but not necessarily a registered therapeutic good. Does that mean that we do not have to give any consideration at this point to the commonwealth’s Therapeutic Goods Act 1989 and its intersection with clause 7?

Hon STEPHEN DAWSON: I already explained the intersection when I read to the member earlier that the Therapeutic Goods Act provides for the establishment et cetera and the standard.

Hon NICK GOIRAN: Yes, I do know that, minister. That is not my question. My question is: is it the case that because a schedule 4 or schedule 8 poison—on the advice that the minister is giving me now—does not necessarily have to be a registered therapeutic good, it means that we do not have to give any consideration for or consideration of the intersection between the commonwealth’s Therapeutic Goods Act 1989 and clause 7? The context of this question is that the Joint Select Committee on End of Life Choices was asked by this chamber and the other place to look into the intersection with federal law, and from a previous debate, we know that that committee did nothing whatsoever on federal law. Not one paragraph, chapter, or sentence in its report dealt with that particular issue. It systemically failed in addressing that term of reference given to it by the Parliament. The competency of that committee fulfilling its job on the terms of reference and the secret minutes that are associated with it is a debate for us to have another day. Because that committee has done nothing whatsoever on that issue, I just want to know now: does the Therapeutic Goods Act 1989, which is a commonwealth law, have any intersection with clause 7 that might have any bearing on it? If it has absolutely no relevance whatsoever, then we can move on.

Hon STEPHEN DAWSON: The intersection is about the establishment of schedule 4 and schedule 8 poisons. Our schedule 4 and 8 poisons are defined by reference to the Poisons Standard made under the Therapeutic Goods Act 1989 and regulation 6 of the Medicines and Poisons Regulations 2016.

Hon NICK GOIRAN: A schedule 4 or schedule 8 poison may be approved by the CEO for use under this legislation. If the CEO approves that poison, it is already a schedule 4 or schedule 8 poison; it has to be one of the two. Actually, before I ask that question, could it be a combination of the two?

Hon STEPHEN DAWSON: Yes, it could.

Hon NICK GOIRAN: There are three scenarios here. The CEO might approve a schedule 4 poison, a schedule 8 poison or a combination of the two to be used under this act, and that approval will elevate that particular substance to the status of a voluntary assisted dying substance. Will it have to be registered in any way with the commonwealth under the register of therapeutic goods?

Hon STEPHEN DAWSON: No, it will not have to be.

Hon NICK GOIRAN: Clause 7 provides that the CEO may approve a schedule 4 or schedule 8 poison for use under this act for the purpose of causing a patient’s death. Does the CEO of the Department of Health currently have the power to approve any schedule 4 or schedule 8 poisons under any other act?
Hon STEPHEN DAWSON: Sorry; will the member ask that again?

Hon NICK GOIRAN: The minister will see at clause 7(1) that we are going to give the power to the CEO to approve a schedule 4 or schedule 8 poison for use under this act. Does the CEO currently have a power to approve schedule 4 or 8 poisons under any other act for any other purpose?

Hon STEPHEN DAWSON: We do not believe so, honourable member. I am not sure whether he is trying to make a point. Perhaps the member might make it for us and then we can give him an answer to that.

Hon NICK GOIRAN: Basically, I am really trying to ascertain whether this is the first time in WA history that we are giving the CEO the power to approve a schedule 4 or schedule 8 poison for use under a statute. Clearly, that is what we are doing here. We are giving him or her the discretionary power to do that. I am interested to know whether the CEO already has that power for other purposes or whether this is the first time that we are doing that.

Hon STEPHEN DAWSON: Not to our knowledge.

Hon NICK GOIRAN: I thought that might be the case, so I guess that leads to my next question. I do not know how the minister wants to describe it, but it is certainly the first time a power has been given, as I understand it from the minister’s advice to the chamber, to a public servant—albeit a very senior public servant, the CEO of the Department of Health—to approve a poison, or a combination of poisons. In this particular instance the use is elevated, because it says here in clause 7 that it is for the purpose of causing a patient’s death. We can all agree, no matter where we sit on this debate, that we are giving this particular individual a fairly significant power. If it is the first time in Western Australia’s history that we are giving the CEO that power, I am curious to know why the decision was made to give it to the CEO and not the Minister for Health.

Hon STEPHEN DAWSON: I am told that this has been done as an important safeguard to restrict what a medical practitioner can prescribe.

Hon NICK GOIRAN: I agree that the poisons need to be approved; we are in furious agreement about that. The question really is: who should have that power to approve? The choices seem to me to be either the CEO of the Department of Health, which is the choice at the moment in the bill or, as I am suggesting, the Minister for Health because, according to the advice given to us, never in Western Australia’s history before have we given the CEO of the Department of Health power to approve a substance for the purpose of causing a patient’s death. If I can perhaps just take a moment to explain some of my concern here, the minister has indicated in previous answers that the CEO has the power to delegate. I am not entirely comfortable with the CEO having the power to approve a poison for the death of Western Australians, let alone for it to be delegated, whereas I feel that there would be far greater accountability if a publicly elected person, in the form of the Minister for Health, whoever that might be, and whatever party is in government at the time, had the responsibility of signing off on this. That is the context in which I am asking the question.

Hon STEPHEN DAWSON: It is intended that, as part of the implementation of the bill, a clinical panel will be convened to determine the schedule 4 and schedule 8 medication protocols suitable for voluntary assisted dying. The clinical panel will also inform the operational requirements for supply, 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 Health and clinical perspective. The CEO has the appropriate expertise at his—in this case—disposal to make recommendations about which schedule 4 and schedule 8 poisons should be approved. For example, he has access to the Chief Pharmacist.

Hon NICK GOIRAN: I accept that minister, but so will the Minister for Health. I draw to the minister’s attention fundamental legislative scrutiny principle 3, which the Standing Committee on Legislation routinely uses to guide scrutiny of legislation. It states —

Does the Bill allow the delegation of administrative power only in appropriate cases and to appropriate persons?

This is a point for discussion. Is the CEO the appropriate person, and is it appropriate to be giving the CEO this power to approve schedule 4 and schedule 8 poisons for use under this act for the purpose of causing a patient’s death? I take the minister’s point that the CEO will obviously have access to other administrators and experts, but so will the Minister for Health. It strikes me that a greater accountability mechanism would be if the Minister for Health rather than the CEO were the authoriser. In the spirit of wanting to make progress, would this be an example of something the minister might take away to talk to the Minister for Health about? All that would be required, potentially, is for clause 7(1) to read “the minister” rather than “the CEO”. It would require one word to change and then we could move on. I guess I am asking: is the minister willing to defer clause 7 in the spirit of asking this question of the minister?

Hon STEPHEN DAWSON: Under section 4 of the Medicines and Poisons Act 2014, the minister will have already recommended which poisons are to be schedule 4 and schedule 8 poisons. The next step is for the CEO to approve a particular schedule 4 or schedule 8 poison.

Hon NICK GOIRAN: Do all schedule 4 and schedule 8 poisons have the capacity to cause a patient’s death or is it only certain schedule 4 and schedule 8 poisons?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: The answer to that is possibly. Any medicine or poison is potentially fatal to a person, depending on the dosage they take.

Hon NICK GOIRAN: I guess it goes to the heart of why schedule 4 and schedule 8 poisons were specifically chosen for insertion in clause 7, in contrast with any other poison.

Hon STEPHEN DAWSON: It came out of discussions with the Chief Pharmacist, who indicated that these two schedules were the most appropriate.

Hon NICK GOIRAN: The minister mentioned that a clinical panel would be involved. From what he has just said, I assume that the Chief Pharmacist will most likely be a participant in that clinical panel. Maybe the minister will indicate whether that will be the case. I have a real concern for the complications that arise as a result of taking these poisons. We know from the international experience that there is a complication rate for that. Will those international experiences, particularly around complications, be taken into account by the clinical panel and will the Chief Pharmacist be a member of the clinical panel?

Hon STEPHEN DAWSON: To answer the first question, yes, the Chief Pharmacist would be on the panel and the panel would take into consideration international learnings.

Hon NICK GOIRAN: Minister, what if the CEO does not want to approve the poison, whether it is a schedule 4 or a schedule 8 poison or a combination of both, because the bill states “may”, not “must”? The CEO “may” approve one of these poisons, and this refers to an earlier discussion the minister and I had under clause 5 regarding the term “CEO”. What if the CEO has a conscientious objection and uses that as the reason for not wanting to approve a schedule 4 or schedule 8 poison? How will that situation be dealt with?

Hon STEPHEN DAWSON: I am just being reminded of our earlier conversation. The CEO has specific obligations under the Voluntary Assisted Dying Bill. The CEO in his role as CEO is not a registered health practitioner. Clause 9 does not provide scope for the CEO to object to his functions as CEO under the bill. The CEO would not be in a position in which his functions overlap with the matters referred to in clause 9. Obviously, clause 9 relates to a registered health practitioner being able to refuse to participate in voluntary assisted dying.

Hon NICK GOIRAN: I agree with that, minister. However, under clause 7(1), at the moment, it appears that the CEO may approve it, but, equally, he may not. It seems to me that he may not approve it for any reason, including the fact that he—privately and personally—holds a conscientious objection and says, “Look, I’m just not going to approve this.” He does not need the benefit of clause 9; he can simply say that he conscientiously objects. I just want to confirm that that is in fact the case.

Hon STEPHEN DAWSON: The member is correct in saying that under clause 7, the CEO has discretion to approve or not.

Hon Nick Goiran: For any reason?

Hon STEPHEN DAWSON: No. But, as I have outlined, clause 9 identifies that he cannot conscientiously object. Clause 9 does not provide scope for the CEO to object to his functions as CEO under the bill, so the CEO would not be in a position in which his functions overlap with the matters referred to in clause 9. The CEO could not object for reasons of conscientious objection. For other reasons, though, he may decide not to approve a schedule 4 or schedule 8 poison. We need to bear in mind, of course, that we have indicated that he will obviously be reliant on the clinical panel when he makes a decision on those schedule 4 or schedule 8 poisons. I have also been advised that clause 7 is an enabling clause, which is why “may” is used.

Hon ADELE FARINA: I would like to get some clarification. My understanding in this area is not as good as Hon Nick Goiran’s. Doctors currently prescribe schedule 4 and schedule 8 drugs, or poisons, and they do not need to get the CEO’s approval to do so. Why do we have a requirement in the bill that the CEO needs to approve the dispensing of a schedule 4 or schedule 8 poison for the purposes of the legislation?

Hon STEPHEN DAWSON: Let me be clear: it is not about approval for dispensing. What this clause says is that the CEO may approve a schedule 4 or schedule 8 poison. It is not about dispensing a poison; it is about what poisons on the list can be used.

Hon ADELE FARINA: Does that mean that not all schedule 4 and 8 drugs can be used for the purposes of voluntary assisted dying?

Hon STEPHEN DAWSON: The list of schedule 4 and schedule 8 drugs is long. The CEO will narrow down that list and decide which schedule 4 and schedule 8 drugs can be used as a poison in reference to this bill.

Hon ADELE FARINA: The usual practice in these sorts of circumstances is that there would be a schedule to the bill listing those drugs—that decision would have already been made and the Parliament, in passing the bill, would know exactly what drugs would be used for the voluntary assisted dying substance. Alternatively, that would be provided in the regulations. As I understand it, while there is a regulation-making head of power in the bill, a view has been expressed that there is no need to make regulations pursuant to this legislation because everything is contained within it. We are now hearing that the CEO will, at some later date, identify those schedule 4 and 8 drugs.
that will be used for the purposes of the voluntary assisted dying substance. We have no idea what they will be, we have no idea of the basis on which that decision will be made, and no-one will be able to easily access that information because it will not be in the act or the regulations. My question is: why were those decisions not already made and those substances that will be used for the voluntary assisted dying substance not identified in a schedule to the legislation, which would have made it very clear for everyone? We would then have known exactly what we were passing and approving to be used, rather than leaving it to some other person to make a decision at some later point in time. It is not even clear to me whether the CEO, once he has made a decision about which drugs will be used for the voluntary assisted dying substance, will be able to vary that from time to time, and the basis upon which he would vary that from time to time. I would have thought a schedule to the bill or using the regulation-making power to provide that list in the regulations would have been a far better way to go.

**Hon STEPHEN DAWSON:** I am advised that they are already listed in the Poisons Standard, which is available in the federal register of instruments on ComLaw, which is the commonwealth legislation database. What is prescribed would depend on each patient themselves, taking into consideration their particular condition, weight and capacity to consume the voluntary assisted dying substance. The coordinating practitioner must prescribe a sufficient amount to cause death for that particular patient in their circumstance. This is particularly important, as some diseases or previous medications may restrict the absorption or counter the effectiveness of other medications. The coordinating practitioner is authorised to prescribe a voluntary assisted dying substance for the patient that is of a sufficient dose to cause death. Schedule 4 and 8 poisons are currently supplied to persons for therapeutic purposes, pursuant to the WA Medicines and Poisons Act 2014. It would not be prudent to allow the public to know which of these poisons, as this may encourage persons to stockpile their supply for the purpose of suicide, assisted suicide or voluntary assisted dying outside the protections of the Voluntary Assisted Dying Act. Furthermore, evidence from overseas has shown that once a substance becomes known as a voluntary assisted dying substance, manufacturers of that substance significantly mark up the price. In summary, there are two main reasons. The first is that the clinical panel is to determine the appropriate poisons and recommend them to the CEO, and the second is obviously that we do not believe it is in the public interest.

**Hon ADELE FARINA:** Clause 7 of the bill identifies schedule 4 and 8 drugs as those that are going to be used as voluntary assisted dying substances. To the best of my recollection, in answer to an earlier question the minister indicated that any of the drugs on those lists, if taken in sufficient quantity, could result in death.

**Hon Stephen Dawson:** I said any medicine taken in enough quantity could result in death, not necessarily schedule 4 and 8.

**Hon ADELE FARINA:** Therefore, the reason the minister provided for not attaching a schedule to the voluntary assisted dying drugs to the bill does not make sense, because they are already listed in schedule 4 and 8 of the Medicines and Poisons Act, so the information is already publicly available. I am just not clear. Is it intended that each time a doctor prescribes a voluntary assisted dying substance that that prescription goes to the CEO and the CEO checks that that quantity is sufficient to kill the person, given the person’s weight and drug history? I am just not clear at what point the CEO is making their decision here and the basis of the decision they are making.

**Hon STEPHEN DAWSON:** The clinical panel would establish the protocols. Just because an individual medication is a schedule 4 or 8 poison does not mean that it is clinically appropriate for use in voluntary assisted dying. This is a complicated area. Can Hon Adele Farina please excuse me for interjecting while she was on her feet, but I had made the point to Hon Nick Goiran that any poison or any medicine taken in sufficient quantity could lead to a person’s death. In this case we have identified that schedule 4 or 8 poisons, either individually or together, are those that will be used under this legislation. The CEO will not have a role in determining the cocktail, if I can call it that—the mixture of two substances. That will be up to the clinical panel to work out. It will then provide that advice to the CEO.

**Hon ADELE FARINA:** Just so I am clear, will a table be produced by this panel that indicates that a person at this weight needs this much of substances A and B mixed together, and that a person of much lesser weight only needs a smaller dose? Is that what is going to be produced by this expert panel?

**Hon STEPHEN DAWSON:** I have a few things to say in response to the member’s question.

**Hon Adele Farina:** Minister, you do not need to keep turning around. Talk into the microphone.

**Hon STEPHEN DAWSON:** Okay; thank you. I wanted to have a break from looking at those opposite! I mean no disrespect to any honourable members here; I am just being lighthearted this late in the evening.

Hon Adele Farina asked about a few different things, so I want to cover off a few different points. I restate that the names of all schedule 4 and schedule 8 poisons can be found in the Poisons Standard. The CEO will approve one or more of those schedule 4 and schedule 8 poisons, subject to panel recommendations. The clinical panel will establish the protocol. It will look at the schedule 4 or schedule 8 poisons and choose which are appropriate. The CEO will then agree, or not. The panel will then decide on the prescription protocol. Obviously, doctors will be trained in that during the training process. The coordinating practitioner will decide on the dose that is provided to the patient. That is based on those things that I mentioned earlier. As I said, what is prescribed would depend on each patient’s condition, weight and capacity to consume the voluntary assisted dying substance.

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Extracted from finalised Hansard
Hon NICK GOIRAN: The minister mentioned that the panel will establish these protocols. Will the protocols then be approved by somebody else, like the CEO, or will the clinical panel have the power to do this?

Hon STEPHEN DAWSON: The bill is silent on the protocols, but in practice they would be agreed by the CEO of Health. It is a clinical operational mechanism. The other point I want to make is that the Chief Pharmacist administers the Medicines and Poisons Act and he provides advice to the CEO.

Hon NICK GOIRAN: We can see at clause 7 that we are giving the power to the CEO. Incidentally, I do not know whether we finished that conversation about whether it should be the minister. I flagged whether we could possibly consider deferring clause 7 for the moment to consider whether the minister would be the person with the power, but I may have missed that. As an aside, assuming that clause 7 proceeds unamended, the CEO will have the power to approve. Once the CEO approves a poison under this particular provision, will the CEO also have the power to remove that approval?

Hon STEPHEN DAWSON: The short answer is yes, but the CEO approves the list of the schedule 4 and 8 poisons, rather than the individual one.

Hon NICK GOIRAN: That is not what it says in clause 7. Clause 7(2) states —

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

The CEO approves either a schedule 4 poison or a schedule 8 poison, or a combination of the two. He approves it and at that time, pursuant to clause 7(2), it becomes a voluntary assisted dying substance. As a matter of statute, it becomes a voluntary assisted dying substance that is approved. It is not clear to me where the CEO has the power to disapprove that. That is my concern. To give some explanation about why I am concerned about this, other jurisdictions have experimented with some of these poisons and have found them to be unacceptable. I will give an example. In Washington and Oregon, a large proportion of the deaths that took place under those regimes in 2016—this is recent data—were caused by the self-administration of a combination of phenobarbital, chloral hydrate and morphine sulfate. In December 2016, it was identified that there were problems with that experiment of those three particular poisons, because, as I understand it, the combination turned out to be too harsh. The chloral hydrate mixture was too caustic for some folks. An individual by the name of Dr Robert Wood from that jurisdiction was reported on Kaiser Health News as saying that it proved to be “too caustic for some folks and our volunteers didn’t like using it”.

An alternative to the phenobarbital–chloral hydrate method, which involved a three-drug mixture of diazepam, digoxin and morphine, was then used. However, I understand that in March 2017 it was reported in The Seattle Times that 20 per cent of cases were taking three or more hours for death to occur, with the longest time of death being 31 hours. When the death takes far longer than expected, family members would obviously become worried and even distressed. That three-drug cocktail has now been abandoned in favour of a four-drug cocktail of diazepam, digoxin, morphine and propranolol. That is the context of my concern. Those other jurisdictions—in this instance, Washington and Oregon—have had these problems as recently as 2016 and 2017. As I said earlier, it should be the minister who approves the substance, but regardless, I do not want our CEO in Western Australia to find that the substance has been approved and, as a matter of law at clause 7(2), he cannot remove that approval because we have not given him the power to do so. We will give him only the power to give approval, but not to take it away. I want clarification that the government has received advice on that and can provide some comfort that the CEO will have the power to disapprove these things.

Hon STEPHEN DAWSON: Under section 50(2)(c) of the Interpretation Act 1984, the power to approve includes the power to withdraw approval thereof, so that is covered.

Hon Nick Goiran: Did you check whether that is for the minister or the CEO?

Hon STEPHEN DAWSON: I sought further advice. We are happy with the bill as it reads, and we think it is most appropriate that the CEO has that power.

Hon NICK GOIRAN: I respect that. The minister has sought advice and I thank him for taking the opportunity to do that. What oversight will exist over this? The minister may not agree with my language, but I think it is a very significant power that we will be giving the CEO. What oversight will be in place over the significant power that we will be delegating to the CEO?

Hon STEPHEN DAWSON: Can the honourable member clarify whether he is referring to potential misconduct? Is that the point that he was getting to or not necessarily? Can the member clarify that for me, please?

Hon NICK GOIRAN: I had moved on in preparation for the next question.

Hon Stephen Dawson: Perhaps I can give you an answer.

Hon NICK GOIRAN: Yes.

Hon STEPHEN DAWSON: The member has said the CEO will have a significant power. I would say that the whole bill is fairly significant. It is a new way of doing things in Western Australia. In that regard, we think it is appropriate for the CEO to be responsible and have the power. I refer to oversight, if that is what the member was getting at. The CEO is captured by the Public Sector Management Act and the Corruption and Crime Commission,
so if he did something untoward, that would apply. If there were an issue to do with the act, clause 162 allows for a review of the act. If the issue were to do with the act, it could be captured that way. But if the member is talking about misconduct or something along those lines, the Public Sector Management Act applies to the CEO and the misconduct could be reported to the CCC.

**Hon Nick Goiran**: My final question on clause 7 is: has the government considered any issues that may arise with importation licences or does the government anticipate that all voluntary assisted dying substances will be compounded locally?

**Hon Stephen Dawson**: That is a matter for the implementation phase of the bill.

**Hon Nick Goiran**: The problem is that if we are looking at importation licences, I assume that this legislation will then intersect with federal law. Has any specific advice been obtained on that issue?

**Hon Stephen Dawson**: We are not looking to breach federal law. We believe that the substances—the poisons—are already available here on the schedule 4 and schedule 8 list, so they are available now without needing to import or to breach federal law.

**Hon Nick Goiran**: Are the poisons used under the Victorian regime also schedule 4 or schedule 8 poisons for the purposes of clause 7?

**Hon Stephen Dawson**: I am looking for the answer for the honourable member now, but we are starting to stray outside of clause 7. We are looking to see what the Victorian act says. Clause 7 before us does not mention the Victorian act, so I think the question is outside the scope. In saying that, my advisers have the Victorian act in front of them, so if I can provide the information now, I will.

**Hon Nick Goiran**: Minister, I am not asking about the Victorian act. I am simply saying that Victoria has a scheme in place; I did not mention the act. Poisons are being used under that scheme. This goes to the heart of my question on whether there would be problems with importation licences or whether it would be compounded locally. In Western Australia, we would be giving power to the CEO to approve certain schedule 4 or schedule 8 poisons. I would like to know whether Western Australians would have access to the same poisons that Victoria has access to—that is my question. It falls very much under the scope of clause 7.

**Hon Stephen Dawson**: The Victorian Voluntary Assisted Dying Act states —

*voluntary assisted dying substance* means a poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for the purpose of causing a person’s death;

The CEO in Victoria approves the permit. In effect, he is doing the same thing as our CEO would be doing here.

**Hon Nick Goiran**: Perhaps I have not explained the question correctly. They must be using some poisons in Victoria to give effect to this scheme. I do not know what those poisons are.

**Hon Stephen Dawson**: Neither do I, but ask the question anyway.

**Hon Nick Goiran**: That is what I want to know. Let us call the poisons they are using in Victoria poisons X and Y. Are poisons X and Y schedule 4 and schedule 8 poisons as defined under section 3 of the Medicines and Poisons Act 2014? In effect, I am asking whether WA will have access to the same poisons as Victoria.

**Hon Stephen Dawson**: I am told that Victoria has not released what medications it uses, so I cannot give the member a definitive answer.

**Hon Nick Goiran**: I will just round this out; the minister probably knows where I am headed. Victoria has not released the information, but is there any capacity for the WA government to extract that information from Victoria to say, “Look, you guys have already started this process. You’ve decided what poisons are working or not working.” Remember that the context of my question is that as recently as 2016 and 2017, Washington and Oregon experienced significant problems with the cocktail of poisons they have been using. The minister will recall the information I provided earlier that when the combination of two was not seen to be successful they then tried a combination of three poisons. Now they have a combination of four. I would like to have some comfort that whatever experiment is going on in Victoria, we might have the lessons of that.

**Hon Stephen Dawson**: If that is your point, I can answer that.

**Hon Nick Goiran**: Yes. If it is not possible for us to know, because there is some shroud of secrecy in Victoria that we cannot penetrate, then I guess that is bad luck for us, but I would be keen to know the answer to that.

**Hon Stephen Dawson**: We can certainly learn from Victoria. Members of the clinical panel could contact their colleagues in Victoria and discuss on a confidential basis the poisons used. We are not aware of what Victoria uses now, but certainly during our implementation phase we can seek to learn from Victoria so that we are not reinventing the wheel, if I may use that phrase.

Clause put and passed.
Clause 8: When request and assessment process completed

Hon CHARLES SMITH: Mr Deputy Chair.

The DEPUTY CHAIR (Hon Martin Aldridge): Hon Charles Smith, if I could just advise you that if you were intending to move the new clause 8A standing on the supplementary notice paper, that would occur after consideration of clause 8 and before consideration of clause 9.

Hon NICK GOIRAN: Clause 8 provides that the request and assessment process will be completed once the coordinating practitioner has completed the final review form and certified in that form that the request and assessment process has been completed. Further assessment of capacity, the voluntariness of the request and the enduring nature of the request is made by the administering practitioner, when the practitioner administration is decided upon. This will occur, I think the minister will agree, after the request and assessment process is deemed completed. Can the minister clarify for us how the request and assessment process will be considered to be completed under clause 8 when the final assessment immediately before the practitioner administration required under clause 58(5) has yet to occur?

Hon STEPHEN DAWSON: It is the end of the request and assessment process. The additional step to which Hon Nick Goiran refers is about the administration decision. The concept of the request and assessment process being completed is important, as it is only after completion that the patient is able to progress to the next stage to access voluntary assisted dying.

Hon NICK GOIRAN: What confidence can we have that the safety and wellbeing of the patient can be safeguarded when clause 8 requires only that the coordinating practitioner be satisfied that they have completed the request and assessment process in accordance with this legislation?

Hon STEPHEN DAWSON: The final review will provide the coordinating practitioner with the opportunity to ensure that all the necessary steps in the request and assessment process have been completed. The coordinating practitioner is not required to repeat these steps. They are required to ensure that every step has been properly adhered to. I draw the member’s attention to clause 50, which lays out the steps in the final review by the coordinating practitioner on receiving a final request. It states —

(1) On receiving a final request made by a patient, the coordinating practitioner for the patient must —

(a) review the following in respect of the patient —

(i) the first assessment report form;

(ii) all consulting assessment report forms;

(iii) the written declaration;

and

(b) complete the approved form … in respect of the patient.

Hon NICK GOIRAN: Why is the Voluntary Assisted Dying Board’s consideration of the coordinating practitioner’s completion of the request and assessment process not required before part 4, division 2, “Administration of voluntary assisted dying substance”, can be applied?

Hon STEPHEN DAWSON: The board does not have a medical decision in the process. It has no clinical role, but it has a monitoring role.

Hon NICK GOIRAN: That is my point. I think the board does have a monitoring role, but it strikes me that clause 8(b) provides that the coordinating practitioner for the patient has certified in the final review form that the request for an assessment process has been completed in accordance with this legislation. At the moment, the safeguard, if you like, is one person—the coordinating practitioner. They sign off and say, “Yes, I certify that I have complied with the act.” I am suggesting that it would be safer if the board were then to do that certification, to say, “We have received the final review form from this coordinating practitioner, and we certify that we have received it.” At the moment, it stops one step earlier. I am wondering whether any consideration was given to that safeguard.

Hon STEPHEN DAWSON: Clause 50(4) of the bill provides that within two business days of completing the final review form, the coordinating practitioner must give a copy of it to the board.

Hon NICK GOIRAN: Clause 50(4) reads —

Within 2 business days after completing the final review form, the coordinating practitioner must give a copy of it to the Board.

If we look back to clause 8, there is no reference to the fact that that has happened. The request and assessment process is completed, and then, apparently within two days, the board can be involved, and perhaps not even be involved, but it does not get to certify the role. What I am getting to here is that a greater safeguard would be if the board certified that the coordinating practitioner has completed things in accordance with this legislation, rather...
than the person themselves. It is a bit like them being required to grade themselves, and it would be better if they, as the minister said, performed the clinical functions, and then an independent body—in this instance, the Voluntary Assisted Dying Board—did the certification. I am questioning whether any consideration was given to that as a safeguard mechanism.

**Hon STEPHEN DAWSON:** I am advised that consideration was given, but that was not the one that was chosen.

Clause put and passed.

New clause 8A —

**Hon CHARLES SMITH:** I move —

Page 9, after line 22 — To insert —

8A. When request for access to voluntary assisted dying ceases to be enduring

(1) For the purposes of this Act, a patient’s request for access to voluntary assisted dying ceases to be enduring if the patient, at any time, indicates to the coordinating practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

(2) Subsection (1) does not limit the circumstances in which a patient’s request for access to voluntary assisted dying ceases to be enduring.

(3) If a patient’s request for access to voluntary assisted dying ceases to be enduring under subsection (1), then —

(a) if the request and assessment process in respect of the patient has not been completed — the request and assessment process ends; and

(b) if the request and assessment process in respect of the patient has been completed — the process for accessing voluntary assisted dying under Part 4 ends and no step under that Part (including the prescription, supply or administration of a voluntary assisted dying substance) is to be taken in relation to the patient.

(4) Nothing in subsection (3) prevents the patient from beginning a new request and assessment process by making a new first request.

New clause 8A is a simple clause. It seeks to better define the existing concept of when a patient’s request for access to voluntary assisted dying is considered to be enduring. Members may like to know for their interest that this, and indeed other proposed amendments, are taken from a Northern Territory piece of legislation called the Rights of the Terminally Ill Act 1995. In this case, it is taken from section 7(o). Clause 15(1)(f) of the Voluntary Assisted Dying Bill 2019 in front of us requires —

the person’s request for access to voluntary assisted dying is enduring.

Prior to practitioner administration, the administering practitioner must also be satisfied that “the patient’s request for access to voluntary assisted dying is enduring”. That is at clause 58(5)(c). They must also certify that they were satisfied of this in the practitioner administration form. That is clause 60(2)(b)(iii). As I said, the amendment simply seeks to define the existing concept when a patient’s request for access to voluntary assisted dying is “enduring”.

This new clause will provide clarity for the coordinating and consulting practitioners assessing a patient’s eligibility under clause 15(1)(f) and for an administering practitioner to satisfy themselves of the enduring nature of the request under clause 58(5)(c) about what it means for the patient’s request to have been enduring. This amendment will ensure that the requirement that the patient’s request be enduring will apply to all stages during the VAD process, including the first assessment, the consulting assessment, the final review and at the moment of the administration of the voluntary assisted dying substance itself. The new clause is very simple. It will provide further clarity and a further safeguard. I commend it to the chamber.

**Hon STEPHEN DAWSON:** I appreciate Hon Charles Smith moving this new clause, but we are not in a position to support it. “Enduring” is given a common, everyday meaning in the bill and we do not think it requires defining.

Clause 18 of the bill already provides that the patient is under no obligation to continue after making a first request and clause 52 states that there is no obligation on the patient to continue after completion of the request and assessment process. We do not believe the amendment is needed so we will not support it.

**Hon NICK GOIRAN:** I am inclined to support this amendment by Hon Charles Smith. I am interested that the minister says it is not necessary. Would the amendment moved by the honourable member undermine any element of the bill or make it in any way inoperative? It is one thing for the minister to say that he does not think it is needed, but, again, I suppose it goes to the question that has been asked on some other clauses: what harm would be done if it provides greater clarity? I am mindful—the minister probably is as well—that the stakes are pretty high here if we get something wrong, so if this adds an extra level of comfort or safety and does not do any harm or undermine anything, it is not clear to me why it ought not be supported.

*Extracted from finalised Hansard*
Hon STEPHEN DAWSON: This amendment relates to some other amendments that Hon Charles Smith put on the supplementary notice paper. He has parked the definition of “enduring”, which is on page 1 of the supplementary notice paper, issue 9, but he has further amendments later on, which seek to formalise a situation in which a patient decides not to continue with a request and assessment process. It is our belief that the inclusion of the amendment adds to the complexity and bureaucratic burden of the bill. Therefore, we are treating the amendments that Hon Charles Smith is moving as a package, linking the three together and not dealing with them alone. We are not supportive of the package.

Hon NICK GOIRAN: It is fair enough that the minister wants to deal with it as a package. One of the amendments the minister referred to is amendment 25/5, standing in Hon Charles Smith’s name, on the supplementary notice paper. It seeks to insert in clause 5, which deals with terms, the word “enduring”. It states —

**enduring**, in relation to a request for access to voluntary assisted dying, has a meaning affected by section 8A;

We are dealing with that clause now. In terms of the package, I assume that that one is not objectionable?

Hon Stephen Dawson: It’s the later one.

Hon NICK GOIRAN: It is the latter one. Can the minister indicate what the latter one is that he is referring to?

Hon STEPHEN DAWSON: It is new clause 52A.

Hon NICK GOIRAN: Therefore, minister, if I understand the objection correctly, it really relates to the package, as you say, and, specifically, new clause 52A. I am reading this on the run here because, as the minister can appreciate, I was not aware that the government’s position was that new clause 52A was relevant to the amendment in front of us. However, amendment 38/NC52A states that the board be notified if the patient decides not to continue or if request for access to voluntary assisted dying ceases to be enduring. Without looking at the ins and outs of all of that now, the title at least seems to suggest that if the patient decides that he or she does not want to continue, the board should be notified. What is objectionable about that?

Hon STEPHEN DAWSON: As I indicated, honourable member, the inclusion of the amendment adds to the complexity and the bureaucratic burden of the bill. If the patient makes a formal decision to withdraw from the voluntary assisted dying process, the coordinating practitioner would be able to make a note in the person’s medical file and record it via the electronic portal.

Hon NICK GOIRAN: The other thing that strikes me, looking at new clause 52A, is would new clause 8A not be able to stand on its own without new clause 52A? Therefore, would it be open to the government to support new clause 8A and then not support new clause 52A because, as the minister says, it is too bureaucratic?

Hon STEPHEN DAWSON: New clause 8A could stand alone. We have considered the amendments as a package, but this new clause has also been considered by itself. I indicated in my earlier response that we do not support the package, but we also do not support any of the three amendments either. They have been considered and we are not supportive of any of them.

Hon NICK GOIRAN: On that basis, I am going to indicate my support —

Hon Stephen Dawson: Are you going to say that you support it because I said that I don’t?

Hon NICK GOIRAN: No; it is because the explanation was unsatisfactory. The explanation was that there is a package of three amendments. We have already agreed that the first one is consequential and not objectionable. The second part of the package is before us at the moment. The third part is the one that the minister indicated the government is concerned about. We have just identified that that one can be dispensed with and that that would not have a consequential impact on the second amendment. It seems to me that it is quite open to members to support this amendment, because we can deal with new clause 52A in due course—it is not necessarily relevant to this amendment. I understand from the minister that it does no harm and does not undermine the provisions of the bill. The minister said that it is not necessary; I think it provides clarity.

I heard the honourable member make some reference to the Northern Territory legislation. I have a copy of that legislation—the Rights of the Terminally Ill Act 1995. If I heard the member correctly, he made reference to section 7(1)(o). Section 7 of that act is headed “Conditions under which medical practitioner may assist”. Subsection (1)(o) states —

at no time before assisting the patient to end his or her life had the patient given to the medical practitioner an indication that it was no longer the patient’s wish to end his or her life;

I would like to think that we would all agree with that—that if a patient did express that desire, the practitioner could not proceed. If this amendment gives effect to a provision similar to section 7(1)(o), I think it is worthy of support. What consultation has the government undertaken into the operation and effectiveness of that particular section of the ROTTI act?

Hon STEPHEN DAWSON: We have not looked into that particular section of the ROTTI act. We have not consulted on it.

Extracted from finalised Hansard
Hon NICK GOIRAN: The government has not given us any advice that section 7(1)(o) of the ROTTI act is a problem. I was on the select committee for a year and attended all the meetings and the hearings, and I can certainly attest that section 7(1)(o) of the Northern Territory legislation was never raised as a problem, so I am inclined to support the amendment.

Hon STEPHEN DAWSON: I cannot say that section 7(1)(o) was never raised as a problem.

Hon Nick Goiran: Well, I can.

Hon STEPHEN DAWSON: Certainly, the whole act was a problem for the federal Parliament. I am not in a position to say that section 7(1)(o) was not a problem, but neither of my advisers were briefed on that act and we have not consulted on that act. As I have indicated previously, we are not supportive of the motion before us in Hon Charles Smith’s name.

Hon NICK GOIRAN: Just to be clear, did the minister just indicate that the government did not review, consider or consult on the Northern Territory legislation prior to the drafting of this bill?

Hon STEPHEN DAWSON: To clarify, we have not specifically consulted on the section that the member has raised.

Hon MARTIN ALDRIDGE: I have a question about this amendment. Subclause (3) anticipates two circumstances. The first, under paragraph (a), is that the process is underway—for example, the patient has not yet qualified; they are mid-assessment—and the second, in paragraph (b), anticipates that the process has been completed. Given that we are contemplating a situation in which a patient is mid-process, why does subclause (1) refer only to a coordinating practitioner or an administering practitioner and does not recognise a consulting practitioner?

Hon NICK GOIRAN: I will move an amendment. I move —

New clause 8A(1) — To insert after “coordinating practitioner” —

or consulting practitioner

I think that will then alleviate the concern of the honourable member.

The DEPUTY CHAIR: We may have to have that in writing. I presume in the second line of new clause 8A(1) after “indicates to the” you could put “consulting practitioner,” which would then be followed by “coordinating practitioner or administering practitioner”. Is that the intent of your amendment?

Hon NICK GOIRAN: Yes, Mr Deputy Chair.

The DEPUTY CHAIR (Hon Dr Steve Thomas): We are dealing with new clause 8A, moved by Hon Charles Smith. It is on page 3 of supplementary notice paper 139, issue 9. We are now dealing with the amendment to new clause 8A moved by Hon Nick Goiran. I do not propose to read the entire motion moved by Hon Charles Smith again, but I draw members’ attention to the amendment to new clause 8A. It consists of an insertion on the third line—to insert the words “or consulting practitioner” after “coordinating practitioner”. The amended new clause 8A(1) would read —

For the purposes of this Act, a patient’s request for access to voluntary assisted dying ceases to be enduring if the patient, at any time, indicates to the coordinating practitioner or consulting practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

Therefore, the question on the amendment to the amendment is that the words to be inserted be inserted.

Hon MARTIN ALDRIDGE: I wanted to ask a few questions before the amendment was moved.

The DEPUTY CHAIR: Can you make sure that you direct your comments to the amendment to the amendment rather than the original amendment. You can come back to the original amendment after the amendment to the amendment.

Hon MARTIN ALDRIDGE: That could be an easy way of dealing with it.

Hon AARON STONEHOUSE: I seek clarification, for my satisfaction. As amended, new clause 8A would read — … the coordinating practitioner or consulting practitioner or administering practitioner …

I wonder whether there should be a comma so it would read — … the coordinating practitioner, consulting practitioner or administering practitioner …

Several members interjected.

Hon AARON STONEHOUSE: I am not being silly.

A member interjected.

Hon AARON STONEHOUSE: Shoosh, member. If you have a contribution, you can make it rather than making quite silly interjections because I actually have a serious point to make.

Extracted from finalised Hansard
The DEPUTY CHAIR: Order! Hon Aaron Stonehouse, proceed with your question and I might respond.

Hon AARON STONEHOUSE: I have a serious point. I seek clarification. If it is determined that a comma rather than the word “or” is more appropriate, would that be easily fixed through a Clerk’s amendment? That is all the clarification I seek. It is a very serious point. I do not think it needs silly interjections, but thank you for your protection, Mr Deputy Chair.

The DEPUTY CHAIR: We consulted the clerks on the proposal to the amendment to determine whether “or” or a comma was more appropriate and it was deemed that “or” was perfectly adequate for the purposes of the amendment. Therefore, I propose to proceed.

Hon COLIN HOLT: I wonder whether we can get an indication from the mover of the original amendment about whether he is happy to accept Hon Nick Goiran’s amendment because there is an oversight or he had some other plan for his amendment originally excluding “or consulting practitioner”.

Hon CHARLES SMITH: It is not an oversight. I support the amendment to the amendment moved by Hon Nick Goiran.

Hon STEPHEN DAWSON: We are not supportive of the amendment to the amendment. We are not supportive of the amendment either for the reasons that I outlined previously.

**Division**

Amendment on new clause put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the ayes, with the following result —

Ayes (18)

Hon Martin Aldridge Hon Nick Goiran Hon Martin Pritchard Hon Dr Steve Thomas
Hon Jim Chown Hon Colin Holt Hon Robin Scott Hon Colin Tincknell
Hon Peter Collier Hon Rick Mazza Hon Tjorn Sibma Hon Ken Baston (Teller)
Hon Donna Faragher Hon Michael Mischin Hon Charles Smith Hon Aaron Stonehouse
Hon Adele Farina Hon Simon O’Brien

Noes (17)

Hon Jacqui Boydell Hon Colin de Grussa Hon Kyle McGinn Hon Alison Xamon
Hon Robin Chapple Hon Sue Ellery Hon Samantha Rowe Hon Pierre Yang (Teller)
Hon Tim Clifford Hon Diane Evers Hon Matthew Swinbourn
Hon Alanna Clohessy Hon Laurie Graham Hon Dr Sally Talbot
Hon Stephen Dawson Hon Alannah MacTieman Hon Darren West

Amendment on new clause thus passed.

Hon MARTIN ALDRIDGE: I wanted to flesh out a few questions before we dealt with the amendment. I heard the minister reflect on the government’s satisfaction with clause 52, which states —

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.

Clause 52 relates to a patient who has qualified through the process, whereas the amendment proposed by Hon Charles Smith anticipates the two scenarios that I mentioned—a patient who is mid-process and has not yet qualified, and a patient who has qualified. The reason I am erring on the side of not supporting this amendment is that if we look at new clause 8A in isolation, it simply requires a patient to indicate that they no longer want to continue; therefore their consent is no longer enduring. In my view, there is no difference between what would occur under new clause 8A and clause 52, as the minister has suggested.

The other thing that concerns me about the amendment as amended is the problem with being too specific in these matters. The amendment now includes the coordinating practitioner, the consulting practitioner and the administering practitioner. I might seek the advice of either the mover of the amendment or the minister in helping me understand this. Several clauses in the bill allow for referral for a range of reasons to assist either the consulting or coordinating practitioner in making a decision on qualification under the legislation. If a patient were to indicate to that medical practitioner—perhaps it is a psychiatrist or a palliative care specialist—that they were no longer willing to participate in the process, would that class of practitioner be captured under the amendment as it now stands, which specifically refers to the coordinating practitioner, the consulting practitioner and the administering practitioner?

Hon CHARLES SMITH: I understand the member’s need for further explanation on enduring consent at each stage of the process. New clause 8A simply seeks to ensure that at each stage that a patient sees various practitioners, if their consent becomes no longer enduring, that is assured from that moment onwards. It is as simple as that. Again, new clause 8A is merely based on the Northern Territory’s Rights of the Terminally Ill Act. I aimed to replicate that additional safeguard in this new clause 8A.
Hon NICK GOIRAN: I think Hon Martin Aldridge’s question is a good one. He has identified that during this process other practitioners can get involved. The minister has indicated that the government does not support new clause 8A because it is unnecessary. If it is unnecessary, what part of the bill will take care of the concern that Hon Martin Aldridge has raised? For example, I will give the minister a hypothetical situation. If one of the doctors is not sure about a patient and refers them to a specialist to get their opinion, that specialist is neither the consulting practitioner nor the coordinating practitioner. If the patient speaks to that specialist and says, “Look, I’ve had enough of this, I don’t want to go ahead with this voluntary assisted dying process”, how is that communicated back to the Voluntary Assisted Dying Board, the consulting practitioner or anyone in authority to make it clear that this process has now come to an end?

Hon STEPHEN DAWSON: There are a few questions floating around at this stage. No; new clause 8A would not include the practitioner or persons the patient has been referred to. Clauses 52 and 18 of the bill contemplate all the roles. I am just waiting on a further bit of advice on that last question.

If I can answer further: the patient who does not want to proceed simply will not proceed. If they tell the referred person, then the referred person would tell the coordinating or consulting practitioner who made the referral.

New clause, as amended, put and negatived.

Clause 9: Registered health practitioner may refuse to participate in voluntary assisted dying —

Hon NICK GOIRAN: As I understand it, clause 9 deals with the conscientious objection provision, which I know is of interest to several members. The minister indicated in earlier dialogue that the CEO would not be captured by this provision because the CEO is not necessarily a registered health practitioner. In any event, when the CEO is performing his functions, he is doing so in that capacity, not as a registered health practitioner. Is there a common law right to conscientious objection that we are enshrining in this statute, or does this conscientious objection only exist because of clause 9?

Hon STEPHEN DAWSON: A person does not have a broader ability to conscientiously object that is not set in this legislation. However, the wider ability does not abrogate a statutory duty. The narrower statutory exemption in the bill would limit the broader application of non-statutory conscientious objection provisions. The bill makes clear that we only seek to extend statutory exemption to a registered health practitioner to conscientiously object. A wider ability would not abrogate the statutory duty of the CEO. The CEO has specific obligations under the Voluntary Assisted Dying Bill. This is supported by section 20(1)(o) of the Health Services Act 2016, which also provides that the functions of the department CEO includes “other functions given to the Department CEO under this or another Act”.

Honourable member, there is a bit of noise around. I would urge Mr Deputy Chair to remind people to keep their voices quiet, in anticipation of the next questions I am going to be asked. I was struggling to hear myself that time.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Certainly, minister. It is a good piece of advice for everybody to keep the noise in the chamber to a minimum if we will. Noting the time, I propose to interrupt business to report progress.

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

Legislative Council

Thursday, 21 November 2019

VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 20 November. The Deputy Chair of Committees (Hon Dr Steve Thomas) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 9: Registered health practitioner may refuse to participate in voluntary assisted dying —

Progress was reported after the clause had been partly considered.

The DEPUTY CHAIR: Minister, do you want to make any opening remarks before we commence?

Hon Stephen Dawson: No.

Hon AARON STONEHOUSE: I note that the language used in clause 9 is “registered health practitioner who has a conscientious objection” and that the title of the clause is “Registered health practitioner may refuse to participate in voluntary assisted dying”. This obviously points to a very specific group of people—registered health practitioners—as opposed to the looser language used in earlier clauses, such as “health practitioner” or just perhaps a “medical practitioner”. I wonder whether under this bill there is any ability for a non-registered health practitioner
who may otherwise be involved in the regime of voluntary assisted dying to be a conscientious objector and to refuse
to take part in the process. I am thinking about perhaps a receptionist at the front desk of a medical clinic, who perhaps
does not want to have anything to do with voluntary assisted dying, or social workers, who are not registered health practitioners but who are referred to, by the minister’s own admission, in the principles of the bill.

Hon STEPHEN DAWSON: The reason that clause 9 refers just to registered health practitioners is that they have particular roles set out under this bill. There is no obligation on anyone to participate. In relation to the issue concerning a receptionist, that would need to be managed between that person and their employer. The bill does not give non-registered health practitioners the protection. There is a wider ability in common law, but it is not enshrined in this bill.

Hon AARON STONEHOUSE: I might have some questions about the common law right to conscientious objection later—that is something I am really interested in and will unpack in detail in a moment. What I am thinking about is an instance in which a social worker is working in palliative care. The minister says that the bill does not place any obligation on them to be involved in voluntary assisted dying. If they are not a registered health practitioner, there is no obligation on them to be involved in this scheme.

Hon Stephen Dawson: By way of interjection, what I indicated was that they have no particular role set out in this bill.

Hon AARON STONEHOUSE: There is no role for them set out in this bill, so the bill places no obligation on them to participate in voluntary assisted dying. That is good; I am glad to hear that. Another scenario I am concerned about is that of a receptionist at a doctor’s clinic. The bill does not place an obligation on them to be involved in voluntary assisted dying. However, there may be an obligation placed on them in their employment contract that would somehow involve them in the voluntary assisted dying regime. For example, when a doctor processes someone’s application, their receptionist will be involved in that to some degree. Is it true, then, that there may be an obligation, perhaps through someone’s employment contract, for a non-registered health practitioner to be involved in voluntary assisted dying?

Hon STEPHEN DAWSON: It is possible, honourable member, but I guess it would be highly unlikely that someone’s contract, a receptionist for example, stipulates that they must be involved in the voluntary assisted dying process. If somebody was about to start a job, they could at that stage say they were not signing the contract because there was an issue in there they do not believe in, and that would be their right. I reiterate that a receptionist does not have an obligation under this bill before us.

Hon AARON STONEHOUSE: I am not saying it is a good or a bad thing; I just think it is worth being completely clear about the obligations people will have to be involved in the voluntary assisted dying regime. To make my view on this clear, I absolutely believe that medical practitioners should be afforded a right to be conscientious objectors; everybody should. However, somebody who voluntarily enters into a contract with an employer has obligations under that contract. That is a voluntary arrangement they have as well. They are not coerced into becoming an employee at a clinic that provides voluntary assisted dying, of course; however, there is the issue of retrospectivity here, I suppose. There is no obligation for, say, a receptionist or some kind of support worker to be involved in the voluntary assisted dying regime in this bill; however, a medical practitioner processing a voluntary assisted dying request may involve their support staff or receptionist in some way; for example, by asking them to photocopy documents or to bring up Mrs Henderson’s file for her VAD request—something like that. They may be involved in that process to some degree.

Hon Nick Goiran: They could even be a witness to the VAD.

Hon AARON STONEHOUSE: They could perhaps even be a witness to practitioner-administered voluntary assisted dying. That is not a requirement or an obligation placed on these people under the bill, but it may be an obligation under their employment contract, which is what I am getting to. An employer hires somebody with the understanding that they will process paperwork for them—before VAD even existed. Once VAD has been passed, their obligations will still be the same—to process paperwork as a receptionist or in an administrative role. Therefore, those people may now have an obligation as employees to continue to carry out that function of processing paperwork or perhaps even being witness to practitioner-administered voluntary assisted dying. Can the minister clarify whether I am on the right track here? There may be an obligation, not through the bill, but merely through the relationship an employee has with an employer. Again, I am not saying this is good or bad. My personal view is that the person can quit if they do not like it. If a person’s employer is administering voluntary assisted dying, they are under no obligation to remain an employee of that employer. If I were an employee of someone administering voluntary assisted dying—I do not personally like the idea—I would quit. I would not be an employee there anymore and it would be absolutely my right to disassociate from people who administer VAD.

Hon Alannah MacTiernan: Do you support the principle of VAD?

Hon AARON STONEHOUSE: I do. I support the principle. We will wait to see what the bill looks like at the end of the Committee of the Whole House.

Hon Alannah MacTiernan: You would not be someone who resigns from their job.
Hon AARON STONEHOUSE: I would. I personally do not like voluntary assisted dying. I would not advocate it for anybody I know; I would try to talk them out of it. But I do not want to use the state to coerce people into living their lives by my standards. I have a personal objection to it, but I do not think I should refuse other people the right to access it if they really want to.

Hon Alannah MacTiernan: Good to hear!

Hon AARON STONEHOUSE: I think that is a pretty standard classical liberal view of this stuff.

Just to get back to the question I was asking the minister, who I think is seeking advice now, it is good to say that new employees would look at their employment contract and the practices of their new employer. They could see that the employer processes VAD applications and decide they do not want to work for them. That is fair enough. What about people who are currently employed, whose current obligations as an employee may put them in a position of being directly involved with voluntary assisted dying in some support or administrative role?

The DEPUTY CHAIR (Hon Dr Steve Thomas): Just before we go on, Hon Aaron Stonehouse, it was mentioned last night that the undertone of conversation around the chamber was an issue. It has just risen again, and I can hear it, so I ask members if they could take their conversations outside to allow Hon Aaron Stonehouse to make his contribution in silence.

Hon AARON STONEHOUSE: I think I have made my question clear, but if the minister needs more clarification, he should let me know.

Hon STEPHEN DAWSON: The employee would still have the ability to refuse to witness a document related to VAD. If the medical practitioner said that they were going to sack the receptionist, that would be an industrial relations matter. Obviously, if a doctor took that action, the receptionist could take recourse under the Industrial Relations Act 1979. Because a doctor can conscientiously object to participate in VAD, I think it would be unlikely for a medical practitioner to sack a staff member, such as a receptionist, who refuses to witness a document. It could happen. In that case, the receptionist could take industrial relations action.

Hon AARON STONEHOUSE: This is rather interesting. The minister raised something that I had not expected. I would not have thought that an employee refusing to witness or process a document because of an objection to VAD would be grounds for some kind of unfair dismissal suit or arbitration at the Industrial Relations Commission. That raises an issue. A medical practitioner may be planning to be a provider of voluntary assisted dying and to process requests, and perhaps they will have an employee who is a conscientious objector, which they obviously have every right to be. If that conscientious objector employee says, “I am not going to do my job related to these requests; I am just going to sit on my hands and refuse to participate”, that creates a bit of an issue. If the employer has no way to oblige their employee to carry out their normal functions of processing paperwork and carrying out administrative tasks, and they fire them, they are liable for an unfair dismissal suit. I think we have a bit of a problem that needs to be looked at closer.

Hon Stephen Dawson: It would depend on the circumstances, but certainly in some cases, there could be an IR case.

Hon AARON STONEHOUSE: I understand the argument from the other side that that might counter some kind of religious discrimination—say, a Christian employee who refuses to carry out their role because they have a conscientious objection and that person’s religious freedom should be protected. I am absolutely a believer in religious freedom and the right to be a conscientious objector, but if someone refuses to do their job, an employer should not be obliged to continue hiring that person. I think this cuts both ways. I am an advocate of freedom of association when it comes to other institutions. For instance, I think religious institutions should not be obliged to hire people who do not subscribe to their specific set of values. I think there should be exemptions and discrimination through Christian schools, religious schools and other religious institutions so they can hire and fire as they please. But it cuts both ways. I believe in freedom of association for all people.

The minister is saying that it would depend on the specific circumstances. I do not have enough experience in IR law. Perhaps other members who are familiar with this area might want to interrogate that further. I am interested in pursuing a couple of other lines. I might resume my seat for a moment while I prepare for a different line of questioning.

Hon NICK GOIRAN: I am intrigued by this line of questioning by the honourable member. I ask the minister to look at the three elements in clause 9(1). Under clause 9, a registered health practitioner will have the right to refuse to do three things on the basis of a conscientious objection. The first is to participate in the request and assessment process; the second is to prescribe, supply or administer a voluntary assisted dying substance; and the third is to be present at the time of the administration of a voluntary assisted dying substance. Notwithstanding clause 9, does every Western Australian have that right?

Hon STEPHEN DAWSON: I am told that every person has the right to refuse, but that right to refuse may be affected by the person’s contractual obligations.

Hon NICK GOIRAN: Let us take the third limb. Notwithstanding clause 9—let us assume for a moment that clause 9 is not in the bill and has been defeated—would every Western Australian have a right to refuse to be present at the time of the administration of a voluntary assisted dying substance? Neither the minister nor I are
registered health practitioners in this state. I want to know that both the minister and I have the right to refuse to be present at the time of the administration of a voluntary assisted dying substance.

Hon STEPHEN DAWSON: My advisers tell me yes.

Hon NICK GOIRAN: That deals with the third limb, so we can go backwards. Every Western Australian has a right to the third limb, not just registered health practitioners. That is very comforting to know. Looking at the second limb, does every Western Australian have the right to refuse to prescribe, supply or administer a voluntary assisted dying substance? I know that only certain Western Australians have the power to do those things. That is a different question. I am not asking who has the power to prescribe, supply or administer. I want to know whether every Western Australian has a right to refuse to prescribe, supply or administer a voluntary assisted dying substance.

Hon STEPHEN DAWSON: Yes, honourable member.

Hon NICK GOIRAN: We now know that every Western Australian has the right to refuse to be present at the time of the administration of a voluntary assisted dying substance and we also know that every Western Australian has the right to refuse to prescribe, supply or administer a voluntary assisted dying substance. My last question on this theme is: does every Western Australian have a right to participate in the request and assessment process?

Hon STEPHEN DAWSON: They have the right to refuse. I am just clarifying that. The member asked the opposite, but I am clarifying that.

Hon NICK GOIRAN: In light of that, if every Western Australian has the right to refuse these three limbs—I want to be clear that I support that—why does this clause refer just to a registered health practitioner and not any person?

Hon STEPHEN DAWSON: It is in here because a statute overrides common law and contract law.

Hon NICK GOIRAN: Yes, that is right. That is why I think it should be “any person in Western Australia”. I will give the minister a practical example. I think the minister will agree with me that in this bill, “registered health practitioner” does not include students. I will give the minister a practical example of a medical student. Medical students will not be protected by this statutory right, but I think that they should be. Why should a medical student, who would be in a lesser position in the power and influence relationship between a student and a supervisor, have to feel any pressure whatsoever to be present at the time of administration of a voluntary assisted dying substance? I think we can imagine a scenario in which a VAD practitioner, if I can call them that, is going to administer the substance and needs a witness, and some form of coercion, undue influence or even subtle pressure is put on a medical student to participate in the process by being present. It strikes me that a statutory right at clause 9(1) for any person would be superior to saying a “registered health practitioner”. This is piggybacking off the line of inquiry raised by Hon Aaron Stonehouse, who was talking about receptionists and others who might be involved with forms. I guess I am taking it to the next level and asking about medical students. Should they not have the same right to refuse to participate in all this?

The other example I want to give the minister is pharmacists. Perhaps the minister can indicate whether pharmacists would be captured by clause 9. I note that section 7 of the Victorian legislation provides that practitioners who have a conscientious objection to voluntary assisted dying have the right to refuse to provide information about voluntary assisted dying. Of course, our bill will not give them that right. I am a bit concerned about various categories of individuals: first of all, medical students; workers in medical practices, whom Hon Aaron Stonehouse referred to; and pharmacists, pharmacy assistants and other persons involved in pharmacy work. Perhaps the minister can clarify whether those people will be covered by this provision. It is clear to me that medical students will not be covered, but I am not as clear about pharmacists or pharmacy assistants.

The DEPUTY CHAIR: Before I give the call to the minister, I again remind members that we need a relatively high degree of silence in the chamber for the minister to be able to communicate with his advisers.

Hon STEPHEN DAWSON: Medical students will not have a role under this bill, so they have not been identified in this clause. A registered pharmacist could object or refuse to participate.

Hon NICK GOIRAN: I take it that a registered pharmacist is a registered health practitioner. What about a pharmacy assistant or another person employed in pharmacy work? Should they also have the right to refuse to participate in any of this, particularly the supply of a voluntary assisted dying substance? I note that this appears at section 7(f) of the Victorian legislation. Our legislation does not include that provision. Section 7(f) of the Victorian Voluntary Assisted Dying Act provides health practitioners who have a conscientious objection to voluntary assisted dying with the right to refuse to dispense a prescription for a voluntary assisted dying substance. The minister has indicated that pharmacists are covered because of the registered health practitioner definition, and I accept that, but we do not have the same provision as that at section 7(f) of the Victorian legislation. Is the minister indicating that the dispensing is covered by clause 9(1)(b)?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: I think that will give comfort to pharmacists, but it will not give comfort to pharmacy assistants and other persons working in pharmacies. Firstly, should they have the same right to not participate in the supply of the substance? I go back to my earlier point: I still think that every Western Australian should have a statutory right to not be present at the time of the administration of the voluntary assisted dying substance.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: I do not think that this is the honourable member’s point, but a pharmacy assistant cannot supply. The pharmacist has to supply or dispense the voluntary assisted dying substance. That could then be handed to a pharmacy assistant or someone on the register, and they would have to participate. The member’s question is about that, not necessarily the supply or dispensing of it.

Hon Nick Goiran: I suppose it is how we define or interpret “supply”, isn’t it?

Hon STEPHEN DAWSON: Yes, but my advisers tell me that the “supplying” or the “dispensing” is done by the pharmacist. I clarify that the member’s issue is about anybody in the chain, if I can use that terminology, and their ability to conscientiously object or opt out. They have a common law right to refuse to participate or object. If a student, pharmacy assistant or register worker is pressured in the way suggested, this could constitute misconduct by the practitioner pressuring them. Further to our supply issue, I am told that supply is defined as per the Medicines and Poisons Act 2014. That is a peripheral issue. At the moment, they have a common law right, and then, if they were being pressured, this could constitute misconduct by the practitioner pressuring them.

Hon NICK GOIRAN: In light of that, I move —

Page 10, line 4 — To delete “registered health practitioner” and substitute —

person

By way of explanation, this amendment simply gives effect to the dialogue we just had. Hon Aaron Stonehouse raised an important issue about conscientious objection. I am grateful to the minister for confirming that every Western Australian has a right to refuse to participate in the three things that are set out in clause 9 and that Western Australians have that as a common law right. This will simply put it into legislation to make it clear that every Western Australian, not just registered health practitioners, has that right.

Hon STEPHEN DAWSON: I appreciate the debate that we have just had. We are not supportive of that change. The reason “registered health practitioner” is in clause 9 is that they have particular roles set out under this bill. That is why it is limited to registered health practitioners, so we do not support the member’s proposed deletion and insertion.

Hon RICK MAZZA: I rise to say that I will be supporting the amendment. I genuinely believe that any person involved in the process, health practitioner or not, has a right to refuse to participate if it is something that they do not want to do. I am most supportive of this amendment.

Division

Amendment put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the noes, with the following result —

Ayes (10)

Hon Martin Aldridge  Hon Simon O’Brien  Hon Aaron Stonehouse  Hon Ken Baston (Teller)
Hon Nick Goiran  Hon Martin Pritchard  Hon Colin Tincknell  Hon Rick Mazza  Hon Charles Smith  Hon Alison Xamon

Noes (23)

Hon Jacqui Boydell  Hon Colin de Grussa  Hon Colin Holt  Hon Matthew Swinbourn
Hon Robin Chapple  Hon Sue Ellery  Hon Alannah MacTiernan  Hon Dr Sally Talbot
Hon Tim Clifford  Hon Diane Evers  Hon Kyle McGinn  Hon Dr Steve Thomas
Hon Alanna Clohesy  Hon Donna Faragher  Hon Michael Mischin  Hon Darren West
Hon Peter Collier  Hon Adele Farina  Hon Samantha Rowe  Hon Pierre Yang (Teller)
Hon Stephen Dawson  Hon Laurie Graham  Hon Tjorn Sibma

Amendment thus negatived.

Hon AARON STONEHOUSE: Minister, I am concerned about the right of not only registered medical practitioners but also, for want of a better word, institutions or organisations to be conscientious objectors. I am thinking particularly about a hospital where the practitioners and employees may be conscientious objectors for religious reasons or otherwise. Will that organisation have a right to be a conscientious objector and not involve itself in the VAD process, or will that right extend only to individual employees, board members or the CEO?

The DEPUTY CHAIR: Again, members, there is a degree of chatter around the room. I ask you to keep that quiet. The minister has the call.

Hon STEPHEN DAWSON: 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 that do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility. Clause 113 protects doctors from being found to have breached principles of conduct applicable to the person’s employment. The government would be deeply disappointed if health organisations discriminated against employees or contractors for undertaking what would be a lawful end-of-life treatment.

Extracted from finalised Hansard
Hon AARON STONEHOUSE: Thank you for that, minister. There is protection under clause 113 for a medical practitioner who is a conscientious objector and breaching their obligations under their employment contract with a hospital. It may not be a hospital; I suppose it could be an aged-care facility or even a palliative care facility or something like that. That is good to know.

I would like to turn now to clause 9 and look at the protections provided there and how they work with later obligations under clauses 19, 20 and 21, which are most of the provisions within division 2 of part 3. I would like to highlight what I see as a contradiction. I am sure the Minister for Health would disagree, but I really do see this as a contradiction. Clause 9 creates a sort of absolute right, which builds upon what is already understood in common law to be a right to be a conscientious objector. It puts it in statute—in the written law—to protect it. Clause 9(1) states—

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;

However, clause 19(5) states—

If the medical practitioner refuses the first request because the practitioner has a conscientious objection to voluntary assisted dying, the practitioner must, immediately after the first request is made—

(a) inform the patient that the practitioner refuses the request;

I have no complaint there; that makes sense. It continues—

(b) give the patient the information referred to in subsection (4)(b).

That refers to the information approved by the CEO about voluntary assisted dying. Although an absolute right is created in clause 9, it is contradicted by clause 19(5)(b) by putting an obligation on registered medical practitioners to provide information. Therefore, they do not in fact have a right to refuse to participate in a request and assessment process; they are obliged to participate in that process. We might say that that is a rather minor obligation and all they have to do is provide information, but it is still an obligation to be involved in that process. It is completely contradictory to that absolute right created in clause 9. I am sure the minister will say that he has read the Hansard of the lower house debate and that it is a general principle that gives way to a specific obligation. It is all good and well to say that, but it makes me really wonder what is the point of even having clause 9(1)(a). Why even have that in there? Why even say that someone has a right to not do something but then put a specific obligation on them to do that? It completely contradicts itself.

Clause 20 states that a medical practitioner has to record the first request and their acceptance or refusal. Again, these are further obligations on a registered medical practitioner to be intimately involved in this process. Medical practitioners have an obligation to notify the Voluntary Assisted Dying Board of the first request. Some of these obligations may have more merit than others. We certainly want some oversight of this if patients are doctor shopping, so to speak. We would probably want the board to know about that. I know that there are is no prohibition on that and that it is absolutely the right of a patient to do that if they would like to seek a second or third opinion. As far as I am concerned, there should not be a prohibition on that. But it seems to me that clause 9 and the obligations created in division 2 of part 3 are contradictory. Whatever rights are created in clause 9 are completely blown away by the obligations in clauses 19, 20 and 21. It makes me really wonder what is the point of having such a right written in statute in the first place. What does it mean to have a right to do something if it is written away in a later clause? I will have a bit to say about the rights of conscientious objectors when we get to division 2, of course, as those clauses are completely contradictory.

That leads me to a question, minister. What is the penalty for a real conscientious objection of a medical practitioner who genuinely refuses to take part in voluntary assisted dying? We have the sort of pretend rights of conscientious objectors in clause 9, but they do not really count for anything. We could probably do away with clause 9 entirely and I do not think it would make any difference to the bill at all. We already have a common law right to be a conscientious objector. What are the penalties for someone who is a real conscientious objector—not a pretend one who still has obligations under later clauses—who refuses to provide information prescribed by the CEO? What would happen to a doctor who has for religious or other reasons a conscientious objection to VAD, who when a patient requests voluntary assisted dying says, “I’m sorry that is against my personal beliefs and I’m not going to help you do that”, and does not provide the information that the CEO wants them to? What would happen to that medical practitioner?

Hon STEPHEN DAWSON: First, giving information is not participating in the process; it is a very different thing. It is a statutory right but not to the exclusion of statutory obligations in the bill. In any case, acceptance or refusal, the medical practitioner is required to provide the patient with information approved by the CEO for the purposes of clause 19. Objectors must still provide general information about voluntary assisted dying. Failure to notify the patient within the specified time frame would be a contravention relevant for consideration under clause 10, “Contravention of Act by registered health practitioner”. That the patient’s decision is well informed is fundamental to the proposed model for voluntary assisted dying in Western Australia.
Hon NICK GOIRAN: Part 3 of the bill is titled “Requesting access to voluntary assisted dying and assessment of eligibility”. Is the first request, which is set out at division 2 of part 3, part of the request and assessment process?

Hon STEPHEN DAWSON: Yes, it is.

Hon NICK GOIRAN: The minister just told Hon Aaron Stonehouse that providing information is not part of the process. I think the honourable member is raising a very legitimate concern. Clause 19(5)(b) says that we are creating an obligation on a medical practitioner, who incidentally is a registered health practitioner, to “give the patient information referred to in subsection 4(b).” The honourable member is absolutely correct. On the one hand, this bill says at clause 19(5)(b) that we will force, we will oblige, medical practitioners in Western Australia to provide information—the minister just indicated to me that that is part of the first request and part of that process—but on the other hand, it says that they have a right to refuse to do any of these things. I draw the minister’s attention to clause 9(2), which specifically says—

Subsection (1) is not intended to limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in that subsection.

That is about as inconsistent as we are ever going to get in a piece of legislation. My question to the minister is which clause prevails? Does clause 9(2) or the clause that concerns Hon Aaron Stonehouse, clause 19(5)(b), prevail? Which one prevails?

Hon STEPHEN DAWSON: If I can just clarify. Standardised information regarding the voluntary assisted dying process, for example eligibility criteria, access points, supports and that a patient’s consent to assisted dying may be withdrawn at any time, will be developed during the implementation stage and be made available to all health practitioners for provision to persons who make a request or require information regarding voluntary assisted dying. This information will help the person access the relevant resources and supports they need to participate in the process. The provisions of clauses 9 and 19 are consistent with the Australian Medical Association’s position statement on conscientious objection, specifically in relation to the provision of information as per part 2.3 of the AMA position statement, which states, in part—

A doctor with a conscientious objection, should:

• inform the patient of their objection, preferably in advance or as soon as practicable;
• inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
• take whatever steps are necessary to ensure the patient’s access to care is not impeded;

I would further say that, as with all legislation, the general must give way to the specific.

Hon NICK GOIRAN: Which clause prevails?

Hon STEPHEN DAWSON: I am told they are not inconsistent, so neither prevails.

Hon AARON STONEHOUSE: The minister pointed me towards clause 10 for penalties that might apply to a medical practitioner who is a conscientious objector. I am looking at clause 10, but there is no mention of penalties; instead, it points me to the Health Practitioner Regulation National Law (WA) Act. Can the minister tell me what the penalty is under that legislation for the contravention of a provision of this legislation by a health practitioner who is a conscientious objector and refuses to provide information under clause 19(5)(b)?

Hon STEPHEN DAWSON: I am told that the Australian Health Practitioner Regulation Agency could investigate the matter, and it could do a number of things. If it found a range of things, it could take action as a result. Examples could include a caution, a suspension, a reprimand, or, indeed, cancellation of registration.

Hon AARON STONEHOUSE: Are there other penalties, such as fines or imprisonment?

Hon STEPHEN DAWSON: Can the member just clarify the question? Is he asking about penalties under the Australian Health Practitioner Regulation Agency process?
Hon AARON STONEHOUSE: If someone contravenes a provision of this bill, what penalties will they be liable for? Obviously, I am specifically interested in clause 19(5)(b). The minister mentioned that there might be a reprimand, or loss of licence. Are fines or imprisonment available as penalties for medical practitioners who contravene this legislation? If it helps to narrow down what I am looking at, it was mentioned in the debate on this clause in the Legislative Assembly that there is a $10 000 fine for medical practitioners who do not carry out their obligations under clause 19(5)(b).

Hon STEPHEN DAWSON: I thank the member for clarifying that. We were looking at documents in relation to AHPRA, and other things as well, so I appreciate the member bringing that to our attention. As the bill currently stands, failure to give a form to the board following a first request may result in a fine of $10 000. That is under clause 107 of the bill.

Hon AARON STONEHOUSE: That is the penalty for failing to notify the board. Would the same penalty apply for failing to provide information to a patient under clause 19(5)(b)?

Hon STEPHEN DAWSON: I am told that failure to provide information is captured in clause 10. The person would not get that $10 000 fine.

Hon AARON STONEHOUSE: I thank the minister for that clarification. The $10 000 fine is for failure to notify the board. However, it still gets to what I see as a failure to protect conscientious objectors. A conscientious objector who refuses to take part in this process is still obliged to provide information to the board, for an application they have not even processed. They have refused flatly from the outset. A person may walk into someone’s general practice and say, “Doc, I want to access VAD”, and the doctor says, “Sorry, I’m a religious person; I’m not your doctor; go elsewhere”, they have to notify the board. They do not even know who the person is. They have just walked in off the street, and all of a sudden they are a patient, as defined in the terms of this bill, and there are obligations on that medical practitioner to notify the board—of what?—“Some guy walked in and asked for VAD, and I said no.” They are obliged to provide information as well. In that case, there is a $10 000 penalty for failure to notify the board. When we get to division 2, I will have a lot to say about how a medical practitioner is meant to even record that on someone’s medical record when they do not know who the person is. In order to be a patient, all a person has to do is make a request. A person does not need to have any kind of therapeutic relationship with a medical practitioner in order to be a patient under this bill. However, I will leave that for when we discuss division 2 of part 3.

For now, I would like to highlight what I think is a great imbalance; we are creating two types of obligations for different health practitioners. A registered health practitioner will, apparently, have the right to be a conscientious objector—although we know that that is not true; they will have extra obligations that come with that—and then all other health practitioners will have no such obligation. The right to conscientious objection will be protected under common law and they will not be obliged to notify the board or provide information. Someone will be able to ask a social worker at a palliative care hospice about VAD, but they will be under no obligation to provide information or notify the board, as I understand it. I am happy to be corrected, if I am wrong. However, if a person asks a Chinese herbal therapist about VAD, all of a sudden that person who sells someone ginseng will have to provide information about voluntary assisted dying and notify the board. It is an absurdity that that absolutely insane obligation will be put on registered health practitioners. For a start, I think it is ridiculous that people such as Chinese herbal medicine practitioners and dispensers, chiropractors or acupuncturists are registered medical practitioners; as far as I am concerned, they are probably all quacks. But they are registered health practitioners and they will have an obligation under this legislation. Someone could get a rubdown and ask their occupational therapist about VAD.

Hon Nick Goiran: Can I make the observation that those obligations, if you look at clause 19, talk about medical practitioners, and they use different language there. It talks about “medical practitioner” compared with “health practitioner”.

Hon AARON STONEHOUSE: I know an amendment on the supplementary notice paper will tidy up things, but we have not got to that yet.

Hon Stephen Dawson: It would be good if you contained your comments to clause 9, because there are other things for discussion later on.

Hon AARON STONEHOUSE: I understand that and I look forward to the opportunity to tidy that up a little bit when we discuss proposed new clause 9A. However, we are still creating a two-tiered system. Some people in the health profession will have no obligation at all, but registered health practitioners will. In this case, a person at a lower level will have more of a right to be a conscientious objector than will a registered medical practitioner. I think that is a little disgusting, to be honest. Some people will have more rights than others under this regime.

I understand, obviously, that we want to ensure the rights of patients are protected and that patients will not be coerced, but who has given consideration to the coercion of medical practitioners? Everybody is very concerned about limiting coercion. No-one should be forced into voluntary assisted dying if they do not want to. We are being
very careful to stress that this is a voluntary regime, but it is voluntary for all but one class of people—that is, registered medical practitioners. There is nothing voluntary involved for them. They can either continue to be doctors or hang up their hat. Unless they want to face a $10,000 fine or lose their licence, they have no other choice, I suppose. If they are genuine conscientious objectors, they will have to hang up their stethoscope, close down their practice and leave the medical profession. I really hope that does not happen; it would be a tragedy. But that is what we are looking at here: a lack of adequate protection for real conscientious objectors and very much a two-tiered system in which some people will have more rights than others.

Hon NICK GOIRAN: Minister, given the dialogue that has taken place on clause 9, it is not clear to me what we are doing for the benefit of registered health practitioners by virtue of this clause. If, as we agreed earlier, every Western Australian will have the capacity to refuse in respect of those three limbs, what is being done by clause 9 that will help registered health practitioners other than, if you like, stating the bleeding obvious?

Hon STEPHEN DAWSON: This clause of the bill will enshrine the rights of registered health practitioners to conscientiously object or otherwise refuse to participate in the steps reasonably related to voluntary assisted dying. We have had a debate on this now. The member might have a different view from me, but that is what it will do and that is why we are saying that this clause is needed in the bill.

Hon NICK GOIRAN: I have compared and contrasted clause 9 of this bill with the similar provision in the Victorian legislation, which is section 7. The Victorian provision has six limbs on conscientious objection whereas we have only three. The minister has confirmed that the sixth of those limbs is covered by the second one in this bill. Under section 7(1) of the Victorian legislation, a practitioner is not obliged to dispense a prescription for a voluntary assisted dying substance. The minister’s advice to the house is that that is already covered by clause 9(1)(b) because it refers to “supply”. I am happy to accept that advice, notwithstanding the fact that the fourth limb of the Victorian provision uses the same words as those in clause 9(1)(b), where it states —

   to supply, prescribe or administer a voluntary assisted dying substance;

I guess what the minister is saying to us is that the sixth limb of the Victorian provision is unnecessary because it is already covered by the fourth limb. I just draw to the attention of members that the Victorian legislation states at section 7 —

   A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —

The very first of those limbs is —

   (a) to provide information about voluntary assisted dying;

Why was it decided not to include that limb in clause 9?

Hon STEPHEN DAWSON: Section 7(a) of the Victorian act states that a registered health practitioner who conscientiously objects does not need to provide information about voluntary assisted dying. This government made a conscious choice to exclude that. There was a discussion of this by the Ministerial Expert Panel on Voluntary Assisted Dying. On page 52 of the report, it states —

   In considering the feedback provided through consultation and in reaching its position on this topic the Panel was guided by the core principle that the person should be fully informed about voluntary assisted dying and all other options before formally requesting voluntary assisted dying.

   If legislation is passed to enable voluntary assisted dying in Western Australia the panel noted the relevance of the principle that a person should not be impeded in accessing what would be a legal option at end of life. In the Panel’s view however, it is not sufficient to simply not impede access. Given known issues with health literacy and challenges faced by some population groups, the Panel was clear that people should be provided with effective access to information. People from culturally and linguistically diverse backgrounds and others (for example those with low literacy levels or limited health literacy) may require additional help to access information in a manner they understand so that they can make informed choices.

Hon NICK GOIRAN: I will conclude on this point. I am troubled that the government made a deliberate decision to not include the provision that is in the Victorian legislation. I am disappointed that registered health practitioners in Western Australia are being treated differently from Victorian health practitioners. Registered health practitioners will be better off in Victoria than in Western Australia on the issue of conscientious objection. In that respect, I had the opportunity to read an explanation provided by a medical practitioner, for which I will give the source in a moment. He says —

   Health care professionals who conscientiously object to professionally contested interventions may avoid participating in them directly, but, as with military conscientious objectors, who are required to perform alternative service, they cannot completely absolve themselves from providing these services. Conscientious objection still requires conveying accurate information and providing timely referrals to ensure patients receive care.

Extracted from finalised Hansard
This individual goes on to say —

Health care professionals who are unwilling to accept these limits have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession.

I think that is what Hon Aaron Stonehouse has indicated is one of his concerns. As a result of this, we do not want to see health practitioners in Western Australia saying, “You have now radically changed medicine in Western Australia by virtue of what you are doing here. When I studied medicine for seven years at university and did all my internships and all the rest of it, I did not sign up for this. You have now radically changed this and now you are even making me have to provide information that goes against the grain of my ethics.” Notwithstanding that, in clause 4(1)(j) we have almost jokingly as a chamber passed a provision in the principles that says —

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

I do not know why we bothered to pass that provision. I remain concerned. I said that I would indicate where the quote came from. It came from an article entitled “Physicians, Not Conscripts — Conscientious Objection in Health Care”, written by Dr Ezekiel Emanuel and Ronit Stahl in April 2017 and published in The New England Journal of Medicine. Although I do not propose to oppose the clause before us, I think it is a meaningless clause.

I have a lot of sympathy for what Hon Aaron Stonehouse has just highlighted. I am concerned that we are forcing registered health practitioners in Western Australia to provide information on this subject. I hope they understand that that is exactly what we are doing.

Hon AARON STONEHOUSE: I thank Hon Nick Goiran for pointing out the fact that the principles of this bill are not worth much. We could essentially rip them out. The idea that all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics is not worth the paper it is written on. Neither is clause 9, really. It is all made irrelevant by the obligations in division 2. It is a tragedy. It is indicative of a type of advocacy, a sort of progressive mindset—apologies to some folks who identify as progressive; I do not mean to tar them all with this brush. There is a certain kind of mindset in progressive politics that mere tolerance is not sufficient. My view that I disagree with voluntary assisted dying, but I do not want to prohibit anybody else from accessing it, is not enough. No, people need to be enthusiastic about it. They need to be advocates too, and if they are not, what is the government going to do? It will give them a $10 000 fine and strip them of their medical practice licence, or whatever other penalties the government can think up. It is not enough to merely be tolerant; it is not enough to live and let live. They have to be involved in this process intimately, with a gun to their head, essentially. What is the government going to do to people who cannot afford the $10 000 fine—put them in a debtors’ prison? Ultimately, that is what we are talking about. We are talking about leveraging the coercive power of the state to force people into a position in which they are involved in a regime that they have a fundamental conscientious objection to and which goes against their moral fibre, and the government wants to force them into being part of this process. I think that is disgusting; I really do. Regarding doctors who do not want to take part in this process, there is not going to be any shortage of doctors who will provide VAD out there. I mean, honestly—as if everybody does not already know about VAD, with the largely publicised debate going on in this place about it. It is not enough for people to live and let live; mere tolerance is not enough. They have to be forced to do it. I am reminded of what has occurred in the United States, where people have been taken to the equivalent of the Australian Human Rights Commission for refusing to bake a cake. If they are Christian bakers and they refuse to bake a cake for a same-sex couple, they are hauled before these human rights commissions as a result. Mere tolerance is not enough.

Hon Alannah MacTiernan: Seriously, bakers in Australia have not had this problem.

Hon AARON STONEHOUSE: No, they have not, and I think that is good, although there was an instance of a photographer being subjected to the same treatment. Luckily, his case was resolved outside of the tribunal. The mere fact that he was hauled before a tribunal because he held certain views is ridiculous. I will be very concise with the rest of it. Ultimately, that is what we are talking about. We are talking about leveraging the coercive power of the state to force people into a position in which they are involved in a regime that they have a fundamental conscientious objection to and which goes against their moral fibre, and the government wants to force them into being part of this process. I think that is disgusting; I really do. Regarding doctors who do not want to take part in this process, there is not going to be any shortage of doctors who will provide VAD out there. I mean, honestly—as if everybody does not already know about VAD, with the largely publicised debate going on in this place about it. It is not enough for people to live and let live; mere tolerance is not enough. They have to be forced to do it. I am reminded of what has occurred in the United States, where people have been taken to the equivalent of the Australian Human Rights Commission for refusing to bake a cake. If they are Christian bakers and they refuse to bake a cake for a same-sex couple, they are hauled before these human rights commissions as a result. Mere tolerance is not enough.

Hon Alannah MacTiernan: Seriously, bakers in Australia have not had this problem.

Hon AARON STONEHOUSE: No, they have not, and I think that is good, although there was an instance of a photographer being subjected to the same treatment. Luckily, his case was resolved outside of the tribunal. The mere fact that he was hauled before a tribunal because he held certain views is ridiculous. I will be very concise because I know that I am getting a little off-track.

Surely, tolerance in this instance and a respect for each other’s rights and autonomy is the kind of debate that we should be having, rather than mandate an obligation to force people to take part in a regime of which they do not approve. I am a supporter of voluntary assisted dying in the sense that I want this bill to pass. Trying to protect the rights of one group of people, patients, to exercise bodily autonomy at the expense of another group of people, doctors, who have just as much right to exercise their autonomy to associate or disassociate with a regime of voluntary assisted dying is disgusting. We cannot correct injustice by punishing another group of people. It does not work that way.

I do not oppose clause 9; I think it needs to be stronger. I also see the futility of the words in clause 9. I do not think they do anything. I will have more to say on this when we reach part 2.

Hon STEPHEN DAWSON: First of all, it is ludicrous to suggest that the bill is not worth the paper it is written on. I find that offensive.

Hon Nick Goiran: He didn’t say that.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: That is what the member said.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Order!

Hon STEPHEN DAWSON: Whether it is the bill or the principle, I find that offensive. This is a very important bill for many Western Australians, and I am disappointed that the member does not agree with that.

We do not want to leave a patient who is dying and seeking medical information floundering in the community. Respecting someone’s culture and religion does not mean that a person does not have to do their job. Approved information is about helping the patient. I am happy to bring to members’ attention, as I did earlier today, the AMA’s position statement on conscientious objection, specifically in relation to the provision of information. Part 2.3 of that statement states, in part —

A doctor with a conscientious objection, should:

• inform the patient of their objection, preferably in advance or as soon as practicable;
• inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
• take whatever steps are necessary to ensure the patient’s access to care is not impeded;

As I have said, this is different from Victoria. We believe it is needed and necessary. I certainly support clause 9.

Hon ADELE FARINA: I want to put on the record that I agree with the views that have been expressed by Hon Nick Goiran and Hon Aaron Stonehouse. In my second reading contribution, I think I mentioned that I met with a doctor in Bunbury who is very disturbed about the fact that, despite very strongly held religious beliefs, he will be put in a position in which he needs to provide information on voluntary assisted dying to patients, even though he conscientiously objects. He told me that he would seriously have to consider closing his practice. That is how strongly he felt about it. I do not think we should undervalue the position in which we are placing a lot of doctors. A lot of doctors will struggle very much with this position. I agree with the views expressed by Hon Aaron Stonehouse that it is just not right. We cannot say that we have to respect one group of people’s rights while we walk all over another group of people’s rights. I agree that that is not an acceptable way to legislate, particularly when no harm is caused.

The other thing that I find particularly insulting is that we do not even know, as we are passing this bill, what information the doctors will be required to pass on to their patients. If it is simply the phone number of the navigator, that might be enough. Will they be required to refer them to another doctor who supports voluntary assisted dying? As legislators, we are supposed to be making informed decisions about exactly what this legislation will mean for the people it impacts. We stand here today about to pass this clause, which I agree has very little value, without even knowing what we are asking doctors to provide to their patients. I think that is pretty poor legislation.

Clause put and passed.

New clause 9A —

Hon MARTIN PRITCHARD: 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.

This new clause is about empowering the patient to raise voluntary assisted dying if they choose and to then have a discussion with their doctor; it is not about getting involved in the relationship or discussions that they may have with their doctor. My belief is that voluntary assisted dying is not a treatment option—something that doctors have always discussed with their patients. It is an alternative choice that should be left up to the patient to raise. If there is a concern that the patient may not be aware of voluntary assisted dying, I say that there is broad support for the discussions that we are having. Many say that this bill has as much as 88 per cent support in the community. Even if some challenge that, few could say that this bill is sliding through this Parliament unnoticed. It is all over the newspapers every day that we have a discussion.

It would also be very unwise to rely on doctors raising this option, as many will choose not to—some because they have contracts or arrangements, some because of their personal beliefs, still more because they just do not want to get involved in the process and some because of where they work.

Extracted from finalised Hansard
The department will have to develop many different strategies during the implementation stage to make sure that every person who is likely to face the challenges envisaged under this bill have the information to initiate the discussion with their doctor.

I support and have moved this new clause because of a lifetime of observing the outcome of discussions between two people trying to make a way forward for one of those participants. Granted, my personal experience has mainly been observing this between a manager and their employee, but I can see enough similarities to make me cautious. I have seen one dealing with this situation, confident in their knowledge and expertise, and the other feeling vulnerable and looking to the manager for guidance. I have seen the most empathetic manager be amazed that their employee came to me, as a union official, with concerns about the outcome of the discussions, and the manager often saying, “Why didn’t the employee raise it with me?” In reference to this bill, I am not saying that that will be the case all the time, but we are talking about a person who has just become aware that they may have as little as six months to live.

I note that the minister also has a new clause in his name and I appreciate the fact that he also has some concerns in this area, but I want members to understand that his new clause does not deal with the fundamental issue that I have, it does not deal with the fundamental issue that the honourable member for Armadale, Tony Buti, has and it does not deal with the fundamental issue that many people have who have raised it with me during the process of bringing this bill to Parliament. My new clause will empower the patient to raise the issue. It will be up to those who endeavour to implement this bill to deliver strategies that will make sure that people have the information so that they can raise this issue. That should be as far as it goes. It should empower the patient.

Hon MARTIN PRITCHARD: I had almost finished when we broke, but I will take this opportunity to re-emphasise a couple of points. The amendment I have put forward has been aired quite a lot. I have had many discussions with the member who moved the amendment originally in the other place. He is very supportive of me introducing it and trying to get it across the line here. The amendment is very specific; it is about empowering the patient to raise an alternative with their doctor and to have meaningful discussions with their doctor about treatment options and the alternative if the prognosis indicates that they are moving towards the end of their life. The amendment is about empowering the patient.

Considering the patient needs to have information, I raise this point again—that is, many doctors and medical practitioners in Western Australia will not raise this. I cannot guess how many, but there will be many. For instance, those who have a contractual arrangement with St John of God will be unlikely to raise this. Those who have a faith-based objection will not raise it. I include in that many doctors who —

The DEPUTY CHAIR: Order, members! It is not parliamentary to cross between the member on his feet and the Chair.

Hon MARTIN PRITCHARD: Many doctors will not do the training so they will not be in a position to have to take up this obligation. Other doctors will avail themselves of the training and, usually because of a specific patient, will get involved in the process. In my view, many doctors will not raise it with their patients. The Department of Health will be obliged to make sure that information is out there that will get to those people who live in faith-based facilities so that they have enough information to inquire if they so choose. People cannot just rely on the doctor having to raise it. If that is the case and as part of the implementation strategy the department has to make sure that people who could avail themselves of voluntary assisted dying have to have the information, why not empower the patient to raise it first? Why should we leave it to a situation whereby a very confident doctor may speak to a person very confidently, and the person who is feeling vulnerable may very well take that as advice that they should accept? If the department does its job and makes sure that every Western Australian is aware of voluntary assisted dying, what is the harm in empowering the patient to be able to raise it first? Do we think that the patient, knowing that it is available, will have some objection to raising it first? If they do, we are only emphasising that that person is concerned with the fact of having that discussion in the first place, and is vulnerable.

Hon Alannah MacTiernan interjected.

Hon MARTIN PRITCHARD: I am not taking interjections, thank you. The minister’s bill deals with some of my concerns, but not my main concern—not the main aspect of my proposed new clause, which outlines who can initiate those discussions in the very private discussions between the doctor and the patient. If the patient is aware of what is available to them, why would they not raise it with their doctor in their very private discussions? The minister’s proposed new clause does not deal with that specific issue.

I ask members to support my proposed new clause. It does not in any way, shape or form invalidate the bill. Whether members support the bill or not, I ask them to support my proposed new clause.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: Can I indicate—no surprises to Hon Martin Pritchard or others, given that I have a proposed new clause 9A on the supplementary notice paper—that the government does not support the member’s proposed new clause, which would wholly prohibit a registered health practitioner from initiating a discussion about voluntary assisted dying with the patient. As we know and has been alluded to previously, Victoria has a prohibition, which was not supported by the Joint Select Committee on End of Life Choices or the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying. One reason for this is that there should not be an attempt to blanket censor the conversations that health practitioners have with patients. A medical or nurse practitioner should be able to raise and discuss voluntary assisted dying in the same way as other serious health or medical decisions and care options so that the patient is fully informed of decisions at the end of life.

Victoria is the only jurisdiction in the world that wholly prohibits health practitioners from starting a conversation about voluntary assisted dying. From the research of my advisers, we have found no other law that imposes a restriction on a doctor discussing with a patient a lawful treatment option that the doctor in his or her professional view believes is an option that the patient may wish to consider.

Preventing a medical practitioner from informing a patient about a legally valid option is an extraordinary measure that is fundamentally out of step with the basic principles of informed decision-making. It is fundamental to the proposed model for voluntary assisted dying in Western Australia that the patient’s decision will be well informed. As with all other elements of health care, medical practitioners will make a reasoned judgement about whether it is appropriate to inform this patient at this time about their choice to consider requesting voluntary assisted dying. This is not about a medical practitioner suggesting voluntary assisted dying to a patient—it is about appropriately informing patients about their choices in a manner consistent with professional standards and in alignment with existing informed consent responsibilities. The bill has been drafted to enable appropriate access and provide essential safeguards. 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 the consulting practitioners—must independently assess the patient. When an assessing medical practitioner is unable to determine whether the patient’s condition meets the eligibility criteria—if they have decision-making capacity, or if their decision is voluntary and without coercion—they must refer for further assessment. Those provisions are under clauses 25 and 36. Furthermore, if they wish to proceed, the patient will be required to make a written declaration of their request to access voluntary assisted dying. That is at clause 41. This must be witnessed by two adults. If the person has completed a written declaration and makes a further final request, the coordinating practitioner must undertake a final review. In the final review, the coordinating practitioner must confirm that the process has been undertaken in accordance with the requirements of the legislation and that the patient has decision-making capacity in relation to voluntary assisted dying, that they are acting voluntarily and without coercion, and that their request is enduring.

Hon RICK MAZZA: I also have concerns, as raised by Hon Martin Pritchard, on this issue. When someone is diagnosed with a terminal disease, they would be in a fairly emotional state at that point in time. The relationship between doctor and patient can be quite an intimate one. I would imagine that many patients would hang on to every word from a medical practitioner. I do not think that voluntary assisted dying will be a secret. I think a patient will find out, whether through general knowledge or family members or friends, and at some point, someone will point out to them that this is an option available to them. I do not think that the medical practitioner necessarily has to instigate that discussion, particularly during those vulnerable moments. I will support the amendment put forward by Hon Martin Pritchard.

Hon ALISON XAMON: I have given this matter quite a lot of thought because I have also been concerned about the power relationship, but from a different perspective. It occurs to me that much of the unwanted pressure on people to consider voluntary assisted dying, when they otherwise may not be inclined to do that, could come from the people immediately around them—family members, for example, and people who may mean well but should not be interfering. When we look at the concerns that have been raised by myself and others in this place around the possibility of elder abuse, with inheritance impatience, for example, we see concern about pressure coming to bear, particularly from people close to someone who may be living with a terminal illness. As such, I hope that it would be better that the information around voluntary assisted dying was first relayed to somebody through a medical practitioner who is bound by a code of ethics, and who is expected to conduct themselves in a particular way. Indeed, if that is then presented, somebody might be in a better position to get the full range of information that they require in a setting that will hopefully be more at arm’s length than with a family member who may have something to personally gain by their death. I have reached the decision that I will not support the amendment as proposed, although I respect that it has been put forward in good faith. It is important that we acknowledge the potential for a power dynamic that may not be positive. I suppose, on balance, I am more concerned about an adverse power dynamic that may come from family members, as opposed to somebody who is bound by professional ethics.

Hon ALANNAH MacTIERNAN: I support the comments of Hon Alison Xamon and I rise to speak on this because I feel very strongly about this provision. Like Hon Alison Xamon, I know that Hon Martin Pritchard has brought this amendment forward in good faith, but I feel very strongly that it is absolutely the wrong way to go. The idea that we might be saying to a medical practitioner that they cannot tell the patient the truth—they cannot
Hon STEPHEN DAWSON: I will not delay the chamber for too long, but I want to make the point that it is important to acknowledge that the amendment that stands in my name proposing new clause 9A has been included following consultation with the Australian Medical Association’s WA branch. I suggest that the amendment standing in my name reflects good clinical practice, and the current holistic context in which medical and nurse practitioners discuss medical options with a patient.

Hon TJORN SIBMA: I want to address the substance of the amendment moved by Hon Martin Pritchard, in a way that is sensitive to the integrity of that gentleman as a person of sound judgement in this chamber, because I absolutely understand the motivation behind the amendment. There is the matter of a power differential that is not insignificant. The context of the consultation is obviously one in which emotions are, significantly, almost immeasurable, coming immediately on the back of a diagnosis or prognosis. We cannot disregard that context. There are a few aspects to my challenge with supporting this amendment, even though I look favourably upon it. The first is the principle we establish by carving out an opportunity for state intervention into a consultation between a medical practitioner and the patient. I truly believe that the state does not belong there. It is problematic that it would be permissible to transmit some forms of information but not others, notwithstanding the precedent that this bill itself establishes. The second issue I have with the proposition is that I think it would be impossible to police. I attempt to adopt a pragmatic view of these issues. Frankly, there might not be a right or wrong moral answer, but the practicality of agreeing to this amendment causes innumerable problems. From that issue, a third problem emerges—that it would, in my view, create the opportunity for vexatious complaints to be levelled between practitioners, or between a family member and a practitioner, that could not be upheld or proven, but that would come at a detriment to the reputation of a general practitioner or any other medical profession engaged in this process. I want to underscore the fact that I think this amendment comes from a very sound moral place. I think Hon Martin Pritchard is a person of great integrity and would not flippantly move an amendment just for the sake of it. I encourage people to treat it with some seriousness; but they are my problems with supporting the amendment as the member has put it.

Hon JACQUI BOYDELL: I also agree that Hon Martin Pritchard has given a lot of consideration to this amendment. The fact that he moved the amendment has allowed the house to have this rather in-depth discussion. It has been a cause for concern of many members of the public, and people have raised this issue with me. They feel sensitive about it, and, rightly so, we should have the discussion.

I think the premise of the amendment comes from a place of wanting to protect the vulnerable, particularly people who may not have support mechanisms around them and who rely on the relationship with their medical practitioner more heavily than do some others and, therefore, comes that mismatch of power in the relationship between doctor and patient. However, I cannot support the motion, because of some of the other ideals put today, particularly by Hon Alison Xamon and Hon Alannah MacTiernan. As a patient, I want the right to have an honest discussion with my medical practitioner and allow them to give me the information and therefore the choice. That is probably my reasoning. The process after that still has to be followed. The coercion and power base is still tested because the process still has to be followed.

The other thing I think the member talked about when moving his amendment was that during this debate, voluntary assisted dying has been something the community knows about. That might be the case at the moment, but it might not be the case into the future. Although it has a lot of media attention and a lot of people are talking about it currently, that might not be the case in 20 years. There has to be a touch point at which people know that they can get some free, frank and honest advice and then have a process that will allow them to make the decision. That is why I cannot support the amendment put today, but I thank the member for bringing the amendment to the house.

Hon SIMON O’BRIEN: This is a very interesting point that we are discussing. I want to join other speakers in acknowledging what I am sure are the purest of motives all round. When it all boils down, one thing we have in common, I hope, is that, firstly, we are all in the people business. We are politicians; we are elected representatives.
Not only that, we are also sons and daughters and mums and dads. We are people ourselves and we are motivated in part to be here because we are concerned about the welfare, in every respect, of all our people and generations to come. That is one humanising aspect that is coming through as we contemplate the honourable member’s proposed amendment here and the motives that I am sure lie behind it. It is in those respectful terms that I want to offer the following comments. Firstly, some people might be thinking, given that I am strongly opposed to the principle behind this bill, that I would embrace the sentiments in this amendment—on the contrary, I do not. Again, I am in the business of being not only a person, but also a legislator, and I do not think that this will work. I think, like Hon Tjorn Sibma, that it creates problems rather than fixes them. I do not think it is necessary at all and, indeed, could well be counterproductive. I will briefly explain why. In the course of contemplating our approach to this bill, we have had the benefit of advice from a range of people. We all have our own life experience, and a number of us have shared little parts of that in ways that are relevant to the issues that we are talking about. We all have that essential human life experience, but we have been further reinforced in that by the advice of professionals in all these health fields. We have had palliative care experts available to us, people from Charlie’s, the Australian Medical Association, in all its various stripes, and a range of other affected, interested parties, not the least of which being a whole lot of well-motivated people in the public who were either strongly for or against the measures that are proposed in the bill, and all the rest of it.

We have learnt from all the professional, expert advice—the people who are dealing with patients and are in the extreme situation that is contemplated by this bill—and we have learnt from those who are near end of life and are suffering from severe pain and distress and are unable to find relief. Mercifully, that is a very small percentage of people. When we talk to professionals who are involved with those people, we hear about the sorts of things that are not remedied by this proposed amendment. I hope that the respectful tone of my remarks just now, when they are printed in black and white on the page, show everyone that what I am about to say is in no way intended to be flippant. I want to make things work for people. That has been my whole history in this place. I want to make things a bit easier for my community in going about their lives.

What happens, as has been discussed here, when someone receives a terminal diagnosis, which I think one member referred to as “bad news”? What is the reaction that we get? We have heard all about this. The immediate reactions are, perhaps, shock, disbelief, a sense of uncertainty and a search for further answers. In not one example have I heard advice that a typical reaction of a patient in that situation is, “Oh, heck! That sounds dreadful! I’d better speed up the process by accessing an early demise.” Again, I am not being flippant when I say this, but that is not what people say. Yes, people will be distressed, people will get a shock, people will perhaps panic and not know what to do, but I do not think that they will start reaching for the Voluntary Assisted Dying Act 2019 as their first avenue of recourse.

Similarly, I do not imagine for a minute—it has been suggested that this scenario might be real, but I ask members to just think about it—that a doctor providing a terminal diagnosis to their patient is in the next breath going to say, “I can see you’re shocked, but don’t worry. It’s all right because you’ve now got access to voluntary assisted dying.” That is not the sort of situation that any of us could seriously contemplate happening. It is not something that needs to be addressed. I also agree with Hon Tjorn Sibma when he strongly put the case of whether we, as legislators, should really be diving so deeply into what a patient and their health professional can talk about and how they are meant to talk about it. No, of course we should not. Perhaps we ought to back off from that for a minute and consider what is actually being proposed.

I am going to draw my remarks to a close very shortly, but the final aspect I ask members to contemplate is how it will work in practice. I have had a number of jobs prior to coming into this place in which I was involved in a practical way in compliance, law enforcement and so on. I have contemplated lots of sets of acts and regulations of all sorts, some with provisions that work and others that were written by people who perhaps did not quite understand what works in practice. We want to produce legislation here that exhibits the attributes of the former rather than the latter. This amendment would provide an extra section in the proposed act. I think that would impose an impediment. I cannot see how it would ever be applied in real life. We are not going to stop doctors and patients from having discussions and no practitioner is going to come forward and say, “Yes, the first thing I did was to initiate a discussion with my patient recommending voluntary assisted dying.” It is not going to happen. It is never going to happen. There will be disputes. Maybe other relatives will say, “I reckon that doctor raised this subject”, but where will that leave us? The doctor will say, “No, I didn’t. My patient was asking whether this was something they would have to do, so I was talking them through it.” That is the reality. Why do we need black-and-white law that will facilitate a problem?

With the greatest respect—the honourable member knows I respect him greatly—I do not wish to put this amendment aside unless I had those reservations I have expressed that are held very deeply but also very practically. I do not offer that in the sense that I think the honourable member’s idea is wrong; I praise the member for his motivation, but I suggest, with respect, that the proposed act would be better if it were silent on this matter.

Contemplating the last aspect is an amendment in the minister’s name on behalf of the government. I might ask members for a little a courtesy in a moment to conclude these remarks. Again, I say with respect that this is an endeavour by the government to address something that, as I have just discussed, is a misrepresented problem. The government’s new clause 9A on the supplementary notice paper does nothing more than to add a whole page of legislation that we really do not need.
Hon SIMON O’BRIEN: I thank members for their courtesy. In conclusion, not to finish on a negative note, I say that because—I think I am offering some support for the minister in doing this—the new clause that is contemplated goes well until the end of new subclause (2). However, new subclause (3) says that they can talk about it and they can raise the issue, but only so long as they do it in the context of a general discussion that raises a whole lot of things. I think it is better—again, I go back to my colleague Hon Tjorn Sibma’s remarks—not to intrude with this sort of specificity on what a doctor and a patient can and cannot talk about within their own private counsel. It might surprise members that I am not supporting this amendment, but it is for those reasons that I am not. Once we adopt the policy of what is contained in this bill, it is at that point that that particular genie is out of the bottle. I have indicated what I think about that, and there will be another vote in due course about that. The thing is, once we let the genie out of the bottle we then have to manage it, but if we start trying all these other extra methods to half-heartedly shove it back in the bottle while still letting it run around, it will only create more problems. My respectful advice to the chamber is: do not let the genie out of the bottle in the first place, but that is a debate for a later stage. I am sorry that I cannot support this amendment.

Hon AARON STONEHOUSE: It is interesting to hear members talk about their reluctance for the state to interfere with the discussions doctors have with their patients. I share that sentiment somewhat, and I look forward to receiving the support of members for my amendment, which seeks to remove the obligations on medical practitioners to provide information to patients who request it. I think that is precisely the same thing we are discussing here. I thank Hon Martin Pritchard for moving this amendment. It addresses a concern that I have raised outside this place and in my contribution to the second reading debate about a problem that I think exists and that I think most people would agree exists, and that is the power imbalance between a patient and a medical practitioner. The question is not whether that power imbalance exists; it is what to do about it. How do we address that power imbalance, and is this amendment the appropriate way to do so, or are there other mechanisms? I am not yet entirely sure. There are questions about how this might be implemented and how it might be enforced. There are also questions about whether it goes too far. I am keen to hear whether there are other ways of addressing the problem, how this amendment compares with the amendment that the minister has on the supplementary notice paper, and whether that amendment might go further in addressing this problem in, perhaps, a less onerous way. It might be in a more onerous way, as has been suggested; it might create its own problems.

To begin with, I would like to ask a couple of questions just for some clarification on an aspect of this amendment. This is a question that the mover of the amendment might be able to answer, or it might be answered by the minister, with the help of his advisers. If this amendment were to be agreed to, would it prohibit medical practitioners from having in their practices material—brochures, pamphlets, posters and what-have-you—that communicates voluntary assisted dying? This amendment takes its wording from the Victorian legislation, and during debate in the Victorian Parliament on its legislation, the responsible minister claimed that it would prohibit the display of material, including pamphlets, brochures and so on. Would the same thing happen here in Western Australia if this amendment were to be agreed to?

Hon MARTIN PRITCHARD: I would envisage not. That may not be a legal response, but I would envisage not.

Hon STEPHEN DAWSON: I think Hon Martin Pritchard has answered the member’s question—no. If the material were on a counter or on a wall somewhere, no; this amendment would not preclude that.

Hon AARON STONEHOUSE: That is interesting, because it was said in the Victorian debate that it would prohibit people carrying that material; at least that is what is in Hansard. I do not have an easily accessible copy of it to provide to the minister or to Hon Martin Pritchard, but I am a little confused as to whether that is the case. It was also asked whether a medical practitioner could advertise on their practice website that they provide voluntary assisted dying services. Forgetting for a moment how that would work with the commonwealth Criminal Code Act—we will put that aside for the time being—there is a question about whether that would be in contravention of the prohibition on medical practitioners initiating discussions about voluntary assisted dying. If a practitioner had on their practice website, “Stop in at Dr Smith’s practice for VAD”, would that be in contravention of this provision?

Hon MARTIN PRITCHARD: If you are asking me—again, this may be not the legal response to this—I would say it does, if it was on their website, but of course that would be in contravention of the federal legislation. That is because it is initiating a discussion. The crucial point in the amendment that I have moved is that a doctor is not to initiate the discussion. Initiating a discussion does not necessarily have to be verbal, in my view.

Hon NICK GOIRAN: If members take a moment to study the experience in the few jurisdictions around the world that have legalised a form of VAD, whether that be voluntary euthanasia or physician assisted suicide or however the regime is described in that jurisdiction, they will know one thing—steering is the elephant in the room. The originating author of the particular provision moved by Hon Martin Pritchard is, of course, as he has attested to, the member for Armadale. This amendment will prevent steering by doctors. As Hon Alison Xamon quite rightly identified earlier, it will not prevent steering by family members. I share her concern that once this regime comes into place, inevitably, and sadly, some family members are going to steer their family member down this particular path. I am saddened by that, but I cannot do anything about that, because, as Hon Simon O’Brien...
has said, if we do not want that to happen, do not allow the genie out of the bottle in the first place. But what I can do, members, is support Hon Martin Pritchard, who is at least trying to ensure that there is no steering by medical practitioners in Western Australia.

I want to correct the record for something that the Minister for Regional Development said. The minister suggested, in good faith, that somehow this amendment will not allow doctors to tell the truth to their patient. I draw to members’ attention proposed new clause 9A(2) moved by Hon Martin Pritchard. That specifically states —

Nothing in subsection (1) prevents a registered health practitioner from providing information about voluntary assisted dying to a person at the person’s request.

Nothing in this amendment will prevent a doctor from providing truthful information.

Hon Alannah MacTiernan: It does. The person is asking for the full range of options, and legally the doctor is prevented from raising one of those options. If the person says, “But what about this other option I’ve heard about?”, truly, you are right, but if the person does not ask that question, they will not know. My point is that when a doctor is purporting to set out the range of options and does not include that one, many people will think, “I must have this wrong. It must not be available to me.”

Hon NICK GOIRAN: What I was about to say —

Several members interjected.

The DEPUTY CHAIR: Order, members! Hon Nick Goiran has the call.

Hon NICK GOIRAN: Let me just indicate that, as always, I have absolutely no problem with any robust debate, and I welcome it. I reiterate that I take the remarks made by the Minister for Regional Development in good faith. I am just trying to explain why I do not agree with what has been said. I do not see that there is anything in new clause 9A proposed by Hon Martin Pritchard that would prohibit a doctor from telling the truth to their patient. That is not what new clause 9A will do. I note, whilst we are talking about the issue of truth and how important that is, that I look forward in due course to getting to clause 81(6), which states, as members might be aware —

The medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

It states that they “must not”. In other words, they must not tell the truth on the death certificate. But we will address that in due course. I emphasise to members that proposed new clause 9A(2), as moved by Hon Martin Pritchard, will allow and absolutely encourage truth-telling by practitioners to patients; the issue is who starts the conversation. Does the doctor steer the patient down this particular path or does the patient say to the doctor, “I would like to consider this as an option. Tell me what the situation is?” It is about who initiates the discussion; that is all. As soon as the patient initiates it, a practitioner, if they want to provide that information, will provide the information in accordance with the act.

I have to say that what persuaded me to support this amendment was clearly the rigorous work undertaken by the member for Armadale in the other place. I want to draw to the attention of members some of the things that the member for Armadale said in the other place. He quoted extensively from the Victorian “Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report”. He said this —

... 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.

He then said —

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.

The member for Armadale then went on to say —

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.

For the benefit of Hansard, that is found at page 6479 of the Legislative Assembly Hansard on 4 September 2019. All those remarks were made by the member for Armadale, who is the original author of the matter that is currently before us, which, thankfully, has been brought to our attention by Hon Martin Pritchard.

I note that recommendation 8 of the Victorian ministerial expert panel accords with the warnings issued by the late disability activist Stella Young, who made it very clear that social attitudes toward people with a disability come from a medical profession that takes a deficit view of disability. On 18 October 2013, in an article entitled “Disability—a fate worse than death”, she had this to say —

As a disabled person, I’m accustomed to conversations about quality of life and dignity. Specifically, I’m accustomed to assuring people that my life is worth living. I’m short statured, a wheelchair user, and I frequently have bone fractures. All the visual cues that make me ‘the other’ are front and centre. People make all sorts of assumptions about the quality of my life and my levels of independence. They’re almost always wrong.

I’ve lost count of the number of times I’ve been told, “I just don’t think I could live like you,” or “I wouldn’t have the courage in your situation,” or, my favourite one to overhear (and I’ve overheard it more than once), “You’d just bloody top yourself, wouldn’t you?”.

What we as a society think we know about what it means to live as a disabled person comes from cultural representations of disability seen through a non-disabled lens. And we, as people with disability, rarely get to tell our own stories.

Also, social attitudes towards disabled people come from a medical profession that takes a deficit view of disability.

The DEPUTY CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: The article continues —

This is my major concern with legalising assisted death; that it will give doctors more control over our lives. As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I’ve experienced some of the very worst disability prejudice and discrimination. Doctors might know about our biology, but it doesn’t mean they know about our lives.

That is a quote from Stella Young in an article under the heading “Disability—a fate worse than death?” on the ABC’s Ramp Up webpage on 18 October 2013. In my minority report from the 12-month inquiry, I referred to the legalisation of voluntary assisted dying, which is being pushed by the government at this time, as taking place —

… ‘within the context of a health care system and a society pervaded with prejudice and discrimination against people with disabilities.’ Already, this prejudice and discrimination play out in life-threatening ways, including pressure by hospital staff on people with disabilities who are nowhere near death to sign ‘Do Not Resuscitate’ orders and reject life-sustaining treatment.

The Joint Select Committee on End of Life Choices received evidence on the inequitable access to health care that people living with disabilities in Western Australia already face. In the absence of a prohibition against doctors raising voluntary assisted dying with a patient, the introduction of this voluntary assisted dying legislation is, in my view, a recipe for disability discrimination, and the outcomes will be fatal.

When the member for Armadale was prosecuting the case for this amendment, he referred to the presumption of undue influence. This is what he had to say on 4 September 2019 at page 6480 of Hansard —

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.

Extracted from finalised Hansard
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.

The Leader of the Liberal Party, Hon Liza Harvey, also raised concerns about the impact of practitioners being able to raise voluntary assisted dying with their elderly patients. This is what she had to say on that same day —

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.

She went on to say —

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.

I note that consideration of presumption of undue influence is not found anywhere in the final report of the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying.

Dr Buti, the member for Armadale, also made reference to concerns raised with the final report of the WA ministerial expert panel, having heard mixed views about doctors initiating the discussion. On page 30 of the WA ministerial expert panel report, this remark was made —

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 the Kimberley Palliative Care Service at a 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 Western Australian ministerial expert panel report continues by saying —

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).

To that I say that we are not leaving it to the implementation phase, we are dealing with it now, because this is what has been brought forward to us by Hon Martin Pritchard.

In the ministerial expert panel’s final report, there is also an excerpt from a submission by the Aboriginal Health Council of Western Australia, which states —

‘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.

I pause there to say that they are not my words; they are the words of the Aboriginal Health Council of Western Australia to the ministerial expert panel. I take the health council at its word when it goes on to say —

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’.

Despite those concerns, in its conclusion on page 31 of the report, the ministerial expert panel said on this issue —

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.

Extracted from finalised Hansard
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.

With all due respect to the ministerial expert panel, it reached this conclusion in its final report without any reference to the presumption of undue influence between doctors and their patients, as drawn to our attention by the member for Armadale. Perhaps he should have been a member of the ministerial expert panel. In contrast with the recommendation made by the Victorian ministerial expert panel, as quoted by the member for Armadale in the other place, the WA ministerial expert panel’s final report contains this recommendation. Recommendation 6 states —

Health practitioners are able to appropriately raise the topic of voluntary assisted dying with a patient.

**Policy intent:** To ensure that people are able to make fully informed decisions at end of life. To ensure that access to voluntary assisted dying is not impeded by a health practitioner not discussing what would be a legal option at end of life for some people.

I am about to conclude my remarks on this issue by referring to an article that appeared in The Australian of 10 October this year. It states —

Australia’s first indigenous surgeon, Kelvin Kong, says he is terrified by the McGowan government’s plan to let doctors suggest voluntary assisted dying, describing patients in remote areas as often so thankful to see a specialist that they are “very compliant”.

**The CHAIR:** Hon Nick Goiran.

**Hon NICK GOIRAN:** That surgeon goes on to say that article in The Australian —

Our medical training is really good at teaching us about disease, but it’s not really good at teaching us an understanding of cultural complexities, particularly with our most disenfranchised people.”

Professor Kong said his urban patients, including indigenous urban patients, were generally confident about their ability to make an informed decision but in rural and remote Australia he met patients who were just thankful to finally see a specialist.

Farmer and indigenous people were among regional patients who were vulnerable.

I fully support the amendment that has been moved by Hon Martin Pritchard. If nothing else, I acknowledge his courage in putting forward the amendment, which I believe will go some way, but cannot entirely, as Hon Alison Xamon quite rightly identified, towards protecting vulnerable members of our WA community, including people living in regional and remote areas, Aboriginal people, the elderly and people living with disabilities, from undue influence and reinforces the voluntary nature of an assisted dying request. For those reasons, I indicate my support for the motion moved by the honourable member.

**Hon STEPHEN DAWSON:** I return to the interchange between Hon Alannah MacTiernan and Hon Nick Goiran earlier about Hon Martin Pritchard’s proposed new clause 9A(2). That allows a medical practitioner to tell the truth but only if asked to do so and not otherwise. I wanted to make that point. That is how I read that new clause.

I wanted to raise a couple of other issues. The ministerial expert panel served to represent the views of the whole of the Western Australian community. This included people with disability, disability advocacy groups and individuals with disability. Views expressed on whether a medical practitioner could raise the subject of voluntary assisted dying were mixed. People with Disabilities (WA) and the Australian Federation of Disability Organisations stated when giving evidence to the joint select committee that there is no evidence to suggest from either the 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 socioeconomic circumstances, children and people with a psychiatric disability or dementia, were not found to be at any heightened risk of assisted dying. Evidence from both Oregon and the Netherlands demonstrates that members of vulnerable communities are no more likely to receive assistance in dying and that the demographic profile of a person accessing voluntary assisted dying was typically someone with comparative social, economic, educational and professional advantage.

There are obviously people with disability who do not support the legislation before us, as there are people with disability who are supportive of the legislation. Ms Samantha Jenkinson, the executive director of People with Disabilities (WA), was part of the ministerial panel, and she is supportive of the panel’s recommendations. We also heard from Hon Nick Goiran that an Aboriginal surgeon is not supportive of the legislation. Aboriginal people are also involved in the process and we had an Aboriginal person on the ministerial expert panel. The reality is that there are Aboriginal people who are for and against, there are people with disabilities who are for and against, there are members of Parliament in this place who are for and against and there are people in the general community who are for and against. Where the government has landed with the new clause that stands in my name has

*Extracted from finalised Hansard*
come after taking into consideration the views expressed by a number of people about, and the issue raised in, Hon Martin Pritchard’s new clause. As I said previously, the new clause standing in my name is there after consultation with the Western Australian branch of the Australian Medical Association. Again, I reiterate that we are not supportive of the new clause that stands in Hon Martin Pritchard’s name.

**Hon MARTIN PRITCHARD:** I would just like to thank everyone for their input on this. I will continue to support my new clause, but I understand that people are landing in a different spot after consideration. I fully respect the fact that they have considered the new clause.

**Hon AARON STONEHOUSE:** The minister has just mentioned his new clause on the supplementary notice paper. It seems to address some of the same concerns that members in the chamber are feeling about the risk of undue influence and the power imbalance between a patient and a medical practitioner, but it is hard to consider the question before us now without knowing how it compares somewhat with the new clause that the minister will put forward. It seems that the aim of the minister’s new clause is to ensure that if a medical practitioner raises the issue of voluntary assisted dying —

**Hon Stephen Dawson:** Honourable member, would you like me to —

**Hon AARON STONEHOUSE:** At a glance, it seems to be far more balanced, although I note that if a patient initiates the conversation, there is no obligation in this new clause for the medical practitioner to provide information when that view may be a mere suggestion rather than anything amounting to coercion. The new clause seeks to balance a person’s right to be informed of all medical options available with the protection of those who are more vulnerable. A breach of this provision would result in sanctions under the Health Practitioner Regulation National Law (WA) Act for registered health practitioners for unprofessional conduct. In the case of a healthcare worker who is not a registered health practitioner, they would fall under the definition of “provider” in the Health and Disability Services (Complaints) Act 1995 and thus be subject to the provisions on unreasonable conduct for the purposes of that act.

In short, the new clause in my name has come about as a result of listening to some of the concerns raised in the other place, talking to the WA branch of the AMA and balancing the issues. We think that where we have landed is the right balance.

**Hon AARON STONEHOUSE:** At a glance, it seems to be far more balanced, although I note that if a patient initiates the conversation, there is no obligation in this new clause for the medical practitioner to provide information about palliative care. That obligation exists only if the medical practitioner initiates the conversation about voluntary assisted dying. That is something that we can discuss in more detail when we get to consideration of the minister’s new clause, if we get there.

It is also worth noting that although it creates or at least confirms that it is a contravention of aspects of this act for a medical practitioner or a registered health practitioner—a health practitioner, in looser terms, such as used in the principles of the bill, and that could be someone such as a social worker—there is no prohibition on them discussing or raising voluntary assisted dying with a patient. That is not necessarily a bad thing. I think it would be impractical to say that nobody can initiate a conversation about voluntary assisted dying. That would be almost impossible to enforce and would be a bit ridiculous. It would prevent families from having frank and open discussions about voluntary assisted dying. They are a couple of observations about it.

During the debate in Victoria, a concern was raised by a palliative care physician about a similar clause. He or she raised the concern that being prohibited from raising voluntary assisted dying as an option with a patient might put them in breach of their obligation to provide care to a patient—it may be a breach of their duty of care to a patient to raise treatment or other options with their patient. At the time it was claimed by the responsible minister that having a prohibition on initiating such conversations would not put them in breach of their duty of care as nothing would

*Extracted from finalised Hansard*
prohibit them from discussing VAD if the patient raised it in the first instance. I wonder whether the minister or the mover of the motion has anything to add to that. If there is a prohibition on a medical practitioner raising voluntary assisted dying, could that be seen as in some way interfering with their ability to carry out their duty-of-care obligations to their patient? Let us say they are in a palliative care setting. They would be able to talk about different palliative care options, such as terminal sedation, but they would be prohibited from raising the option of VAD with a patient. Does the member see that as a violation of their obligation to provide a duty of care? Does it raise any ethical issues in the member’s mind, or does he think the risk is too great, so it is better to put the prohibition in place in the first instance? Does the member have anything to add on that? It is something that I noticed was raised as an issue in the debate in Victoria when they discussed a similar clause.

Hon STEPHEN DAWSON: Returning to my amendment for a second, I want to draw the member’s attention to something. In my amendment we use the words “health care worker”, which is broader than “registered health practitioner”. This widening is to address concerns that have been raised that those people who provide health services to a patient may influence a patient to act in a manner other than they ordinarily would. “Health care worker” does include social worker and Aboriginal health worker. I just wanted to make that point.

Hon AARON STONEHOUSE: Under the minister’s new clause 9A(1)(b), “any other person who provides health services or professional care services” could be interpreted pretty broadly, I suppose.

Hon Stephen Dawson: Absolutely.

Hon AARON STONEHOUSE: That would include perhaps a social worker or Aboriginal care worker or something along those lines; okay.

Hon MARTIN PRITCHARD: Just briefly, if I may: it does not raise any concerns in my mind, mainly because I do not believe that voluntary assisted dying is a treatment option; I think it is an alternative choice.

The CHAIR: Members, we are contemplating the proposed new clause moved by Hon Martin Pritchard. I am about to put the question, but we need to clarify that. I also clarify that I think it is quite proper that we have allowed the Committee of the Whole to contemplate an alternative amendment that deals with substantively the same issues. However, if and when we get to that in due course, I hope that members will concede that a large part of that debate has been had. I do not want it to get repetitive.

Division

New clause put and a division taken, the Chair casting his vote with the noes, with the following result —

Ayes (9)
Hon Donna Faragher
Hon Rick Mazza
Hon Aaron Stonehouse
Hon Adele Farina
Hon Martin Pritchard
Hon Colin Tincknell
Hon Nick Goiran
Hon Charles Smith
Hon Ken Baston (Teller)

Noes (23)
Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Tim Clifford
Hon Alanna Clohesy
Hon Peter Collier
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTiernan
Hon Kyle McGinn
Hon Michael Mischin
Hon Simon O'Brien
Hon Samantha Rowe
Hon Tjorn Sibma
Hon Matthew Swinbourn
Hon Dr Sally Talbot
Hon Darren West
Hon Alison Xamon
Hon Pierre Yang (Teller)

New clause thus negatived.

The CHAIR: We now move to contemplate new clause 9A, as shown on the supplementary notice paper at 458/NC9A. I have not forgotten the other one standing in Hon Charles Smith’s name, and we will come back to that, but, for now, because we have already canvassed this proposed new clause, unless there is violent objection, we will go directly to that one.

Hon NICK GOIRAN: I just want to confirm that this will not create any problem with moving 30/NC9A in the name of Hon Charles Smith. The context in which I ask that question is what I understand was a ruling, an expression or a direction earlier in our debate, that it would be necessary for us to continue on the supplementary notice paper in the order that is before us, and that, when we want to vary that, there would have to be some other mechanism to go back. I am, perhaps like you, Mr Chairman, very relaxed about this; I think that is the expression you used. I am relaxed as well. I just want to make sure that we are not creating any issue for Hon Charles Smith.

The CHAIR: Member, please be reassured that it is all under control. The point you make is valid to the extent that we do not go backwards on a supplementary notice paper, but we are at exactly the same point, which is a proposed new clause 9A, as it was just a moment ago. Indeed, once we have disposed of this matter, we might have a new clause 9A, in which case we will contemplate Hon Charles Smith’s proposed new clause 9B, I think, which is moving in the right direction. Hopefully, your Chairman has saved the day yet again, Hon Nick Goiran! You can relax.

Extracted from finalised Hansard
New clause 9A —

Hon STEPHEN DAWSON: I move —

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;
   (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.

Chair, I appreciate your guidance in enabling us to deal with the issue immediately after we dealt with the amendment in the name of Hon Martin Pritchard, MLC. I have already indicated during consideration of the previous amendment the reasons that the government is supportive of the amendment standing in my name. For those reasons, I will not go over them again. I hope to receive the support of the chamber.

Hon AARON STONEHOUSE: Thank you, Mr Chairman, for the opportunity to discuss this amendment immediately after the last, and for the latitude that was provided to discuss aspects of this amendment during the consideration of the last amendment. We have already canvassed this pretty well. One issue I did not get a chance to talk about when we discussed the previous amendment is that when we talk about vulnerable people, we often talk about people with a disability, people who are susceptible to suggestion, the elderly, and people in a situation in which there is a power imbalance. I mentioned this in my contribution to the second reading debate or perhaps the clause 1 debate, but I am concerned about cultural and language differences when discussing voluntary assisted dying with a patient, and the cultural attitudes towards a medical practitioner’s authority. Different cultures and societies have different views about the authority of a medical practitioner. A discussion about something may be viewed by some people as an explicit recommendation, and I have a bit of a concern about that. We normally try to be very sensitive about cultural differences when it comes to Indigenous Australians, but I am also concerned about migrant communities, in which, in some instances, there might be more emphasis on family or on the authority of somebody who holds a position, such as a doctor or a policeman or some other official position. It is very important that we look at the risk of undue influence through the lens of not just vulnerable people with a physical or cognitive impairment, but also people who are vulnerable merely because of cultural attitudes towards that relationship.

Leaving that aside for now, looking at the amendment currently before the chamber, in some ways, this is a better way of addressing that issue than the amendment we discussed a moment ago. It is perhaps in some ways a little more onerous, but it ensures that when a discussion is had about voluntary assisted dying and it is initiated by the medical practitioner, there is also an obligation on that medical practitioner to provide information about palliative care at the same time. This amendment probably does a better job of enabling a patient to be informed about their options. However, I mentioned previously that if a patient initiates a conversation on voluntary assisted dying, under this proposed clause there is no obligation on the medical practitioner to provide information about palliative care, from my reading. Is there, somewhere else in the bill, an obligation on medical practitioners to provide information about palliative care when having a discussion about voluntary assisted dying?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: Proposed new subclause (3) seeks to address the context in which voluntary assisted dying may be raised with a patient. The member will note in that subclause the holistic approach by which the medical or nurse practitioner can raise voluntary assisted dying.

In relation to the member’s last question, the coordinating practitioner and the consulting practitioner are required to present information about palliative care options under clauses 26 and 37.

Hon NICK GOIRAN: This amendment in the minister’s name, now before the chamber, introduces a new term, “health care worker”. What is the difference between a health care worker and a health practitioner?

Hon AARON STONEHOUSE: While the minister is seeking advice to answer that question from Hon Nick Goiran, I might wrap up my contribution to the debate on this amendment. I can see that the minister is right that under clause 26, there is an obligation on a coordinating practitioner. The clause begins —

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 —

There follows a list of care and treatment options.

However, it is at a different stage. That is not necessarily a problem, but I think it might be worth recognising that. Clause 26 refers to the point at which a medical practitioner has become a coordinating practitioner and has assessed the eligibility of a patient, and that is when the coordinating practitioner has to ensure that the patient is informed about palliative care, whereas new clause 9A taken in its entirety refers to ensuring palliative care is raised at the initial stage. The conversation seems to be happening at two different times. Under new clause 9A, it would be raised during that initial conversation with the patient; whereas, under clause 26, it is at a later stage. I do not think that causes a problem necessarily. I want to point it out so that we are clear about when that conversation happens.

I do not think it is a problem necessarily because in new clause 9A, we are talking about a situation in which the medical practitioner raises VAD and initiates the conversation. It is therefore incumbent on them to also talk about palliative care in that same conversation, whereas clause 26 would cover situations in which a patient goes to a medical practitioner who assesses their eligibility. If they are determined to be eligible, then they can begin the conversation about palliative care. They happen at different times but that is because the conversation may be initiated in different scenarios. I feel fairly satisfied about new clause 9A and the provisions under clause 26 working together to ensure the patients are notified about their options of palliative care. On that basis, I am happy to support new clause 9A at this stage.

Hon STEPHEN DAWSON: I thank the member for his comments.

Back to the question asked by Hon Nick Goiran, a “health care worker” definition is wider than a “health practitioner” definition. A healthcare worker is a person who may be unregistered and is providing health services; a healthcare worker’s role is broader.

Hon NICK GOIRAN: I am not sure that is what the minister said to us the other day. I appreciate that it is difficult because the advisers are probably interchangeable; nevertheless, I draw to the minister’s attention a very detailed discussion we had about clause 4, “Principles”. He will see in clause 4 that the words “health practitioner” or “health practitioners” are used, from my count, on three occasions. The minister might remember that I suggested that it might be a drafting error and should read “registered health practitioners”. He said no, that he did not want to do that; the government had purposely put in “health practitioners”. When I asked why we do not define that, the minister said that we did not need to define it, and we had a big dialogue. At first, I asked whether “health practitioner” was defined anywhere in the Western Australian statutes and the minister said no. I think I probably even asked him a second time and he said no. Later on, we were told, “Sorry, that advice to the house was wrong; ‘health practitioner’ is defined in Western Australian law.” We continued to have a dialogue about that and the intent of the government to purposely make sure that it is “health practitioner”, not “registered health practitioner”.

One of the examples the minister gave me was social workers. So convinced I was of his position to include social workers, that I even moved an amendment to add “social worker”. Being an amendment in my name, the government was not supportive of it, which is, of course, its right. Given this latest definition of “health practitioner”, I am curious to know where a social worker fits in that mix. It seems to me that the bill now has “registered health practitioner”, “health practitioner” in clause 4 and now “health care worker”. Where does a social worker fit in that mix?

Hon STEPHEN DAWSON: I am advised, honourable member, that there is no inconsistency in what I said the other day and what I have said now. A social worker who provides a healthcare service can be a health practitioner. Essentially, a social worker could be a health practitioner or healthcare worker. As part of what the member has asked, does he want me to go back over the definition of, or the professions that are covered by, a registered health practitioner?

Hon Nick Goiran: No.

Hon STEPHEN DAWSON: Okay. Good.

Hon NICK GOIRAN: Minister, what is an example of a class of person who is a healthcare worker but not a health practitioner?
Hon STEPHEN DAWSON: I have an answer for the honourable member, but I am seeking to go further, so, if he does not mind, we will pause for a second rather than me giving him a quick answer and then him asking for further advice. I want to be able to give the member a full answer.

I am told the example would be health support staff in an aged-care setting—potentially, someone with a certificate III.

Hon NICK GOIRAN: Minister, proposed new clause 9A(5) states —

A contravention of subsection (2) by a registered health practitioner is unprofessional conduct …

The contravention of new subclause (2) could be by somebody other than a registered health practitioner. For example, if we look at the definition of “health care worker”, we see it includes —

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

What is the penalty for that class of person if they contravene new subclause (2)?

Hon STEPHEN DAWSON: I am told that the rest would be covered by new subclause (7). The honourable member can read that for himself.

Hon NICK GOIRAN: Is the minister’s advice to the chamber that the class of person under new clause 9A(1)(b) is the same as a provider under new subclause (7); that the classes of people are identical and there is no person who is outside those classes?

Hon STEPHEN DAWSON: I am told that the definition of “provider” is very broad; and, yes, they would be covered.

Hon NICK GOIRAN: Why does the new clause 9A(1)(b) that the minister wants us to agree with not refer to a provider as defined in section 3(1) of the Health and Disability Services (Complaints) Act 1995 and instead uses the words “any other person who provides health services or professional care services”? Why was that decision made?

Hon STEPHEN DAWSON: We did not use the word “provider” because provider under the Health and Disability Services (Complaints) Act 1995 also includes a body. The bill focuses on the individual, so we did not use the word “provider” in new clause 9A(1)(b).

Hon NICK GOIRAN: I do hope, minister, that a Western Australian healthcare worker who is not a registered health practitioner understands that, because if they do not, it will be taken to be unreasonable conduct.

I do not know whether other members have received a letter from Dr Anil Tandon about this issue, but I received one today. It is dated 20 November. I do not know whether the minister has seen it. Of course, Dr Anil Tandon is a very, very experienced palliative care specialist in Western Australia. He is highly regarded and highly respected. Dr Tandon has, on multiple occasions, presented to the Parliamentary Friends of Palliative Care. I did not realise he had such an interest in new clause 9A until I read his letter this morning. This is what he said —

Dear Honourable Members

…

We represent a network of 800 health professionals who have serious concerns around the introduction of euthanasia and physician assisted suicide bills in Australia. We write to you especially concerned about the New Clause 9A from the Minister for Agriculture —

I pause there to note that I think that is a typographical error by Dr Tandon; I think he means the Minister for Environment —

… representing the Minister for Health, suggesting to move 458/NC9A Page 10, to insert Subsection 3 & 4.

The suggested additional sub-clauses are too broad and open the door for unethical behaviour, and potential for undue and dangerous influence of the therapeutic relationship toward a patient’s decision making, by potentially allowing a health practitioner to initiate a discussion around VAD.

The additions suggested by the Minister for Agriculture —

Which, for the benefit of Hansard, really should read “Minister for Environment”, but that is what the letter says —

… are unnecessary and will extend the scope of Clause 9 and potentially compromise the safety of WA citizens, and particularly the vulnerable, in its application. We respectfully ask for the subsections 3 and 4 to be removed and for Clause 9 to be clear in its instruction that NO health professional or health care worker should initiate a discussion on VAD.

The Victorian Act, Clause 8 clearly states:

Voluntary assisted dying discussions must not be initiated by registered health practitioner.

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 that person that is in substance about voluntary assisted dying; or

(b) In substance, suggest voluntary assisted dying to that person.

Extracted from finalised Hansard
(2) Nothing in subsection (1) prevents a registered health practitioner providing information about voluntary assisted dying to a person at that person’s request.

Our concerns are especially supported by the recent findings of Royal Commission into Aged Care Quality and Safety, and additional findings for those with disabilities … The need for clarity around this and the potential for harms are further supported by worldwide, recognised evidence about the influence of the therapeutic relationship and care application in regards to the desire to die and outcomes … and also in terms of what constitutes ethical medical behaviour.

Yours sincerely,
Dr Anil Tandon

My question is: has the government received this letter; and, if so, what is its position in response to it?

Hon STEPHEN DAWSON: I have not received it, and to the best of my knowledge the government has not received it; certainly, my advisers are unaware of it. That is the status. While I am on my feet, I again make the point that the new clause 9A that stands in my name on the supplementary notice paper came about following consultation with the Western Australian branch of the Australian Medical Association. As we have discussed previously, whether it is people with disability, Aboriginal people, members of Parliament or, indeed, doctors, there is a variety of views out in the community in relation to this bill; some are supportive and others are not. But certainly, I have not received that letter.

Hon NICK GOIRAN: I have received the letter and I take seriously the views of the very learned and respected palliative care specialist Dr Anil Tandon. For those reasons, I will move to amend the Minister for Environment’s amendment 458/NC9A. I move —

New clause 9A — To delete proposed new clause 9A(3) and 9A(4).

The DEPUTY CHAIR (Hon Adele Farina): I might take this opportunity to ask Hon Nick Goiran whether he wants to table the letter he referred to.

Hon NICK GOIRAN: Yes, I take this opportunity to seek leave to table this document under the authorship of Dr Anil Tandon. It is dated 20 November 2019.

Leave granted. [See paper 3417.]

The DEPUTY CHAIR: Members, the copy of the amendment to the new clause moved by Hon Nick Goiran has been distributed, so we are able to proceed.

Hon NICK GOIRAN: Briefly, by way of explanation, those members who have a copy of the amendment will see that part of it is typed and part of it is handwritten. The reason that is the case is that yesterday, when I considered the amendment that had been foreshadowed by the honourable minister, it struck me that proposed subclause (3) should be struck out. However, today I received the letter from Dr Anil Tandon, which has been tabled, and I encourage members to look at that letter, because it ultimately forms the basis of my amendment to the amendment, and it suggests that proposed subclause (4) should also be removed. For those reasons, I have moved the amendment on the amendment that stands in my name.

Hon STEPHEN DAWSON: I thank Hon Nick Goiran for tabling a copy of that letter. It is interesting to note that although the letter says it represents a network of 800 health professionals, they are in fact doctors from right across Australia—New South Wales, the Australian Capital Territory, Victoria and other jurisdictions, as well as Western Australia. We do not support the amendment that stands in the name of Hon Nick Goiran, because it will essentially widen the amendment that was proposed by Hon Martin Pritchard and remove any ability for a medical or nurse practitioner to carry out a fundamental role of providing all available options to a patient.

Hon AARON STONEHOUSE: I was out of the chamber on urgent parliamentary business when Hon Nick Goiran discussed the reason for his amendment to the amendment. I understand a letter has been circulated and I will read it in a moment. At a glance, if we removed proposed new clauses 9A(3) and 9A(4), it would take us right back to what we were discussing in Hon Martin Pritchard’s proposed new clause 9A. The minister just said that his new clause 9A is broader than Hon Martin Pritchard’s proposed new clause 9A. Is there the intention here to merely replicate what would have been achieved by Hon Martin Pritchard’s new clause or will the proposed changes that Hon Nick Goiran has moved in his amendment somehow create a better or lesser version of what was proposed in Hon Martin Pritchard’s new clause?

Hon NICK GOIRAN: That is a very good question from the honourable member. My view is that the proposed new clause, if amended, would be a superior version of the excellent proposed new clause moved by Hon Martin Pritchard. I say that for one reason: as I said to members earlier, my concern is steering. Hon Martin Pritchard’s proposed new clause would have prevented steering by registered health practitioners. My amendment will be wider than that, as identified by the honourable minister, because it will prevent steering by healthcare workers. For that reason and for the same rationale previously, I support that.

Amendment on new clause put and negatived.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: I know this is a little difficult, because we started debate on another proposed new clause and now we are dealing with this one. If I am not mistaken, I heard the minister say when he responded to Hon Martin Pritchard that one of the reasons the government did not support his proposed new clause was that there was no other statutory provision that provided for a restriction on the doctor–patient relationship in the way that Hon Martin Pritchard had anticipated. If that is the minister’s argument, would it still not be relevant to the proposed new clause before the chamber, which is standing in the minister’s name now, that this would be the first occasion that we would be inserting into statute some restriction on that patient–doctor relationship?

Hon STEPHEN DAWSON: I think that was what the government said. It is not about the doctor–patient relationship, it is about the practice of the profession. Hon Martin Pritchard is trying to cap the role of the practitioner. The government said there is already a statutory restriction on the doctor–patient relationship. The member is correct that the proposed new clause before the chamber is about the practice of the profession.

Hon MARTIN ALDRIDGE: Thank you for clarifying that, minister, because I certainly heard something else.

I understand that with respect to “nurse practitioners”, which is mentioned in this proposed new clause for the first time in subclause (3), it was the ministerial expert panel’s recommendation that they be given a greater role, to which the government took a different approach. If I am not mistaken, nurse practitioners can only be administering practitioners; they cannot be consulting or coordinating practitioners. Why is it then that nurse practitioners are relevant in the context of this new clause if indeed their role is confined to that of an administering practitioner? I am not sure that initiating a discussion would be relevant at the point when a nurse practitioner is about to administer.

Hon STEPHEN DAWSON: The member is correct; they can be only administering practitioners. The inclusion here is about the senior role of nurse practitioners and their training and experience, which makes them appropriate to carry out this responsibility.

Hon NICK GOIRAN: In what circumstances would a nurse practitioner inform a person about the treatment options available to the person and the likely outcomes of that treatment? Is this something a nurse practitioner would usually undertake in the course of their duties?

Hon STEPHEN DAWSON: I am told that a nurse practitioner who is working with someone with an advanced or a progressive illness could provide them with information.

Hon NICK GOIRAN: They can provide them with information. My question was: in what circumstances would a nurse practitioner inform a person about the treatment options available to the person and the likely outcomes of that treatment? That is the language used in the bill. In what circumstances would they do that?

Is it something that they routinely do or is it outside the scope of their normal duties? If it is outside the scope of their normal duties, that is fine.

Hon STEPHEN DAWSON: I am receiving further information, but it is probably worthwhile me putting on the record exactly what a nurse practitioner is. A nurse practitioner is a person who is registered under the Health Practitioner Regulation National Law (WA) Act in the nursing profession and endorsed as a nurse practitioner. In order to be so endorsed, the person must first be a registered nurse who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. They must also have completed an approved postgraduate 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 National Board of Australia. On top of this, the bill requires that to be eligible as an administering practitioner, a nurse practitioner must have practised for at least two years post-registration as a nurse practitioner and must have the requirements approved by the CEO. Therefore, yes, it is within the scope of a nurse practitioner to provide information within a clinical context on the treatment options available to a patient.

Hon NICK GOIRAN: It is also about the likely outcomes of that treatment. I have emphasised now that it is those two things together. I want to be clear that the things we are saying they would have to do are actually within the remit of a nurse practitioner.

Hon STEPHEN DAWSON: I am told, yes, honourable member.

Hon MARTIN ALDRIDGE: I think Hon Nick Goiran went to this issue with respect to the definition of “health care worker” earlier, but I am just trying to understand the application of new clauses 9A(5), (6) and (7). New subclause (5) relates to a registered health practitioner and new subclause (7) relates to a provider as defined in the Health and Disability services (Complaints) Act 1995. Is the way that “health care worker” has been defined relevant in the context on the treatment options available to a patient?

Hon NICK GOIRAN: What I said was that Victoria has a prohibition that was not supported by the joint select committee or the ministerial expert panel. I also said that Victoria is the only jurisdiction in the world that wholly prohibits health practitioners from starting a conversation about voluntary assisted dying.

Hon STEPHEN DAWSON: What I was saying is that Victoria has a prohibition that was not supported by the joint select committee or the ministerial expert panel. I also said that Victoria is the only jurisdiction in the world that wholly prohibits health practitioners from starting a conversation about voluntary assisted dying.

Hon MARTIN ALDRIDGE: I might just take this opportunity to remind members to keep the audible conversations very low or to leave the chamber if they are having private conversations, because it is making it very, very difficult to follow the debate.

Hon STEPHEN DAWSON: Clause 10(1) says that a practitioner is capable of constituting professional misconduct, whereas new clause 9A goes further and says it is unprofessional conduct in that it is a breach. 

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: Thank you minister; that makes it clear. Would new subclauses (5), (6) and (7) when read together cover all the people who it is anticipated will fall within the definition of “health care worker”?

Hon STEPHEN DAWSON: Yes.

Hon MARTIN ALDRIDGE: I have just one last question. This is obviously an amendment standing in the minister’s name, so it is a government amendment. I want to quote from a second reading contribution by a government member given on 15 October 2019, who said —

This legislation has been developed over the past two or so years. I acknowledge the extensive work that has been put into it, from the health minister right through to the Joint Select Committee on End of Life Choices. I acknowledge the tremendous amount of work that was done by that committee and also by the Ministerial Expert Panel on Voluntary Assisted Dying. Due to the fine work put in by those dedicated people, I am satisfied with the provisions of this bill and I will be supporting it without amendment through the house. The Agricultural Region and its voters want this bill passed, as does the broader community. I think the broader community is satisfied with the bill as presented.

They are the words of Hon Darren West, who is a member of the government, on Tuesday, 15 October 2019. Does the minister know whether Hon Darren West is supporting his amendment in light of his comments on that date?

Hon STEPHEN DAWSON: It is inappropriate to ask me how any member might be voting on this bill.

Hon Martin Aldridge interjected.

Hon STEPHEN DAWSON: That is not an appropriate question to ask me. The member will know how honourable members are voting if we ever get to a vote on this clause.

Several members interjected.

The DEPUTY CHAIR: Order, members! The minister has the call.

Hon STEPHEN DAWSON: I reiterate that the government has always indicated that it would give consideration to proposed amendments.

Hon Michael Mischin: No, it hasn’t.

Hon STEPHEN DAWSON: Yes, I have said that. We have listened to members.

Several members interjected.

The DEPUTY CHAIR: Order, members!

Hon STEPHEN DAWSON: We have listened to members and stakeholders, such as the WA branch of the Australian Medical Association. We have engaged with them about their genuine concerns. In that context, this amendment appears on the supplementary notice paper in my name.

Hon NICK GOIRAN: I turn to my last question on this issue. I take the minister to new clause 9A(3) and paragraphs (a) and (b). Does the medical or nurse practitioner have to inform the person about both (a) and (b) or one of (a) and (b)? Obviously, if the practitioner does anything wrong, they will be guilty of unprofessional conduct. Do they have to do both or one of the things to avoid unprofessional conduct?

Hon STEPHEN DAWSON: They have to do both.

Hon NICK GOIRAN: Given the severity of what is happening here, after the word “treatment;”, should there be an “and” to make it clear to the practitioners that they will have to inform the person of both those things? If the minister provided a handwritten amendment, we could deal with it on the spot. With all goodwill here, there could be some pretty serious consequences, and I think the addition of that one extra word would be appropriate.

Hon STEPHEN DAWSON: I agree with Hon Nick Goiran. I am very happy to get a copy of supplementary notice paper 139 from one of our fantastic staff in the chamber so I can handwrite the amendment on it and we can progress.

The DEPUTY CHAIR (Hon Adele Farina): To ensure that members are aware of what is occurring, the minister has agreed to add the word “and” after new subclause (3)(a), so that it will read —

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

(b) …

That will be incorporated into the minister’s new clause that has been moved. Is that correct?

Hon STEPHEN DAWSON: Sorry, Madam Deputy Chair, I was not listening to you. I was trying to seek the guidance of the assistants. Could you ask that again, please?

The DEPUTY CHAIR: Is it the minister’s intention to move this amendment inserting a new clause 9A with that word included?

Hon STEPHEN DAWSON: Yes, that is my intention.
The DEPUTY CHAIR: The minister seeks leave to amend his new clause 9A, to include the word “and” after new subclause (3)(a).

New clause, by leave, altered.

New clause, as altered, put and passed.

Committee interrupted, pursuant to standing orders.

Reserved from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Robin Chapple) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Committee was interrupted after the new clause 9A moved by Hon Stephen Dawson (Minister for Environment) had been agreed to.

New clause 9A —

The DEPUTY CHAIR: Hon Charles Smith, do you want to move your new clause 9A?

Hon CHARLES SMITH: Thanks, Mr Deputy Chair. The amendment is now new clause 9B.

The DEPUTY CHAIR: It is new clause 9A on the supplementary notice paper. I just make that point.

Hon CHARLES SMITH: I move —

Page 10, after line 5 — To insert —

9A. Palliative care and treatment

(1) This section applies if, at any time after making a first request, a patient is provided with palliative care and treatment that relieves the patient’s suffering to a level that is tolerable to the patient.

(2) If the request and assessment process in respect of the patient has not been completed, the request and assessment process ends.

(3) If the request and assessment process in respect of the patient has been completed, the process for accessing voluntary assisted dying under Part 4 ends and no step under that Part (including the prescription, supply or administration of a voluntary assisted dying substance) is to be taken in relation to the patient.

(4) Nothing in subsection (2) or (3) prevents the patient from beginning a new request and assessment process by making a new first request if the palliative care and treatment options available to the patient subsequently cease to relieve the patient’s suffering in a manner that is tolerable to the patient.

The remaining amendments under my name on the supplementary notice paper are largely safeguards that I have taken from the Northern Territory model and that are currently absent in our WA model. To that end, these amendments will focus primarily on palliative care, as I attempt to put palliative care first, followed by mental health assessments, and then the changes in accordance with those amendments.

Proposed new clause 9A under my name as it stands currently provides that a specialist palliative care assessment must take place before a patient can access assisted dying. Members will know that an essential eligibility requirement under this bill is that the patient is experiencing suffering caused by disease, illness or a medical condition. This new clause will simply make it clear that if the patient is offered specialist palliative care treatments or services that go on to relieve the patient’s pain or suffering, the patient is no longer eligible for access to voluntary assisted dying and the request and assessment process ends there.

The amendment is simple. I think it is reasonable. It is logical. It plugs a small hole in the safeguarding system. I commend it to the chamber.

Hon STEPHEN DAWSON: Hon Charles Smith’s amendment seeks to introduce a new clause that requires the voluntary assisted dying process to end if the patient receives palliative care and treatment that relieves the patient’s suffering to a level that is tolerable to the patient. We are not supportive of the amendment. The bill already provides for the patient to not continue the process, or withdraw from the process. I refer members to clauses 18, 52 and 56. If the person has been assessed as eligible, they are eligible under the bill. If a patient chooses to receive palliative care and treatment and finds that they are not suffering, or their suffering is tolerable or acceptable to them, it is highly unlikely that they will want to continue in the voluntary assisted dying process. The bill already more than appropriately covers the patient’s ability to cease participation in the process or to not continue. It is for those reasons that we will not be supporting the proposed new clause.

Hon NICK GOIRAN: I understand the proposed new clause moved by Hon Charles Smith is based on something in the Northern Territory legislation. The Rights of the Terminally Ill Act 1995 contained 21 sections. Maybe Hon Charles Smith can correct me if I am wrong by way of interjection, but the part of the Rights of the Terminally Ill Act 1995 that appears to deal with palliative care is section 8.

Extracted from finalised Hansard
Hon Charles Smith: Yes.

Hon NICK GOIRAN: Section 8 of the Rights of the Terminally Ill Act is entitled “Palliative care”. It reads —

(1) A medical practitioner shall not assist a patient under this Act if, in his or her opinion and after considering the advice of the medical practitioner referred to in section 7(1)(c)(i), there are palliative care options reasonably available to the patient to alleviate the patient’s pain and suffering to levels acceptable to the patient.

(2) Where a patient has requested assistance under this Act and has subsequently been provided with palliative care that brings about the remission of the patient’s pain or suffering, the medical practitioner shall not, in pursuance of the patient’s original request for assistance, assist the patient under this Act. If subsequently the palliative care ceases to alleviate the patient’s pain and suffering to levels acceptable to the patient, the medical practitioner may continue to assist the patient under this Act only if the patient indicates to the medical practitioner the patient’s wish to proceed in pursuance of the request.

Has the minister obtained any advice on, or can the minister help us to know, whether section 8 of the Northern Territory legislation is consistent with what would be new clause 9B, which is before us.

Hon STEPHEN DAWSON: I ask the chamber to bear with us. We do not have a physical copy of the Rights of the Terminally Ill Act 1995. We are seeking to use the marvels of modern technology to access a copy. I will look for it and come back to the member.

Hon CHARLES SMITH: It is also worth noting that this proposed new clause, for those who are interested in safeguards, will put in additional safeguards. There is nothing new in this proposed new clause to prevent a patient from making a new first request for access to voluntary assisted dying further down the track should the specialist palliative care treatment cease to alleviate the patient’s pain and suffering.

Hon COLIN HOLT: While the minister is consulting, I have a question for the mover of the amendment. Is Hon Charles Smith saying that if a patient decides to, for want of a better word, push pause on their assessment journey, they will have to start all over again? Is the premise of the member’s proposed new clause that they will have to go back to the beginning and do a first request?

Hon CHARLES SMITH: In a nutshell, yes. It is alluding to that pause/stop situation; they would have to do a first access treatment.

The DEPUTY CHAIR: I am allowing this, with some limitation.

Hon COLIN HOLT: As soon as the minister seeks the call, I will sit down.

Hon STEPHEN DAWSON: I will happily seek the call. I am told that section 8 of the Rights of the Terminally Ill Act 1995 of the Northern Territory is different. I am advised that it prohibits a medical practitioner from assisting a patient in the process if palliative care options are reasonably available to the patient to alleviate their pain or suffering.

Hon NICK GOIRAN: Do I take it from that that the Northern Territory provision to which the minister referred is more restrictive than the one Hon Charles Smith has moved?

Hon Stephen Dawson: Yes, that is my advice.

Hon NICK GOIRAN: Okay. I would prefer the new clause not to be less restrictive; I would prefer it to capture everything in the Northern Territory legislation. Nevertheless, in the absence of another amendment being produced by the government or another member, this would go at least partly towards addressing the Northern Territory safeguard. My next question probably goes to a theme or question that we have asked with other amendments. I assume that, in the end, this will be new clause 9B, so I will refer to it as such. If new clause 9B were to pass, would it undermine the operation of the bill? I know that the health minister has previously said that he would effectively rule out amendments if it was considered that they would make the bill inoperable. Would this make the bill inoperable? I suspect the answer is that it would not make it inoperable. However, would it do any harm?

Hon STEPHEN DAWSON: I am advised that it would not undermine the bill, but it is superfluous, unnecessary and not legislatively concise.

Hon NICK GOIRAN: I note that the amendment uses the words “if a patient is provided with palliative care and treatment”. It would be inappropriate to ever suggest that a patient must be provided with palliative care and treatment—that is entirely a decision for the patient—but if it were provided, that is when this clause would kick in. Is there anything in the bill that mandates that palliative care must be offered to a patient?

Hon STEPHEN DAWSON: There is nothing in the bill that says they must be offered palliative care. Clause 26 says that the coordinating practitioner must inform the patient about certain matters, and one of those is the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment. I think clause 37 also refers to something similar.

Extracted from finalised Hansard
Hon NICK GOIRAN: Just to clarify, what is difference between offering palliative care to a patient and informing them of the palliative care and treatment options available and the likely outcomes of that care and treatment? What is the distinction?

Hon STEPHEN DAWSON: I guess offering is more affirmative—"Do you want this treatment that is available?"—whereas clause 26 says that we must inform the patient of the options available, not necessarily offer them palliative care.

Hon NICK GOIRAN: This really goes to the intersection between clause 26, which the minister has just raised, and the one we just passed, which is new clause 9A. The minister may recall that that clause prohibits a health worker from initiating a discussion; however, a medical practitioner or a nurse practitioner can initiate it so long as they advise the person of two things, and one of those things is the palliative care and treatment options available. That mandatory requirement on the health practitioner is only if they initiate the conversation. If they do not initiate the conversation, that provision does not apply. Is the minister saying that clause 26 then kicks in? I just want to make sure that, whether the practitioner or the patient initiates the conversation, either way, they will be informed as a matter of law. It will be a requirement that they be informed of the palliative care and treatment options available to the person and the likely outcomes of that care and treatment. I seek clarification that that is the case and there is no gap there, because if that was the case, it would certainly receive my support.

Hon STEPHEN DAWSON: Yes, they are given the information.

Hon NICK GOIRAN: Is that why the government says this proposed new clause 9B is not necessary? Is it because in every instance a patient is going to be informed about the palliative care options available to them?

Hon STEPHEN DAWSON: It was not because of clause 26. That was not the reason I gave for why the new clause was not needed.

If a patient is going through a coordinating or consulting assessment, they will receive information about palliative care. The government’s position is that there is no additional requirement, as proposed in new clause 9A.

Hon NICK GOIRAN: If Hon Charles Smith’s proposal was defeated and the bill continues in its current form without further amendment, would it be open for a patient in Western Australia to access voluntary assisted dying—be it on the VAD pathway—and could they simultaneously access palliative care and treatment?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: I ask the minister to help me understand the necessity of a patient in Western Australia wanting to access both simultaneously. I think the amendment would prohibit a patient accessing palliative care and treatment simultaneously; they would either be on one pathway or another—that is, the care pathway or the death pathway. That is unfortunately the situation. I do not think we can suggest that the taking of a lethal substance is the care pathway or the life pathway; it is not. I want clarification on that. On what basis is it appropriate for somebody to be on both pathways at the same time?

Hon STEPHEN DAWSON: The government respects the patient’s autonomy to choose voluntary assisted dying at the end of life. Patients can choose to be on the palliative care “pathway”, if we wish to use that word, until the moment of administration. They are entitled to palliative care if that is what they want to access. Some patients receiving palliative care still experience total suffering, as we know.

Hon NICK GOIRAN: Is a person in regional Western Australia who wants to, and makes the decision to, access voluntary assisted dying entitled to palliative care up until the point of administration?

Hon STEPHEN DAWSON: Every Western Australian is.

Hon NICK GOIRAN: It is interesting that every Western Australian is entitled to palliative care. Under, I think, clause 1, I asked for a guarantee that if it was the choice of a person in regional Western Australia, they would have a palliative care specialist and an interpreter flown to them, and the minister said that he could not guarantee that that would happen, but he could guarantee that this squad of eight—I am paraphrasing now—would go there. I was concerned about that at the time. If the position has changed or evolved, or whatever language we want to use, since then or we have an enhanced understanding between us, that is a good thing. I just want clarification on that.

Hon STEPHEN DAWSON: That is not what I have said just now; I said that they are entitled to palliative care. How they access palliative care would not necessarily involve a specialist flying to the Kimberley, for example. I said that they are entitled to it.

Hon NICK GOIRAN: I have no further questions, but I just indicate that I will support the new clause because I think, on balance, it is effectively another safeguard against doctor steering. When I consider some of the experiences in other jurisdictions, it troubles me that there are enthusiastic doctors, proponents of voluntary assisted dying or whatever terminology is used in the various jurisdictions who steer or push patients down a particular pathway. If this is a small measure to mitigate that by saying, “No; if the person is taking palliative care treatment and it’s at a level that is tolerable to them, that ceases the voluntary assisted dying process”, that will be some kind of a brake on the enthusiasm of a voluntary assisted dying practitioner who wants to enthusiastically continue with...
the process. It may well be the case that there are not too many voluntary assisted dying practitioners who are enthusiastic, but I remind members and the minister that we all know of Dr Philip Nitschke. I would say that he is a pretty infamous character in this type of regime around the world. I will say this much about him: he is highly experienced and he is intellectually honest, because he has said on the record that where we have these regimes, there will be casualties. On balance, if this is a measure to put a brake on some of the enthusiastic practitioners, it is a good thing.

**Hon Martin Pritchard:** To the honourable member who has moved the new clause, I am afraid that I am not going to support it. Of course, many of us have had doctors and such talk to us about whether they are for or against voluntary assisted dying. During that time, it was explained to me that for a small number of people in palliative care, palliative care treatment cannot get on top of their suffering. A number of people I spoke to said that they have good days and bad days. They have intolerable pain, but on occasion they do not feel too bad. My concern is that a person who wishes to be on a path towards voluntary assisted dying might shy away from palliative care treatment that may help them during the intervening period because at some point when they are not feeling too bad, it may be viewed that they have to start the whole process again. My view is that the process is fairly onerous for a person in their last six months of life and we should not force them to go through it twice. I am glad the member brought the new clause to the chamber, but after thinking about it deeply, I am not sure that I can support it.

**Hon Aaron Stonehouse:** I have been listening to the debate on this new clause and trying to weigh up its pros and cons. I am not entirely sure that it is necessary. That comes from someone who is very sceptical about the clauses in this bill. I am very interested in ensuring that the safeguards are adequate, but in this case clause 18 already provides that a person has no obligation to continue the voluntary assisted dying process and that they can cease the process at any time. I am unsure why it is necessary to put in another break. A break is already there for a person to initiate if they like. Having an additional one for a specific circumstance seems somewhat redundant. A person can call a stop to the process for any reason. Specifying an additional reason—if palliative care addresses someone’s suffering—seems a little unnecessary.

This may be intentional, but I also see a problem in that someone merely having their suffering addressed by palliative care being a reason for a patient to have to opt out ignores the fact that patients whose suffering is addressed by palliative care may still wish to access voluntary assisted dying. Someone with a degenerative disease with a 12-month prognosis may still wish to access voluntary assisted dying because they know that it will get worse. Their suffering may currently be addressed by palliative care, but they may still want to go through the process. Some members may find the idea disturbing that someone who is not in pain may want to access voluntary assisted dying, but the bill allows for people who have a degenerative disease to access voluntary assisted dying. As I understand it, a lot of people with degenerative diseases want to have that choice. They want to empower themselves, so they know that when it starts to get to the point where they lose functionality and are facing incapacitation, that option will be available to them. They may start the process a little earlier with the goal of taking the substance later. For those reasons, I am not sure that this is necessary. I see that it would require somebody who puts a stop to the process to go back to the beginning and start again. I do not mind that aspect necessarily. It would make it a little more onerous, but I do not think that it is a bad idea that someone’s capacity is constantly reassessed and that they are provided with updated information. I do not mind that aspect of it. I get back to the redundancy of new clause 9A(1) or 9B(1), or whatever it ends up being numbered in the end. For that reason, I find it difficult to support this amendment.

**New clause put and negatived.**

**Clause 10: Contravention of Act by registered health practitioner** —

**Hon Nick Goiran:** What provisions might a registered health practitioner contravene that would enliven this clause?

**Hon Stephen Dawson:** I am told that it would be any provision of this bill.

**Hon Nick Goiran:** All right. If I take the minister to clause 1, clause 2 or clause 3, I think he will agree that that is not correct. Can we get some proper advice about which provisions a registered health practitioner might contravene that would enliven this clause? This is not an insignificant matter. We are talking about a registered health practitioner in Western Australia being capable of an action constituting professional misconduct or unprofessional conduct. I think registered health practitioners in Western Australia have a right to know which of the 184 clauses, if contravened, will enliven this clause.

**Hon Stephen Dawson:** Thank you for that clarification. I am advised that it is any provision in which a registered health practitioner has a duty.

**Hon Nick Goiran:** Which clauses create a duty on a registered health practitioner in our state?

**Hon Stephen Dawson:** There are quite a lot in the bill, but I can give the honourable member an example. A registered health practitioner would fall foul of this provision, if, for example, they did not lodge a form under clauses 45, 54 or 59(1). There are a range of clauses that that would contravene. There are quite a few throughout the bill.

Extracted from finalised Hansard
Hon NICK GOIRAN: Maybe just to speed up the process, because this particular theme does not necessarily have to be dealt with today and does not need to hold up the passage of clause 10, would the minister be agreeable to undertaking, between now and not necessarily tomorrow, but, if possible, prior to us resuming next week, to provide a list of the clauses that a registered health practitioner might contravene that would enliven this clause, and also what penalty or offence would be applicable to that contravention? Could we get a schedule or a table and maybe have that tabled next week?

Hon STEPHEN DAWSON: I do not have a list in front of me, but I will undertake to get a list for next Tuesday. I do not think it would be available before tomorrow, but I can provide that for next Tuesday.

Hon NICK GOIRAN: I thank the minister for that. Would a student who is registered under the national law be capable of professional misconduct or unprofessional conduct?

Hon STEPHEN DAWSON: Can the member clarify whether he is talking about a student or a student doctor?

I am not trying to be smart; I am trying to give the honourable member an answer.

Hon NICK GOIRAN: I actually had not considered that, so my question applies to both.

Hon STEPHEN DAWSON: A medical student could not, but a junior doctor could.

Hon NICK GOIRAN: I go back to the schedule that will be prepared hopefully for next Tuesday. Clause 10(2) states —

Subsection (1) applies whether or not the contravention constitutes an offence under this Act. For the sake of clarification, it would be good if the different contraventions could be listed, and obviously some of them will have an offence associated with them and some will not. I make that as a point of clarification, and perhaps if that is not clear, we can talk about it behind the Chair after today.

The next question on clause 10 is: how is clause 10 to be read in light of the provisions in clause 113?

Hon STEPHEN DAWSON: Clause 113 essentially provides that a person is not breaching clause 10 if they are acting in good faith. Clause 113 is a protection when a person acts in good faith, and then clause 10 operates outside of that.

Hon NICK GOIRAN: I am not suggesting that there be an amendment; I am just making sure that we all understand clause 10 correctly. In effect, are we saying that if we were to insert into clause 10 the words “in bad faith” after “a contravention”, is that how clause 10 would operate in practice; in other words, “A contravention in bad faith 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)”, and, conversely, if it is a contravention but it is in good faith, there is no professional misconduct or unprofessional conduct? Is that how we are to read clause 10?

Hon STEPHEN DAWSON: No; not necessarily. Clause 113 mentions good faith. It would not necessarily need to be in bad faith, just not in good faith. There is a difference.

Hon NICK GOIRAN: I will perhaps pick up that issue of good faith when we get to clause 113 but I think it is potentially a disturbing element that given the stakes here, the taking of a patient’s life, albeit said to be with the consent of the person, that good faith shields practitioners from any liability whatsoever. But we will look at that at clause 113. Just to round out clause 10, minister, I notice that in the other place on 4 September 2019 there was an exchange between the member for Churchlands and the health minister when the member for Churchlands said —

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?

The health minister replied —

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.

The member for Churchlands then asked —

Is the minister intending to establish some sort of redress scheme attributed to any contraventions of the legislation?

The Minister for Health responded, “No.”

Given that the health minister mentions that the remedies under this bill are detailed in the relevant clauses, can the minister identify for the chamber which remedies are detailed in this bill and in which clauses?

Hon STEPHEN DAWSON: Is the honourable member talking about criminal breaches or civil breaches?

Hon NICK GOIRAN: I am talking about any contravention because clause 10(1) refers to —

A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct …
Any contravention, as we described, that is not in good faith would be capable of constituting those categories of either misconduct or conduct. I would like to know what remedies would be available to patients, given that the health minister said in the other place that the remedies under the bill are detailed in the relevant clauses. I could not find any clauses that detail that. Perhaps the minister has advice to the contrary.

Hon STEPHEN DAWSON: Under part 6 of the bill there are specific offence provisions, but there are also Australian Health Practitioner Regulation Agency sanctions. With regard to AHPRA notifications and sanctions, I am advised that there are possible outcomes following an AHPRA investigation.

The CHAIR: Order, members. The question is that clause 10 do stand as printed. We are not considering part 6, and I am sure we will not be for some time.

Hon NICK GOIRAN: I have not asked any questions about part 6; I am asking about clause 10(1), which relates to a contravention by a registered health practitioner being capable of constituting professional misconduct or unprofessional conduct. My question is: what remedies are available to a patient or a family member in the event that there is such a contravention? I note from the debate in the other place that the Minister for Health indicated that those remedies are outlined in the bill. It is not apparent to me that that is the case. I am just seeking clarification. I suspect it is not in the bill at all, in which case I think it would be helpful for patients and family members who might regrettably be subjected to a contravention by a registered health practitioner, not in good faith, to be able to know what remedies are available to them.

Hon STEPHEN DAWSON: The patient can lay a complaint to the chief executive officer of the Department of Health or the board, and they will refer to AHPRA. Also, the patient—or, indeed, the family—could take a civil remedy. They could bring legal action and seek that remedy.

Hon NICK GOIRAN: Obviously the patient cannot take civil action if they are dead, but would the family member be —

Hon Stephen Dawson: I said patient or family.

Hon NICK GOIRAN: Yes. Would a family member be able to take civil action if the patient is now deceased?

Hon STEPHEN DAWSON: I am advised that it is up to the court to decide, on a case-by-case basis.

Clause put and passed.

Clause 11: Voluntary assisted dying not suicide —

Hon RICK MAZZA: I have some concerns about this particular clause. Clause 11 states —

For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not commit suicide.

However, the definition of “suicide” is that it is an act of intentionally causing one’s own death. I think that this statement in the bill does not take away from what voluntary assisted dying actually is—that is, the intentional act of causing one’s own death. To simply call it one thing and hope that it will be another is nonsense. At the end of the day, voluntary assisted dying is the act of intentionally causing one’s own death.

Hon Alannah MacTiernan interjected.

The CHAIR: Order! Members! Members! Members! We are just about at the end of the day.

Hon RICK MAZZA: I understand that the government is probably trying to limit the stigma around suicide, in that voluntary assisted dying is for someone who is terminally ill. The government does not want that stigma. My concern, however, is how this interacts with the commonwealth law about the use of a carriage service. In around August of this year, the Attorney General wrote to Hon Christian Porter in relation to the commonwealth law. I know that this letter has been tabled. The letter states, in part —

Clause 11 of the Bill makes it clear that voluntary assisted dying is not suicide. Further, I note that clauses 156 and 157 of the Bill state that those clauses do not authorise the use of a method of communication if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth.

Clause 156 refers to being able to use basically telehealth or some form of communication unless there is a conflict with the commonwealth law. The reason I really worry about this is in the circumstance in which a medical practitioner, quite reasonably, refers to the bill for guidance as to whether they can use telehealth or how they will actually administer voluntary assisted dying. If a medical practitioner on a reading of the bill sees that voluntary assisted dying is not suicide, they may go ahead and use a carriage service in some way to communicate with their patient. I also have a letter from one of the advisers that goes back to August and states, in part —

Victoria has at this stage instructed its health practitioners not to engage in telehealth, but to consult face-to-face. This is in relation to the Commonwealth Crimes Act. The provisions in that Act were included in 2005 to address cyber bullying.

Extracted from finalised Hansard
If we retain the clause that voluntary assisted dying is not suicide, there is the possibility that a medical practitioner may refer to the act, which is quite reasonable, for guidance about whether they are able to use telehealth or some other means of communication apart from face to face, and then find themselves offending the commonwealth law and in all sorts of trouble. That is why I have proposed the following amendment at 414/11 —

Page 10, lines 13 to 16 — To oppose the clause.

The CHAIR: The question is that clause 11 do stand as printed. The function of placing an “amendment” on the supplementary notice paper in the terms proposed by Hon Rick Mazza is actually as a vehicle to make sure that the clause is debated. But, in effect, it is not an amendment as such. The avenue that Hon Rick Mazza needs to take, of course, is simply to vote against the clause. Therefore, we will not treat it as an amendment as such, and I am not proposing any amendment wording, so we return to the question that clause 11 do stand as printed.

Hon STEPHEN DAWSON: I note the view of Hon Rick Mazza, but the government certainly believes in the inclusion of clause 11. I have spoken at length about this issue, both at clause 1 and, indeed, I believe, during debate on clause 5 too. The views of the government are on the record, so I do not feel the need to further explain its view on that. We certainly support clause 11 as it stands.

Hon MICHAEL MISCHIN: I have a few questions about this clause to simply understand some of the rhetoric around it. To start with, I refer to the second reading speech in which the minister—it reflects, I believe, what was said about the bill in the other place—put to us, and I quote —

I would like to emphasise that this bill has nothing to do with euthanasia. This is about providing assistance to someone who is 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 a voluntary assisted death is not a suicide.

I take that on board. But then we get to a general proposition, which is —

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.

Does the government maintain that blanket definition of what is not suicide and what is suicide?

Hon STEPHEN DAWSON: I stand by the second reading speech.

Hon MICHAEL MISCHIN: If it is not suicide, why is it that we need clause 11 in the first place?

Hon STEPHEN DAWSON: This clause reflects the tenor of the bill and the views of the government that voluntary assisted dying is not suicide. It is our belief that suicide occurs when a person takes their own life in circumstances outside that which is permitted by this bill. Voluntary assisted dying is a new concept and we are making it crystal clear in this case, in clause 11, that voluntary assisted dying is not suicide.

Hon MICHAEL MISCHIN: I would like to tease that out a little more. The blanket comment that suicide involves the tragic loss of life of a person who otherwise is not dying —

Hon Stephen Dawson: Member, could you say that again, please?

Hon MICHAEL MISCHIN: Is the minister telling us that this is not suicide provided that all the strictures and processes under the bill are followed, but otherwise would be suicide?

Hon STEPHEN DAWSON: There are four of us at the table and we have three different views on what the honourable member asked. I am not being obtuse, but does the honourable member mind asking his question again, please?

Hon MICHAEL MISCHIN: Let us try an example. We are told under clause 11 —

For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not commit suicide.

Let us say that I fulfil all the criteria mentioned in the second reading speech, but I do not get the approval of two doctors. However, I do get hold of a “prescribed substance”, within the meaning of clauses 6, 7 and 11, and I administer it myself. Have I committed suicide?

Hon STEPHEN DAWSON: In that case, it would be a decision of the coroner, but it would potentially be suicide.

Hon MICHAEL MISCHIN: Okay. That gets me back to my earlier point: what is this clause for? As I understand it, the minister is trying to tell us that suicide involves the tragic loss of life of a person who is otherwise not dying. Let us say that I am dying from a terminal illness, death is imminent, and I am in terrible pain and distress. I have a number of choices. I could put myself out of my misery by shooting myself or by using one of the other grim ways to hasten my death described in the second reading speech. However, I happen to acquire one of these prohibited substances—perhaps it was left over from someone else’s attempt to use this legislation—and I administer it to myself. Have I committed suicide or not?

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Hon STEPHEN DAWSON: If I can answer it in this way: the proper execution of this bill is to access voluntary assisted dying and not suicide. However, if a person seeks to breach the bill, clearly they are not following the intended purpose of the bill.

Hon MICHAEL MISCHIN: Sorry, are they or are they not?

Hon Stephen Dawson: They are not.

Hon MICHAEL MISCHIN: So it is suicide—is that what the minister is telling us?

Hon Stephen Dawson: I said it could be.

Hon MICHAEL MISCHIN: Yes—is.

Hon Stephen Dawson: I said it could be.

Hon MICHAEL MISCHIN: What would not make it a suicide? I have not followed the scheme in the legislation but I have achieved the same end—surely it is a suicide, is it not?

Hon STEPHEN DAWSON: I think I answered that it could be, because it is not for us to decide if it was a suicide. That is a decision that the coroner would make.

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

VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 21 November. The Deputy Chair of Committees (Hon Matthew Swinbourn) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 11: Voluntary assisted dying not suicide —

Progress was reported after the clause had been partly considered.

Hon ALISON XAMON: Yesterday, we were debating whether clause 11 should be removed. I rise to indicate that I will not support the removal of this provision and I would like to explain to members why. I recognise that there are some who wish to equate the voluntary assisted dying provisions with the horror of suicide. As someone whose life has been defined by the trauma and horror of suicide, I want to say how much I object to people trying to equate the two.

My grandfather, in his 90s, was dying of cancer and wanted to cut his life short by two weeks, in order to avoid inexpressible suffering and pain—which is what he died with, in his final weeks. My 35-year-old father, strong of body and healthy, but with a troubled mind that was fully capable of recovery, chose to take his life. The fact that people would attempt to equate these two is, for me, abhorrent.

I think it is wrong to try to belittle the trauma of genuine suicide. Suicide is what happens when people give up on life when they have their whole life ahead of them. There is a fundamental difference here. We are talking about people whose time has come, who are at the end of their life, and who are seeking to simply bring forward an inevitable death at the very end. Do not ever try to tell a parent who has buried a child because they have taken their life that they are going through, the lifelong trauma that they are going to experience, is the same as someone whose time has naturally come to an end and whose body is failing them.

I think it is really, really important that people be very careful when they try to loosely pull together those sorts of provisions, because I think it actually belittles the trauma and horror of suicide. I feel offended by that, and as someone who is a staunch suicide prevention advocate and will be until the day I die, I am very capable of distinguishing between the provisions in this bill and the horror of suicide.

However, I do have a small amendment that I wish to make. I think there has been an inadvertent error in the drafting, and I am sure the minister, as the former opposition spokesperson for mental health, would have some sympathy with my amendment and would understand why I seek to move it. I move —

Page 10, line 16 — To delete “commit” and substitute —

die by

I move this amendment because people no longer refer to “committing” suicide. It is recognised as being stigmatising language. If people are not aware of the language that we now use around suicide, I urge them to go
to the Suicide Prevention Australia website and look at the language we now use when we talk about the trauma of suicide. People no longer “commit” suicide; that is a hangover from when suicide was in the Criminal Code. Fortunately, it no longer is. We now recognise that suicide is largely a mental health issue, but also an issue of other life circumstances that need to be addressed accordingly. I move that simple amendment because I believe it serves a better purpose within the bill. I also will not support the removal of clause 11 in its entirety.

Hon MICHAEL MISCHIN: I can indicate that I would be supportive of such an amendment. I recall that in my contribution to the second reading debate I think I referred to the rather quaint use of the terminology “commit” suicide, which imports the sort of offence that was removed from the Criminal Code some years ago. I queried why it was that we were using that kind of language for what has been acknowledged in both fact and law as being not a criminal or moral offence but simply a tragedy. I indicate that I will support the substitution of the word “commit” with the words “die by” if that is what Hon Alison Xamon has in mind. Might I also say that I am saddened to hear what Hon Alison Xamon has said, because I know her experience in these matters, and I hope that my questioning has not been misconstrued as trying to conflate the two extremes of action in a way that will trouble her. However, I wish to make a point about the legal status of those sorts of actions, because that will have consequences for the manner in which this bill will operate, not only in the distinction between actions—which will be a fine one—but also in whether the same level of scrutiny will be available to the authorities to ensure that what is done under this bill, or is purported to have been done under this bill in the future, is properly accounted for. I will develop that theme very shortly when I continue the line of questioning that I commenced yesterday. I say at this point that, once again, my sympathies go out to Hon Alison Xamon for her experience in this area, and I hope that my comments have not been misconstrued in a way that will upset her.

I indicate also that the proposed amendment is worthy, and that unless the minister can point out some legal consequence that turns on the word “commit” being necessary for the purposes of this clause, it ought to be supported by the chamber. I asked yesterday what the point of this clause was, and I was told that it fits with the theme and the tone of the legislation. Is there some legal consequence that would require the use of the word “commit” rather than an alternative formulation? I would not want to inadvertently expose people to an undesirable and unintended consequence through a well-meaning amendment that would defeat what the government has in mind. I say that bearing in mind that not only have we had the work of the Joint Select Committee on End of Life Choices, but also the Ministerial Expert Panel on Voluntary Assisted Dying and parliamentary counsel have helped in its drafting. We were assured in the other place by the Premier that this bill was perfection itself when it entered this chamber. Therefore, we need an assurance that this is not simply an inadvertent and infelicitous use of the phrase “commit” but was carefully crafted, because I would not want to interfere with that.

Hon STEPHEN DAWSON: I thank Hon Alison Xamon for her contribution, and also for her proposed amendment. I indicate that the government is happy to support the amendment. In fact, the amendment is consistent with the language used in the draft “Western Australian Suicide Prevention Action Plan 2021–2025”. My advisers tell me that the change of wording will have no legal consequence. We are of the view that this amendment is warranted and worthwhile. I am told the meaning of the word “commit” is the ordinary English meaning and that it was not intended to import the meaning of the old Criminal Code provision. With those comments, I indicate that the government will support the amendment.

Hon JACQUI BOYDELL: I rise to support not only the amendment put by Hon Alison Xamon, but also the principle of her argument around the reason that there is a fundamental difference between an intended suicide and voluntary assisted dying. I do not think anyone could have articulated that in quite the same manner as she has done. I am glad that she has put that to the chamber because that absolutely, in my mind, lays bare any question about whether there is any correlation between voluntary assisted dying or suicide. Therefore, I wholeheartedly support the member’s principled view on the matter. I support the amendment.

Hon TJORN SIBMA: I also rise to indicate my support for the minor but significant amendment proposed by Hon Alison Xamon. I think it is sound, compassionate and realistic. However, I also want to indicate that although I oppose Hon Rick Mazza’s opposition to the entire clause, I do not intend to impugn to him any negative intent; I know him as a person who would not do that knowingly. I have a similar view of suicide versus voluntary assisted dying as enunciated by Hon Alison Xamon; I just indicate that I consider them to be very distinct categories of departure. I will leave it at this: anybody who has witnessed the scene of a suicide would know exactly what I am talking about. I leave it at that.

Hon ROBIN CHAPPLE: I commend my colleague for having picked up on this very subtle difference and I certainly will be supporting the amendment moved by my colleague.

Hon AARON STONEHOUSE: I rise to support the amendment in this instance, although when we get back to debating the substantive clause, I will have more to say on the topic and the position put by Hon Rick Mazza. At a first reading of this clause, I read “commit” merely to mean to oblige oneself or to commit to an action, rather than any reference to the Criminal Code. However, I understand that it might be read that way and merely changing the language in this instance does not seem to change the effect as far as I can tell. Although I wonder whether
rather than “die by”, language such as “perform” or “carry out” might have been more suitable. In any case, after surveying the chamber, it seems that there is a significant amount of support for the words “die by” in this instance, so I will not argue the finer points. The effect is the same, from what I read.

Hon Michael Mischin: You could probably leave out the words altogether and not have “die by suicide” but just “suicides”.

Hon AARON STONEHOUSE: The effect does not seem to change insofar as I can tell and I am eager to debate the substantive clause when we get to that point. Therefore, for the time being, I am happy to support the amendment put by Hon Alison Xamon.

Hon NICK GOIRAN: The language that I would normally use in this context is just to say “suicide”. I associate myself with the element of the remarks by Hon Alison Xamon that it is no longer appropriate to refer to “commit suicide”. I have, over many years, retrained myself to not use that language; I just generally talk about a person who suicides. I have no problem with the amendment moved by the honourable member; it achieves the same effect and I think it is worthy of support. However, I foreshadow that I have an amendment of my own on the supplementary notice paper, which this amendment moved by Hon Alison Xamon will not create any impact upon, so this amendment has my support.

Amendment put and passed.

Hon SIMON O’BRIEN: The question that has just been decided is instructive. I listened very carefully to the words of Hon Alison Xamon and, indeed, have great sympathy for the situation she shared with us. I appreciate the trauma that she and some loved ones around her have suffered and, indeed, I think continue to suffer. I respect that and have great sympathy for it—absolutely. I reach out with those remarks in the first instance.

In contemplating this clause, I want to indicate that that is not an area or a theme that I am seeking to examine. Quite simply, I am more concerned about the actual wording of the clause and what it means in terms of the future administration of the law. We had some discussion about this clause late yesterday and again this morning, and it has all revolved around a sentiment contained in what is proposed in this clause—that is, about whether it is within the tenor or demeanour of the rest of the bill, and about empathy and so on. I think that is a fair way of describing how the minister has expressed it. I actually read the clause quite differently. My attention is drawn to the first phrase, which says —

For the purposes of the law of the State —

It then goes on to say —

a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide.

It is that first phrase, though, that I think this clause is all about. However, all the discussion has been about the semantics, sensitive though they are, in the balance of the clause. My question on that first part of the clause, which is the words “for the purposes of the law of the state”, is this: What law of the state are we talking about? Is it contained only within this proposed act or are there other laws that will be impacted by this consideration?

Hon STEPHEN DAWSON: My advisers tell me that this refers to all laws in Western Australia.

Hon Simon O’Brien: And what might they be?

Hon STEPHEN DAWSON: What sorts of things do they touch on?

Hon Simon O’Brien: I am told that it is every law in Western Australia. It is not a specific law, category or subject, but, indeed, the laws in Western Australia.

Hon SIMON O’BRIEN: This is not an attack on the clause per se; I am just trying to get a handle on it, because I think it could be important. I will ask the minister a specific question that has been raised elsewhere. Is this about people with life insurance? If people avail themselves of voluntary assisted dying, could that therefore void an insurance policy that says that the policy will be void if the person dies by their own hand, commits suicide or whatever terminology they use? Is this therefore an attempt to get around that? I make no judgement about whether that is a legitimate thing to do—I am not going there—but it is a valid consideration. If that is one of the drivers of clause 11, we had better know about it to make it explicit.

Hon STEPHEN DAWSON: No, honourable member. Insurance and superannuation are private contractual arrangements. This is not about circumventing insurance or superannuation. The Voluntary Assisted Dying Bill specifically provides that a voluntary assisted death is not suicide under Western Australian law. Leaving the Voluntary Assisted Dying Bill silent on life insurance provides agency to all insurers and the public.

Hon RICK MAZZA: I just want to make it very, very clear that my opposition to clause 11 is in no way intended to diminish suicide from people in emotional distress—I have also been touched by the horrors of suicide through

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emotional distress—compared with what we have before us, which is suicide because somebody is reaching the end of their life. That is not my reason for opposing this clause. In fact, I would rather that the bill remained silent on this matter. The reason for my opposition to the clause is more a forensic one on the application of how this would work within the bill. My major concern with it is that the government is still uncertain about whether this could be interpreted as suicide. The email I received on 22 August says —

Victoria at this stage has instructed its health practitioners not to engage in telehealth …

Clause 156 of this bill refers to not offending the commonwealth law. My opposition to the clause is that I do not want to see a misinterpretation by a medical practitioner that something is not suicide and then later on it be interpreted on the very common application of the definition of “suicide”, which is the deliberate ending of one’s life. That is my opposition to it. It is the practical application of how this will work, not the distinction between emotional suicide and what we have before us in the Voluntary Assisted Dying Bill. I want Hon Alison Xamon to understand that fully. What I am talking about is the forensic application. I think sometimes we get very emotional, as we should do, but then we have to home in on how this bill will operate and its practical application. That is why I think we may be asking for trouble by retaining clause 11.

Hon CHARLES SMITH: I just want to pursue what I think Hon Simon O’Brien was alluding to. I wonder whether the minister could help me with this. How does the government reconcile voluntary assisted dying with legislation such as section 288 of the Criminal Code, which notes that it is a crime to aid another in killing themselves?

Hon STEPHEN DAWSON: The short answer is that if the procedures in this bill are properly followed, this clause would override that.

Hon AARON STONEHOUSE: I am looking forward to further interrogation of this clause, because I am starting to get a little concerned about how we draw the distinction in this bill, but also in wider criminal law in WA, between what would be physician-assisted or physician-administered voluntary assisted dying and self-administered voluntary assisted dying. With no intention to cause any distress to anybody—I understand how loaded these words can be—self-administered voluntary assisted dying in the most forensic, basic sense, would be suicide, which is the taking of one’s own life, whereas when it is physician-administered, it gets a little trickier. I think at its most basic level it would be forensically and technically homicide. That is not to say it is murder or that it is even necessarily criminal, but if a person injected someone with a poison or a voluntary assisted dying substance, it would be the act of one person taking another’s life. When we start to redefine things or at least say that something is not what we understand it to be at a forensic level, I am just thinking out loud, I suppose. That is what I am looking at right now. How does the government reconcile voluntary assisted dying with legislation such as section 288 of the Criminal Code, which notes that it is a crime to aid another in killing themselves?

I am looking forward to further interrogation of this clause, because I am starting to get a little concerned about how we draw the distinction in this bill, but also in wider criminal law in WA, between what would be physician-assisted or physician-administered voluntary assisted dying and self-administered voluntary assisted dying. With no intention to cause any distress to anybody—I understand how loaded these words can be—self-administered voluntary assisted dying in the most forensic, basic sense, would be suicide, which is the taking of one’s own life, whereas when it is physician-administered, it gets a little trickier. I think at its most basic level it would be forensically and technically homicide. That is not to say it is murder or that it is even necessarily criminal, but if a person injected someone with a poison or a voluntary assisted dying substance, it would be the act of one person taking another’s life. When we start to redefine things or at least say that something is not what we understand it to be at a forensic level, how we assess an investigated death post–voluntary assisted dying process in accordance with the bill, they are not assisting suicide; they are assisting with the proper access to voluntary assisted dying.

Hon MICHAEL MISCHIN: I listened with interest to the comments that have been made. That gets back to the question I asked initially about the point of this clause. Although I am quoting from the uncorrected Hansard—it seems to reflect the explanatory memorandum when I asked what clause 11 is about and what is the point of it—I was told that the clause reflects the tenor of the bill and the view of the government that voluntary assisted dying is not suicide. That is great as far as it goes. We have the blanket statement in the second reading speech that draws a distinction between voluntary assisted dying and the tragedy of suicide and the like. Perhaps some other things have been exposed during some of the contributions. I might be able to assist, even at the risk of the Premier considering that it is a disgraceful antic; we are holding up the passage of the bill and people are suffering while I speak, and I do not mean just because of the sound of my voice! Clause 11 appears to be saying that, for all the

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purposes of the state, if we follow the very strict procedures that are prescribed under the bill when it becomes law, it is not to be regarded as suicide. When I asked a hypothetical question, the minister did say that if I fulfilled all the criteria in the bill, I would be entitled to end my life by the self-administration of an approved substance or have someone administer that substance to me; if I did not comply with one or more of the provisions or I obtained the approved substance from some other source, I would be committing suicide, but if I tick all the boxes in the bill, then I would not.

The minister would cavil at that and say that it is not for him or the government to say; it is up to the coroner. Of course, the minister now has the benefit of Mr Malcolm McCusker, and I mention that only because he was a member of the advisory panel and also he is an adviser to the Minister for Health and is learned in the law. Prima facie, it would be a suicide if I, being entirely eligible, self-administered; if I did it myself, instead of going through several doctors, I would have suicided. That suicide would be the subject of a coronial inquiry to determine the circumstances and how it could have been prevented. There would be some public accountability through an appropriate authority for that death, which is the whole point of having a coroner—so that deaths in our community are accounted for. That is how much we value life. However, if a person follows, or at least purports to follow, the procedures in this bill, it will not be a suicide and the coroner will have a death certificate in the case of self-administration that will not even reveal the fact that it was done by way of resort to this bill. That troubles me, because we will be relying not on a proper investigation or on public accountability, but on the word of doctors, and we have already had one public case of a doctor who has claimed to have relieved the suffering of a patient and the police have not even been able to identify whether that was the case. That is the sort of level of accountability we will have. A doctor will come in a couple of days later and say they reasonably think this was done by self-administration under the act and comply with it and fill in a death certificate accordingly, even though they did not witness the act. It could have been a suicide or it could have been a murder, but we will not know from the death certificate. I would like to explore later on just how much insight a coroner would have into these circumstances to account for these deaths. It would take only one death that was in fact a murder concealed by the provisions of this bill to raise concerns for me. That is not through a lack of compassion for those who are suffering and wish to be relieved under this regime. It is a concern that some people may—dare I suggest, people such as Hon Adele Farina’s father—by a lack of empowerment in a relationship with a medical practitioner and the like, and thinking that they are doing the right thing by their family, be steered into something that they really do not want. That troubles me. I do not expect that any of the advocates for this—the Premier at the least—will stand up and say, “I should have thought of that and fixed it. Perhaps the Legislative Council should have spent a little more time thinking about it, rather than rushing our bill through.”

The other implications of this, I thought, were for insurance policies, so that as far as the law of the state is concerned, a person who follows this procedure cannot have their life insurance negated or somehow affected by reason of resort to this lawful strategy. I would like that confirmed. But, of course, there are life insurance policies that are governed by the laws of other jurisdictions. It is not uncommon for a contract executed in this state to have a provision saying that the contract is governed by the laws of New South Wales, the United States or some other jurisdiction. I would like to know the implications of that, and whether this provision addresses that problem.

The other question has been raised by Hon Aaron Stonehouse about the relationship of the operations of this legislation with the criminal law. I do not have the Criminal Code in front of me but, essentially, it goes something like this: an act causing or accelerating the death of another is a killing, and it is an unlawful killing unless it is authorised, justified or excused by law. If a medical practitioner, even with the best of intentions or for the highest of motives, were to inject a patient with an approved substance without the support of this legislation, that would be an unlawful homicide. Quite apart from being a suicide or assisting in a suicide, it would be an unlawful homicide—an unlawful killing. That does not seem to have been addressed by a similar provision stating that any practitioner or other who assists in this process for the purposes of the law of the state has not committed an unlawful killing, that it is lawful killing, or some other formulation. I would like to know whether that has been considered and to get advice on whether that problem needs to be addressed—the problem that Hon Aaron Stonehouse has touched on. I think that needs to be considered and that we need to be given some comfort on that.

We will deal with it at a later stage, when we come to what needs to be disclosed either to the Voluntary Assisted Dying Board that will be responsible for administering this legislation, or for the purposes of public accountability.

The DEPUTY CHAIR (Hon Robin Chapple): Hon Michael Mischin.

Hon MICHAEL MISCHIN: That is so that at least someone will know what is really going on and, in due course be able to provide an appropriate assessment of the merits and deficiencies of the operation of this legislation, understand, through a simple check, how many deaths have been attributed to the regime under this proposed law, verify whether the idea that only a small proportion of people are gaining access to and availing themselves of it is correct, and see whether it is being misused. At the moment, I do not see a great deal of accountability that can be extracted from what is being proposed. That troubles me as well. That is for a later argument down the track but, nevertheless, flows from the way that this is being categorised partially by way of proposed section 11 of the legislation. If the minister can address those matters, it may satisfy me. On the other hand, I might ask some further supplementary questions regarding it, but that will be a pretty good start. I hope that I have been of some assistance by putting quite frankly where my concerns lie rather than by a teasing-out process.

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Hon STEPHEN DAWSON: I think the member was trying to be helpful, but I am not sure he was that helpful to me. He veered over quite a number of issues.

Hon Michael Mischin: I was hoping to save a bit of time.

Hon STEPHEN DAWSON: But many of those were addressed under clause 1 and, obviously, clause 1 is a more expansive debate. Many of those will be dealt with later on—some of them under clauses in part 6, part 8 and in other clauses. Those will be more appropriate places to deal with them. There were a number of questions. I make the point that there will be consequential amendments to the Coroners Act as a result of this bill, and clauses 165 and 166 outline those. Clauses 112 to 114 provide for protection from any criminal liability—for example, for unlawful killing under the Criminal Code—for persons acting in accordance with the act. There was also a question about the interaction of this bill and the commonwealth because of provisions in the commonwealth Criminal Code Act. Those issues were asked and addressed at clause 1. I also make the point that the board could refer any concern about a voluntary assisted dying case to the coroner at any stage. A doctor will not complete a death certificate unless satisfied as to the cause of death. Regarding notification, when the medical practitioner reasonably believes or knows that the cause of the person’s death was the administration of a voluntary assisted dying substance in accordance with this bill, they must notify the Voluntary Assisted Dying Board in writing of the patient’s death on an approved form. In this way, the board will be able to maintain complete and accurate statistics of participation in voluntary assisted dying in WA, and the information will be provided to the Australian Bureau of Statistics and available in a de-identified form to Parliament and the community so that we can form a view on how well the legislation is operating. They were all the pieces of advice I have been given in relation to the comments specific to this clause, but obviously members will get the chance to further tease out or ask questions on some of those issues at more appropriate clauses later.

Hon MICHAEL MISCHIN: I also raised specifically the point of this clause and how it interacts with the other matters, and yes, I know them. But the minister said that it only reflects the tenor of the bill. Does it? I ask specifically: to what extent will it preserve life insurance payouts, for example, under contracts governed by laws of another state? Will it protect a person’s entitlement to a payout?

Hon STEPHEN DAWSON: I have addressed that issue earlier today. I will say it again and I will give the member some further information. This also was an issue addressed at clause 1; we had a very expansive debate. No-one can possibly expect me to continue to go over issues in the bill countless times. There was a very broad discussion at clause 1. I will make this point, generally. It was a very expansive conversation and line of questioning at clause 1. If I referred to answers previously, whether it was at clause 1 or clause 5, I do not propose to go into that level of detail again at every clause to the same extent that I went into at clauses 1 and 5, because I do not think it is appropriate. I will give the honourable member an answer. I make that point generally; there are standing orders about repetition for me as well as everyone else. Insurance is a matter between the insurer and the policyholder. I make the general point that I do not propose to keep going over these points again. With the greatest respect to honourable members in this chamber, if they have been away from the chamber on urgent parliamentary business at clauses 1 or 5, or earlier in the debate, it is not for me to go over those points again. I will provide a concise answer at the appropriate time, but I do not propose to have an expansive debate at every clause on the same issue multiple times. I do not think it is appropriate and Parliament would not expect that of me.

As I said, insurance and superannuation are private contractual arrangements. Leaving voluntary assisted dying silent on life insurance provides agency to all insurers and the public. People can usually access entitlements when they are terminally ill and expected to die within a certain time frame. Upon diagnosis, the individual would either already have life insurance or not; they may be able to take out life insurance after being diagnosed. Many life insurance policies include terminal illness cover, so a person who is diagnosed with a terminal illness and is not expected to live more than 12 months will be entitled to receive their benefits in full prior to their death. Many Australian life insurance policies cover suicide, but only after a specified exclusion period. I am advised that that is usually around 13 months.

Hon AARON STONEHOUSE: I appreciate the effort the minister has gone to in trying to get us full and frank answers. It is a credit to him, and it is a credit to the processes of the Legislative Council. Thank you for that. I want to make a couple of comments. The discussion on how this might impact insurance policies makes me a little concerned, perhaps from another perspective. I know it is weird to say so, but I think the idea of redefining or excluding a certain interpretation of voluntary assisted dying, and that impacting on an existing contract, concerns me somewhat. It seems to undermine the sovereignty of the contract. Someone has a contract that they have entered into voluntarily with their insurance company, and then the state comes along and states that something is no longer that. That then has implications and impacts on an insurance company’s contract. That concerns me a little, although I think I might be in the minority expressing that view. It is not that I really care about insurance companies in this case—I do not—I just care about the institution of contracts and keeping those intact, and not trying to retrospectively alter the conditions or terms of the contract. This would not really change the terms of the contract, but it would at least redefine something that we understand now in different terms, and that would have an impact on it. That makes me a little uncomfortable. In any case, it will really depend on the insurance policy.

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and on the contract as to whether that has an impact and how it might have an impact. As the minister has said, this may not affect some policies at all, but it does make me a little uncomfortable when we go back and redefine things in this way.

I am looking at clause 11 and the language of it, and picking up on something that Hon Michael Mischin was talking about. I forewarn people who find this topic a bit distressing. I normally speak in pretty frank language about this kind of stuff, but I will try to be as sensitive as I can. The unamended clause read —

For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not commit suicide.

I would like to focus on the aspect of “in accordance with this Act”. There might be a couple of ways of reading this. For instance, a patient may have followed the procedures of this act, obtained the substance, took it and died as a result of that, but it was then determined that some form was not filled out properly or the coordinating doctor did not dot their i’s and cross their t’s. If that person died from a voluntary assisted dying substance, but not in accordance with the act because the procedure was not followed fully, it seems to me that clause 11 would not apply in that case. In those cases, their death could be viewed as a suicide, or at least the prohibition on considering it a suicide would not apply in that instance. I would like the minister to confirm that for me — whether I am right in my reading and understanding of that.

Hon STEPHEN DAWSON: Clause 51, in division 6 of part 3, provides that a technical error will not invalidate the request and assessment process. We can delve into that issue further at that stage.

Hon NICK GOIRAN: I will leave it to the honourable member to continue to pursue that. I think it is an excellent line of questioning—ascertaining what would be a contravention under clause 10 that would trigger whether clause 11 applies or does not apply. I know that the minister has indicated that, hopefully, by Tuesday, we might have a list of those contraventions and the offences. We will look at that next week when we get to it, but there will be a range of contraventions on that list that will be tabled by Tuesday next week. It will be interesting, Hon Aaron Stonehouse, to know which one of those contraventions in that list that gets tabled next week triggers whether clause 11 is in play. My question picks up on a theme raised by Hon Rick Mazza. I am keen to know, notwithstanding that the proposal is that clause 11 be amended, if clause 11 were to pass in its current form, would the death of a person as a result of the administration of a prescribed substance in accordance with this act still be considered a suicide under commonwealth law?

Hon STEPHEN DAWSON: Yes, it would, because this applies only to Western Australian law.

Hon NICK GOIRAN: It is unfortunate that Hon Rick Mazza is away on urgent parliamentary business because I know that this point was very much at the heart of his proposal that this clause be opposed. If I understood his rationale, he said that he was concerned that medical practitioners might be left in some state of confusion because, as the minister can understand, if a medical practitioner in Western Australia is trying to understand the VAD scheme and to comply with the law, they will go through this legislation; they are not going to pause for a moment and consider commonwealth law at the same time. If that is the case, one can understand why a medical practitioner could read clause 11 and say, “If we proceed in accordance with this act, it’s not a suicide, so therefore I have no problems with any law; for example, I could continue to use telehealth and the like.” I think that this demonstrates that what Hon Rick Mazza has said is a legitimate concern and is worthy of further consideration by members.

I have an amendment standing in my name on the supplementary notice paper, but before I move to that, I have a concern that a medical practitioner might be unclear about their duty of where to refer a person. The context of that is the Lifeline website. The Lifeline website lists the changes in a person’s life that might make them more at risk of ending their life by suicide. The Lifeline website lists these four situations —

• Recent loss (a loved one, a job … a relationship …
• Major disappointment (failed exams, missed job promotions)
• Change in circumstances (separation/divorce, retirement, redundancy, children leaving home)
• Mental disorder or physical illness/injury

The Lifeline website goes on to state —

Events and life changes —

Including physical illness —

can be difficult and sometimes devastating. Most people who experience them don’t consider suicide, but some do. Be aware of:

• How the person feels about what’s happened
• What it means to them
• Whether the pain feels bearable

Extracted from finalised Hansard
Interestingly, Beyond Blue’s website also identifies physical illness or disability as a risk factor, or a vulnerability factor, which increases the likelihood of suicidal behaviour. If this bill is passed and a person with a terminal illness indicates that they wish to die, should a medical practitioner refer them to a Lifeline or Beyond Blue counsellor or to a voluntary assisted dying care navigator?

Hon STEPHEN DAWSON: The medical practitioner would make a clinical decision. It is probably not for Parliament to speculate on the clinical decisions of medical practitioners; however, the issue would certainly be covered under the implementation phase of the bill. There would be education and training provided to practitioners who want to participate in the actions under this bill. Certainly, I cannot speculate on that issue.

Hon NICK GOIRAN: The Joint Select Committee on End of Life Choices received submissions from the State Coroner. I was interested in the exchange that took place between the minister and the shadow Attorney General on the role of the coroner. The coroner’s supplementary submission states —

In some cases, the deceased suffered from both mental and physical conditions which may have contributed to their intentional self-harm. In some instances, it was difficult to determine if the mental or the physical condition made a more significant contribution to their intentional self-harm based on the information provided within the attached documentation …

In addition, it should be noted that the inclusion of reference to the deceased’s physical condition is not standardised across coronial documentation. As such, in some cases, it was difficult to ascertain the extent to which the deceased’s condition influenced their motivation to self-harm.

My question is: what feedback has the government obtained from the coroner on clause 11 of the bill?

Hon STEPHEN DAWSON: The coroner did not provide any advice on clause 11, but we note the coroner’s view as provided in her evidence to the joint select committee. She said —

It is a different nature, a different type of death … from my perspective, if this does come to pass, then I think it is different to a suicide.

Hon NICK GOIRAN: There is an amendment standing in my name at 155/11 on supplementary notice paper issue 9. However, listening to the debate that has taken place—I am particularly mindful of the remarks made by Hon Rick Mazza—I am not inclined to move that amendment. I am going to move a substituted motion. I am glad that Hon Rick Mazza is back from urgent parliamentary business. While he was away, the minister was able to confirm the honourable member’s suspicion that notwithstanding clause 11 in the bill, under commonwealth law, exactly the same thing would be classed as a suicide. I share the honourable member’s concern that this will only confuse medical practitioners who, quite understandably, would look only at this legislation and would not have at their disposal the commonwealth statute and be reading through it to try to understand that this particular clause has no bearing on commonwealth law. If they were to counsel somebody by way of an electronic communication or carriage service, they would be in breach of commonwealth law. That is a big problem for medical practitioners. I am not personally satisfied that it is satisfactory to simply say that we will deal with that in the implementation phase in the hope that the implementation is good and sufficient to train medical practitioners.

The amendment in my name at 155/11, which I do not propose to move because I will move a substituted one, was seeking to concede to the government’s position and say, “This type of death is not a suicide because the government and the Parliament have said so, but it is something, so what is it? If it is not a suicide, what is this kind of death?” The proposal was that if it were a death as a result of a section 57 self-administration process, we would describe that as assisted suicide, and if it were by way of a section 58 death or administration by a practitioner, it would be voluntary euthanasia. I am inclined not to move that at this stage, because I think it will re-enter the whole debate about voluntary euthanasia, and that has been had. I do not want that to be a distraction from the good contributions made by members so far. Instead, I move —

Page 10, line 16 — to delete “suicide” and substitute —

suicide but is taken to have died by assisted suicide —

(a) if the prescribed poison was self-administered in accordance with section 57; or

(b) if the prescribed poison was administered by an administering practitioner in accordance with section 58.

The DEPUTY CHAIR: In effect, the amendment is similar to the original proposed amendment on the supplementary notice paper but slightly altered by adding the words “by assisted suicide” and removing at the end of paragraph (b) “by voluntary euthanasia.”

Hon NICK GOIRAN: Before we proceed further, I seek leave to amend the amendment that is before us, because on two occasions the word “poison” has been used and the correct word is “substance”. I seek leave to amend that, and I am happy to sign a corrected copy.

Amendment, by leave, altered.  

Extracted from finalised Hansard
Hon STEPHEN DAWSON: Can I indicate that we are not supportive of the altered amendment. We do not support the insertion of the term “assisted suicide”. I have indicated previously—certainly in debate on clause 1 and indeed probably on clause 5—why the term “assisted suicide”, amongst other terms, is not appropriate for the bill. We are committed to the term “voluntary assisted dying” for this bill, and we do not support this amendment.

Hon NICK GOIRAN: If I understand correctly, is the minister then saying that the person is taken to have died by voluntary assisted dying?

Hon STEPHEN DAWSON: No, I am not saying that, honourable member. What I am saying is that we do not want to change the clause as it stands.

Hon NICK GOIRAN: Minister, if they have not died by suicide, assisted suicide or voluntary assisted dying, what have they died of?

Hon STEPHEN DAWSON: What we are saying in this clause is that voluntary assisted dying is not suicide.

Amendment, as altered, put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the ayes, with the following result —

Ayes (5)
Hon Simon O’Brien Hon Aaron Stonehouse Hon Nick Goiran (Teller)
Hon Charles Smith Hon Dr Steve Thomas

Noes (27)
Hon Martin Aldridge Hon Peter Collier Hon Colin Holt Hon Matthew Swinbourn
Hon Ken Baston Hon Stephen Dawson Hon Alannah MacTiernan Hon Dr Sally Talbot
Hon Jacqui Boydell Hon Colin de Grussa Hon Rick Mazza Hon Colin Tincknell
Hon Robin Chapple Hon Sue Ellery Hon Kyle McGinn Hon Darren West
Hon Jim Chown Hon Diane Evers Hon Michael Mischn Hon Alison Xamon
Hon Tim Clifford Hon Adele Farina Hon Martin Pritchard Hon Pierre Yang (Teller)
Hon Alanna Clohesy Hon Laurie Graham Hon Samantha Rowe

Amendment, as altered, thus negatived.

The DEPUTY CHAIR: Honourable members, Hon Nick Goiran’s second amendment to clause 11 therefore lapses.

Hon NICK GOIRAN: The answer is no, clause 81 applies. Clause 81, “Notification of death”, lists what a coordinating practitioner is to do with regard to a death certificate. I note that clause 81(6) states —

The medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

Do I take it that under clause 11, in conjunction with clause 81, a medical practitioner will not be able to record on the death certificate that the person has died of voluntary assisted dying? They will not be able to do that, and they will not be able to record “suicide”, so what will they be able to record?

Hon STEPHEN DAWSON: If a person has undergone voluntary assisted dying, it will not be on the death certificate. If a medical practitioner suspects suicide, they will refer to the coroner to make that finding.

Hon NICK GOIRAN: I am in two minds about whether to ask the minister this question now or leave it, because my question is about what can be recorded on the death certificate. We will leave it to that stage. I indicate that I will be opposing this clause.

The DEPUTY CHAIR: Hon Nick Goiran, you will not be moving amendment 156/11?

Hon NICK GOIRAN: No, because the minister has indicated that there is no limitation. I think the answer earlier was that a medical practitioner is at liberty to write whatever they like on the death certificate. Let us just clarify that again so that we are clear: clause 11 does not limit what a medical practitioner can put on the death certificate.

Hon STEPHEN DAWSON: No, it does not.
Hon NICK GOIRAN: I thank the minister for that confirmation. That is precisely why I will not be moving the amendment standing in my name. The minister is confirming that that is already a matter of law. I could say let us put it in there to put it beyond doubt, but I imagine, given that I am the author of the amendment, that it will not receive much support from the government, so there is no point. If it is already in the bill, according to the minister’s advice, let us be satisfied with that. Nevertheless, minister, I will be opposing the clause. The reason is precisely the concern articulated by Hon Rick Mazza. This has been a very beneficial interrogation of clause 11. We now have on the record, I think for the first time in this whole debate, in both the other place and this place, and outside, that, according to the government, a death under this bill is a suicide under commonwealth law. That is pretty telling, members. The commonwealth is going to say this is a suicide, but we are about to say it is not a suicide. That is a plain inconsistency, and I am not going to support that.

The DEPUTY CHAIR: Hon Nick Goiran, you will not be moving the amendment in your name, 156/11; therefore, the question before the chamber is that clause 11, as amended, be agreed to.

Hon RICK MAZZA: I have just one question. I am not trying to labour this point too much, but just before we divided, the question was asked whether voluntary assisted dying was suicide, and the minister very ardently said no, voluntary assisted dying is not suicide. I do not have the Hansard in front of me, but that is my recollection in general terms. I know that we picked up on this in the debate on clause 1 and we thrashed it out somewhat. But I would like to confirm again, if the government is so certain that voluntary assisted dying is not suicide, why is the government going to advise medical practitioners not to use telehealth or an electronic communication in order to consult patients?

Hon STEPHEN DAWSON: I think that this issue will probably be aired again at clause 156. Under the act, it will not be suicide; we cannot legislate for the commonwealth.

Hon ADELE FARINA: Can the minister clarify for the record whether that will then create an inconsistency between state and commonwealth law and bring about the application of, I think, section 109 of the commonwealth Constitution?

Hon STEPHEN DAWSON: I am told that the short answer is no.

Hon ADELE FARINA: Would the minister please explain the reason for the advice that he has just given the chamber?

Hon STEPHEN DAWSON: The commonwealth does not legislate with respect to suicide; it does have power to legislate with respect to carriage services, which is a different issue.

Division
Clause, as amended, put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the noes, with the following result —

Ayes (24)
Hon Martin Aldridge  Hon Stephen Dawson  Hon Colin Holt  Hon Tjorn Sibma
Hon Jacqui Boydell  Hon Colin de Grussa  Hon Alannah MacTiernan  Hon Matthew Swinbourn
Hon Robin Chapple  Hon Sue Ellery  Hon Kyle McGinn  Hon Dr Sally Talbot
Hon Tim Clifford  Hon Diane Evers  Hon Michael Mischin  Hon Darren West
Hon Alanna Clohessy  Hon Adele Farina  Hon Martin Pritchard  Hon Alison Xamon
Hon Peter Collier  Hon Laurie Graham  Hon Samantha Rowe  Hon Pierre Yang (Teller)

Noes (9)
Hon Ken Baston  Hon Simon O’Brien  Hon Dr Steve Thomas
Hon Jim Chown  Hon Charles Smith  Hon Colin Tincknell
Hon Nick Goiran  Hon Aaron Stonehouse  Hon Rick Mazza (Teller)

Clause, as amended, thus passed.

Clause 12: Inherent jurisdiction of Supreme Court not affected —

Hon NICK GOIRAN: To whom does this clause provide protection?

Hon STEPHEN DAWSON: This clause provides that nothing in the bill affects the inherent jurisdiction of the Supreme Court. This is intended to make clear that the parens patriae jurisdiction of the Supreme Court is not excluded. This has often been raised as an issue for matters relating 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. What is relevant for present purposes is that the parens patriae jurisdiction may be invoked for people who have mental capacity but whose autonomy has been compromised because they are under constraint or are subject to coercion or undue influence. In one case in the United Kingdom, the court granted an injunction to restrain a man who was living with his elderly parents from engaging in various forms of conduct towards his parents, including assaulting or threatening to assault them, or preventing his parents from having contact with friends and family members. An order was also made inviting the official solicitor to investigate the parents’ true wishes and ascertain whether they were operating under the influence of their son in relation to the contact they had with him.

Extracted from finalised Hansard
Hon NICK GOIRAN: Could the jurisdiction of the Supreme Court in this instance be invoked to intervene in a voluntary assisted dying request and assessment process to prevent the supply or administration of a voluntary assisted dying substance when the decision-making capacity of a person is being challenged?

Hon STEPHEN DAWSON: The answer is yes.

Hon NICK GOIRAN: Who can make an application to the Supreme Court in relation to a voluntary assisted dying request and assessment process? For example, could a family member be a potential applicant? What class of persons could make a relevant application in this instance?

Hon STEPHEN DAWSON: I am told it is any person who has an interest in the care and welfare of the interested person.

Hon NICK GOIRAN: Is the phrase "the interest in the care and welfare of a person" a defined term? It is obviously not a defined term in this bill, but is it defined in some other provision or is there some case law that would set out the classes of persons in this bill who would qualify as an interested person in the care and welfare of another?

Hon STEPHEN DAWSON: It would depend on the factual circumstances. The court would decide in each case whether someone has standing. I am told it is well recognised in common law. In the case of an elderly person, for example, it could be the local government authority that is providing service—care and welfare service—to that person, but the court will decide the standing.

Hon NICK GOIRAN: I am interested to know the hierarchy of family members who would be able to apply in this instance. For example, if a son were concerned about the care and welfare of his mother, would the fact that he has a concern for the care and welfare of his mother be enough to be considered as standing—as having an interest in it—or does the interest that the minister talked about refer to something else? I am mindful of the case that was raised when we last had one of these debates, I think in around 2009–10; Brightwater Care Group (Inc) v Rossiter. Christian Rossiter was an individual who I had the honour and privilege of visiting with one of my former parliamentary colleagues prior to that case with Brightwater. The point is that Brightwater clearly had an interest in his care and welfare because it was the provider of the care and welfare. That is quite different from, for instance, a son who might not be providing the care and welfare for his mother. Would that person still qualify?

Hon STEPHEN DAWSON: I cannot give the member a definitive answer to that hypothetical question about someone’s son. The court would need to determine, in each case, whether an applicant is someone with an interest.

Hon NICK GOIRAN: I respect that response but it troubles me somewhat. The context is that quite a few of my constituents have raised their concern about this part of the bill and the hypothetical scenario of an 18-year-old, who is clearly an adult person. Let us assume that that 18-year-old has decision-making capacity. I understand—I have relayed this back to those constituents—that this bill would allow that person to proceed with all of their rights under this legislation without any conferral with a family member. As a father of several children, one of whom is 17 and soon to be 18, it sends a chill down my spine that an 18-year-old would be able to proceed with voluntary assisted dying without conferring with their family. I accept that an 18-year-old obviously has rights under the laws of our state, including the right to autonomy, decision-making capacity and so forth; however, it does trouble me. I would be interested to know in what circumstances a parent of an 18-year-old with a terminal illness would not be able to intervene in this situation, make application to the Supreme Court and be determined as not having an interest in the care and welfare of, in this scenario, their son.

Hon STEPHEN DAWSON: I guess they could intervene and go to the Supreme Court but it is up to the Supreme Court to decide whether they have standing. I also make the point that many things an 18-year-old does would probably put chills down the spine of a lot of us!

Hon NICK GOIRAN: I accept that, though nothing compares with the final consequences of this particular regime. This situation is irreversible.

Given the very short time frames in this legislation—I think the minister previously referred to a period of nine days—what measures are being put in place by the government to ensure urgent consideration and access to legal aid if somebody wants to avail themselves of this Supreme Court option?

Hon STEPHEN DAWSON: It is not part of the bill. The Legal Aid Commission comes under a different act.

Hon NICK GOIRAN: I understand that. I understand the purpose of clause 12 is that the government wants to put beyond doubt that applications to the Supreme Court can be made by family members or any person who has an interest in the care and welfare of the person. I am saying that this is the first time under Western Australian law we will have this short, compressed time frame, possibly nine days, in which an 18-year-old with a terminal illness can access voluntary assisted dying, and not consult with their family. I would like to know that a Western Australian family would have access to legal aid in that very urgent situation—that is, having to apply in that nine-day period. Is that under active consideration by the government? Has it been given any consideration? Would a family member in that particular situation even have access to legal aid?

Hon STEPHEN DAWSON: They could apply for legal aid but it would be up to Legal Aid WA to determine the merits of the case.
Hon NICK GOIRAN: Just to finish off on this particular theme, I obviously understand that a family member could apply to Legal Aid WA. My concern is: is a conversation happening at the moment within government, or will a conversation happen within government, to say to Legal Aid, “If you get one of these applications, you don’t necessarily have to approve it, because obviously there are criteria”—personally, I would like Legal Aid to approve it; nevertheless, that is a decision for government—“but you’re going to need to drop everything and make sure that you consider this application as a priority because there’s no point in considering the application after 10 days if the person has died after nine days”?

Hon STEPHEN DAWSON: I make the point that the government would not seek to interfere in the decision-making of Legal Aid about how it uses its resources. A person could approach Legal Aid, and that would obviously be considered on its merits. Following the passage of the bill, during the implementation phase, there could be dialogue between the Department of Health —

Hon Nick Goiran: Or there will be.

Hon STEPHEN DAWSON: “There could be” is probably the answer. There could be dialogue between the Department of Health and Legal Aid identifying this clause. Then it would be for others to decide the capacity of Legal Aid and whatever else. Legal Aid might talk to government in the future about resources or whatever.

Hon NICK GOIRAN: I hope that is taken up by somebody in government.

This inherent jurisdiction of the Supreme Court does not extend to deceased persons; therefore, an application to the Supreme Court must be made before the administration of the voluntary assisted dying substance. If the death of the person had already occurred, how would the lawfulness of the request and assessment process be reviewed if questions were raised about the decision-making capacity of the person prior to their death?

Hon STEPHEN DAWSON: That would be done by the Voluntary Assisted Dying Board.

Hon NICK GOIRAN: My final question on clause 12 is: why is it necessary, given that no act can affect the inherent jurisdiction of the Supreme Court?

Hon STEPHEN DAWSON: I am told that it has been included to ensure that there is no possible doubt. Similar provisions have been included in other acts. The one that has been brought to my attention is the Children and Community Services Act 2004, but my advisers tell me that it has been used elsewhere.

Hon NICK GOIRAN: I just make the observation that if it is being included to make sure that it is clear and beyond any doubt—it sounds like it is beyond any doubt anyway and we are just including it for the sake of including it—it is perhaps no different from the amendment I flagged earlier to indicate that clause 11 is not intended to limit the information that a medical practitioner may include in a certificate given under section 44 of the Births, Deaths and Marriages Registration Act. It seems to me that there is a bit of a double standard in the drafting of the legislation; notwithstanding that, if it does no harm, and keeping in mind the remarks that I made earlier, I hope that someone in government has a conversation with Legal Aid WA to say that once this legislation is operative, which will be in at least 18 months’ time, those applications will be given priority consideration.

Clause put and passed.

Clause 13: Relationship with Medicines and Poisons Act 2014 and Misuse of Drugs Act 1981 —

Hon NICK GOIRAN: What are the conflicts and inconsistencies that this clause is concerned with?

Hon STEPHEN DAWSON: It is included because we want to address any potential inconsistencies. It is about futureproofing the bill.

Hon NICK GOIRAN: As far as the government is concerned, there are no conflicts or inconsistencies with any provisions in the Medicines and Poisons Act or the Misuse of Drugs Act.

Hon STEPHEN DAWSON: No, we do not believe there are. We have sought to address those issues through express provisions in the bill and consequential amendments.

Hon NICK GOIRAN: It is interesting that even though the government cannot identify any provisions in which there is an inconsistency or a conflict, it is taking this measure to put it beyond doubt. Yet I seem to recall that in a dialogue that the minister had with Hon Charles Smith about an earlier clause today, he indicated that, to the extent that there is a conflict between this legislation and the Criminal Code, this legislation would prevail. If that is true, should we not include the Criminal Code in clause 13?

Hon STEPHEN DAWSON: No, we do not think it is necessary, because this legislation will prevail.

Hon NICK GOIRAN: That is a circuitous situation. If this act prevails, the logic that the minister has just given about the Criminal Code must surely follow for the Medicines and Poisons Act and the Misuse of Drugs Act. As far as I understand, the Criminal Code does not have some special status that makes it impeachable, and the Medicines and Poisons Act and the Misuse of Drugs Act do not have some kind of second-class status in the statutes of Western Australia. They are all the same. Hon Charles Smith has rightly identified a specific provision in which there is a conflict, and it has been acknowledged by the minister. The minister has indicated that this
Hon STEPHEN DAWSON: We rely on the common law principle that the latest statute prevails over the earlier when a provision is inconsistent. Either or both the Misuse of Drugs Act and the Medicines and Poisons Act could be amended to create an inconsistency in the future.

Hon Nick Goiran: Is it same with the Criminal Code?

Hon STEPHEN DAWSON: We do not believe that that inclusion is needed in the legislation before us.

Hon NICK GOIRAN: We will take a little longer on this then. We have to apply the same standard and principles with our statutes in Western Australia. Clause 13 is either necessary or unnecessary. The minister indicated to us that it is the government’s preference to have it in the legislation, yet he cannot identify a single clause, a single sentence or, dare I say it, a comma in the Medicines and Poisons Act 2014 or the Misuse of Drugs Act 1981. He cannot identify a single thing in those two acts, yet he wants us to agree to clause 13. When Hon Charles Smith brings to the minister’s attention that section 288 of the Criminal Code is in conflict and the minister agrees with him and says, “Don’t worry about it, member, because this act prevails”, and I say to him now, “Why don’t we include that?” he says that it is not necessary. That is illogical. Surely, if we are going to say, according to the minister, that clause 13 is necessary as a futureproofing mechanism, because—if I understand the minister’s answer correctly—his concern is that perhaps in the future, whether it be this Parliament or another, the Medicines and Poisons Act or the Misuse of Drugs Act might be changed and he wants to ensure that under no circumstances is anyone ever going to interpret that the latter amendment will prevail over this legislation, the same logic will apply with the Criminal Code. Can the minister explain to us why it is necessary for us to include the Medicines and Poisons Act and the Misuse of Drugs Act but not the Criminal Code?

Hon STEPHEN DAWSON: The Criminal Code makes it an offence to assist a suicide; this act before us says that it is not suicide. The Criminal Code does not regulate poisons, whereas the Misuse of Drugs Act and the Medicines and Poisons Act do. I have already said that we believe we have already found inconsistencies between those two acts, and we have sought to fix those by express provisions in this act or by consequential amendments to other acts. As I said earlier, should an issue arise in the future, or should the MDA and the MPA be amended to create an inconsistency, then this general provision will allow us to address that issue.

Hon NICK GOIRAN: I draw to the attention of the minister that clause 13 does not draw the Medicine and Poisons Act and at the Misuse of Drugs Act together; it looks at any inconsistency with this bill —

Hon Stephen Dawson: Sorry, if you thought I was drawing the two together, I wasn’t. I was saying any inconsistency between this and the others.

Hon NICK GOIRAN: I draw to the minister’s attention that, in part 11, six Western Australian statutes are sought to be amended. Why are only the fifth and the sixth included in clause 13, and not the first four?

Hon STEPHEN DAWSON: The others do not regulate poisons.

Hon NICK GOIRAN: Is the only reason that clause 13 is necessary a concern about poisons?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: What other Western Australian statutes engage poisons?

Hon STEPHEN DAWSON: My advisers are not aware of any other such statutes.

Hon NICK GOIRAN: That gives me great comfort, minister. Is there any other Western Australian statute with which there could be a conflict or an inconsistency with this piece of legislation before us?

Hon STEPHEN DAWSON: We do not know of any at all.

Clause put and passed.

Clause 14: When person can access voluntary assisted dying —

Hon NICK GOIRAN: I acknowledge that other members have amendments to clause 14 on the supplementary notice paper, but I have one theme I want to pursue with the minister at the moment. Section 6 of the Victorian Voluntary Assisted Dying Act 2017 is the equivalent to the clause before us. Section 6 of the Victorian legislation includes the requirement that a person is subject to a voluntary assisted dying permit. I draw members’ attention specifically to section 6(g) of the Victorian Voluntary Assisted Dying Act 2017. Why is it that the permit process has not been included in the Western Australian bill?

Hon STEPHEN DAWSON: In the WA context, the provisions in the Voluntary Assisted Dying Bill and the Medicines and Poisons Act 2014 provide appropriate mechanisms to ensure safe and appropriate prescription, supply and dispensing of the voluntary assisted dying substance. The permit system adopted in Victoria is
a bureaucratic layer that is based on its existing medicines regulation model and does not confer additional protection. 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 built into the Medicines and Poisons Act; thus, there is no need to replicate this in the bill. A permit system in the WA context does not materially add any further safety, but may cause delays to access for people. Furthermore, express authorisations are built into the bill, which further negates the need for a permit system like that in Victoria.

**Hon Nick Goiran:** Would not the Victorian safeguard of a permit ensure that there was confirmation that all the various criteria and elements of the process have been concluded to the satisfaction of the authoriser of the permit?

**Hon Stephen Dawson:** Is the honourable member asking about internal Victorian processes? Sorry, the member might have to ask his question again.

**Hon Nick Goiran:** I am not, minister; I am simply asking about the lack of a safeguard in the provision currently before us. We are considering clause 14. Clause 14 is largely replicated in section 6 of the Victorian legislation, but the one stark safeguard that is absent in our legislation is this notion of a permit. I note that section 6(g) of the Victorian legislation says that a person may access voluntary assisted dying if “the person is the subject of a voluntary assisted dying permit.” I am simply asking why that particular safeguard has not been included in the Western Australian legislation. If we were to include a new clause 14(h) that replicates the Victorian legislation saying that the person is the subject of a voluntary assisted dying permit, would that not be a superior safeguard, because at least then somebody—the certifier of the permit—would be able to say that everything else has been done?

**Hon Stephen Dawson:** As I have indicated, we do not believe that this is needed. In the Western Australian context, a permit system based on Victorian legislation would not materially add any further safety, but may cause people bureaucratic delays to access voluntary assisted dying. Furthermore, express authorisations are built into the bill that further negate the need for a permit system like that used in Victoria. It is expected that a system would be developed to ensure that only medical practitioners eligible to participate would have access to the system, and that they would have access to the prescription component of the system for an individual only once all requirements are completed, thus negating the requirement for arbitrary bureaucratic checking.

**Hon Charles Smith:** Can the minister confirm that, just then, he was answering why a person should not have first undertaken palliative care prior to their voluntary assisted dying journey?

**Hon Stephen Dawson:** Sorry, member, there is a bit of noise around. I did not hear what the member said.

**Hon Charles Smith:** Sure. In the answer that the minister just gave, was he explaining why a person should not first have undertaken palliative care before embarking on their VAD journey?

**Hon Stephen Dawson:** No; that is not what I said.

**Hon Charles Smith:** I would like to ask the minister to explain why the government’s position is that a person should not first have undertaken —

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**Point of Order**

**Hon Stephen Dawson:** We have not moved on to the member’s amendment. I am not talking about the amendment. I have not mentioned palliative care. I was answering particular questions from Hon Nick Goiran on the requirements under the Victorian legislation for a permit and the differences between the Victorian legislation and ours. Just to clarify: I have not mentioned palliative care or, indeed, the amendment that stands in the member’s name.

**The Deputy Chair (Hon Martin Aldridge):** Minister that is not a point of order. That is an explanation.

**Hon Stephen Dawson:** That’s the only opportunity I have got.

**The Deputy Chair:** You will get that opportunity when the member takes his seat and you get to respond to him.

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**Committee Resumed**

**Hon Charles Smith:** It was a new question. What are the government’s reasons why a person should not have first undertaken a mental health assessment or received palliative care before their VAD journey begins?

**Hon Stephen Dawson:** It is our view that it would be impinging on a person’s medical autonomy to require that a person should not first have undertaken palliative care.

**Hon Charles Smith:** I would now like to move amendment 31/14 standing in my name. I move —

Page 11, after line 10 — To insert —

(ba) the person has been assessed by a palliative care specialist who has advised the person about the palliative care and treatment options and other services available to the person to treat their pain symptoms and discomfort and address their physical, psychosocial and existential distress; and
This is another safeguard amendment from the Northern Territory model. In this case, it is section 7(3) and section 8 of the Rights of the Terminally Ill Act 1995. It focuses on palliative care requirements. The amendment requires that before a patient can access voluntary assisted dying, the patient must have received or at least have had the opportunity to have been informed and made an informed decision to refuse specialty palliative care treatments and services. It is associated with another new clause, 25B, and sits well with clause 4(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;  

Indeed, clause 4(1)(h) states —  

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;  

Minister Cook even stated in the other place, “Palliative care is the solution for nearly everyone”, in which case, it should be available to someone before they access voluntary assisted dying to hasten their death.  

Hon AARON STONEHOUSE: I am just considering the amendment moved by Hon Charles Smith. It is worth taking this in context as yesterday the chamber agreed to an amendment moved by the minister that when a patient raises the question of voluntary assisted dying, it would require medical practitioners to inform the patient of the palliative care and treatment options available to the person and the likely outcomes of that care and treatment. Under a later clause in the bill—I forget the number—there is a requirement that after a medical practitioner has assessed the eligibility of a patient, they must inform the patient of their palliative care options. This amendment would go a little bit further and instead put in place a requirement for a palliative care specialist to inform a patient of their treatment options. It sets a much higher standard rather than having a medical practitioner, who may not be that well versed in the available palliative care options, informing a patient of their palliative care options; it would require a palliative care specialist to inform a patient of their options. It is far more thorough in ensuring that patients are aware of their palliative care options. I am not sure yet if that is necessary, but I wanted to make sure that we are very clear about the higher standard of information that would be provided under the proposed amendment of Hon Charles Smith. In this case, it is a very high standard of information than what is currently required in the bill, even taking into account the amendments moved by the minister and agreed to yesterday.  

Hon STEPHEN DAWSON: Can I indicate that I am not supportive of this amendment. In fact, I will broaden my comments to a couple of amendments that stand in the name of Hon Charles Smith on the issue of palliative care specialists. There is a suite of amendments on that topic. We do not support these amendments. Firstly, whether a disease, illness or medical condition is causing suffering to the 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 on End of Life Choice and the Ministerial Expert Panel on Voluntary Assisted Dying formed the view that a patient’s suffering is an intensely personal experience and may take a variety of forms such as physical, mental, emotional, social, spiritual or existential. Secondly, the bill already requires that a person have a disease, illness or medical condition that is advanced, progressive and will cause death within the time frame of six to 12 months, on the balance of probabilities. Thirdly, it is not appropriate to require a person to exhaust all treatment options or be deemed ineligible because of options that the practitioner considers would reduce or remove their suffering. Every person is able to choose which treatment options they want to undertake. An adult patient of sound mind may refuse medical treatment even if that refusal will lead to their death. The bill does not require a patient to undergo treatment that will prolong the life or that might cure them, because to do so would cut across the fundamental principle of patient autonomy. It should be noted that the bill requires the assessing medical practitioners to provide the patient with a suite of information, including treatment and palliative care options.  

Hon NICK GOIRAN: I am supportive of this amendment. I am grateful to Hon Aaron Stonehouse. I think his explanation of the distinction in what is going on with this amendment is excellent. As I read it, this amendment absolutely lifts the standard of ensuring that a person cannot access voluntary assisted dying unless a palliative care specialist has assessed them. From my perspective, that is a very good thing. I take the point of the minister. Maybe a palliative care specialist assesses a person, the person gets some advice and then says, “Thanks, but no thanks.” But at least they have been informed. This amendment would ensure that we as legislators create an environment in which an expert in the field—in this instance, a palliative care specialist—can inform a person. I support this amendment to clause 14, moved by the honourable member. I think it will actually see a huge improvement in palliative care access statewide, but most especially in regional and remote Western Australia. I note there has been quite a bit of discussion about that. I also note that Hon Charles Smith, in prosecuting the case for his amendment, referred us to a couple of principles. We spent a bit of time debating the principles under clause 4. Hon Martin Aldridge moved an amendment that sought to say—I am paraphrasing—that every Western Australian should have equal access to voluntary assisted dying. I sought to amend that amendment to include palliative care. One of the reasons members gave for opposing my amendment to the amendment was the view that clause 4(1)(d) already captured it. Clause 4(1)(d) 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;  

Extracted from finalised Hansard
We have all agreed to that as a principle—that a Western Australian approaching the end of life should be provided with high-quality care and treatment, including palliative care. High quality, in that context, is from a palliative care specialist; it is not from somebody who has a rudimentary understanding of palliative care. That is not high quality; it has to be something higher than that. In this context, where the stakes could not be any higher, I passionately hold the view that Western Australians, if they are going to access this, need to be fully informed. I am particularly passionate about that in light of the response that was provided during the interrogation of clause 1. The government has said that it would guarantee access to voluntary assisted dying in regional Western Australia, even if it means flying up to eight people out to somebody in remote Western Australia, but it cannot provide that guarantee with regard to palliative care. That still troubles me. I think this amendment will go some way towards addressing that. For members from regional areas who might be concerned about access, I note that Hon Charles Smith has not said that the assessment has to be in person. Unlike voluntary assisted dying, which cannot happen via telehealth because that would breach commonwealth law, Hon Charles Smith’s palliative care specialist assessment could be done by telehealth. Would it not be a good thing for a Western Australian to have that sort of information before making a final decision? This amendment has my support.

Hon AARON STONEHOUSE: When reading this amendment on its own, I see a problem in that there is a requirement for someone to be assessed by a palliative care specialist, but it does not provide for a process. We have to really read this along with new clause 25B, which the mover of this amendment has on the supplementary notice paper. When we get to clause 25 we will have to discuss the operation of new clause 25B and how it might work. There is a process there for the assessment, which I will not go into. The minister raised the question of patient autonomy, which is an important issue.

Progress reported and leave granted to sit again, pursuant to standing orders.
Hon Rick Mazza: My amendment at 415/14 is a consequential amendment and can stay on supplementary notice paper, issue 9, for now.

The Chair: I note the intention for amendment 415/14 to remain on the supplementary notice paper for future consideration but not to be contemplated now.

Clause put and passed.

 Clause 15: Eligibility criteria —

Hon Nick Goiran: How is clause 15 consistent with the principle set out in clause 4(1)(b)?

Hon Stephen Dawson: A person will have autonomy to choose voluntary assisted dying but, of course, this will not be an absolute right for everyone. They must still meet the clause 15 requirements.

Hon Nick Goiran: That is quite telling, minister, because in the multitude of emails that I have received—I am sure that other members will have received a multitude of emails on this as well—it strikes me that a significant number of Western Australians do not yet understand that the bill before us will not apply to them and that they will not be eligible to access this scheme, notwithstanding the mantra that has accompanied this bill, including in the title of the Joint Select Committee on End of Life Choices report, “My Life, My Choice”. Do I understand, minister, that clause 15 will restrict Western Australians’ autonomy with regard to end-of-life choices?

Hon Stephen Dawson: It necessarily restricts access to those who meet the eligibility criteria under this bill. There will be an 18-month implementation period and that will build in proper implementation of the criteria of the bill.

Hon Nick Goiran: Why has the balance of probabilities test been adopted in this bill while the Victorian act requires the highest standard of assessment, under section 9(1)(d)(iii), that the disease, illness or condition “is expected to cause death within weeks or months, not exceeding 6 months”?

Hon Stephen Dawson: The probabilities test has been agreed to by the ministerial panel, including the medical experts on the panel. This concept is easily understood and has case law to support it. It provides the greatest clarity and most utility. Clinicians use this concept and the language rather than considering it as a test. For example, when considering possible diagnoses, a clinician may consider one diagnosis more probable than another on the basis of presenting symptoms and clinical test results et cetera. With regard to the usage in the context of the bill, a clinician would be familiar enough with the concept of balance of probabilities, or more probable than not, to be able to apply it to the question at hand when possible to do so.

Hon Nick Goiran: Is it the case that the test that is being applied here under the Western Australian legislation is at a lower level than that applied under the Victorian legislation?

Hon Stephen Dawson: No.

Hon Nick Goiran: How does the minister explain the difference between the Western Australian test and the Victorian test?

Hon Stephen Dawson: We believe the WA test is appropriate for Western Australia. In Victoria, “expected to cause death” approximates more than 50 per cent. “Balance of probabilities” is clearer language. We wanted to use language that medical practitioners in Western Australia are used to.

Hon Nick Goiran: Is the test, in effect, the same between the Western Australian legislation and the Victorian legislation and the only difference is the choice of language?

Hon Stephen Dawson: I can answer it this way: we do not believe we are lowering the standard.

Hon Nick Goiran: The minister in the other place said on 5 September, at page 6606 of Hansard —

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.

How does the balance of probabilities test provide greater clarity and utility than other tests relating to a patient’s prognosis, including the reasonably foreseeable test?

Hon Stephen Dawson: I think I have answered that question already when I said that we are using language that medical practitioners are familiar with. When I provided an answer earlier about the balance of probabilities, I said that in regard to the usage and the context of the bill, a clinician would be familiar enough with the concept of balance of probabilities to be able to apply it to the question at hand when possible to do so.

Hon Nick Goiran: I have not asked that question this afternoon. I have not mentioned reasonably foreseeable until this latest question, so the suggestion that the minister has somehow answered it previously is incorrect.

Hon Stephen Dawson: I have provided the answer previously.
Hon NICK GOIRAN: The minister provided an answer about the difference between the Western Australian legislation and the Victorian legislation. I remind the minister that the Victorian legislation uses the phrase, and the test is “expected to cause death”, which is different from the test of reasonable foreseeability and is different again from the Western Australian legislation. I refute any suggestion that I have already asked this question this afternoon. Hansard will accurately record exactly what has transpired. At no stage has there been any discussion until this last question about reasonable foreseeability. Can somebody with a 49 per cent chance of surviving more than six months be eligible to access voluntary assisted dying under this bill?

Hon STEPHEN DAWSON: I ask the member to ask his question again, please.

Hon NICK GOIRAN: Can someone with a 49 per cent chance of surviving more than six months be eligible to access voluntary assisted dying under this bill?

Hon STEPHEN DAWSON: If a person meets the six-month criterion in clause 15(1)(c) of the bill, they may be eligible if they meet all the other criteria; if not, no.

Hon NICK GOIRAN: The six-month criterion the minister referred to is at clause 15(1)(c)(ii). Would a person who has been determined as having only a 49 per cent chance of surviving more than six months meet the six-month test the minister has referred to?

Hon STEPHEN DAWSON: Doctors have to ask whether it is more probable than not that the patient will die within the requisite period. The language of medical practitioners is the balance of probability, not discrete increments of percentages—hence the language that is used in the bill.

Hon NICK GOIRAN: I move —

Page 12, after line 3 — To insert —

(i) is ordinarily resident in Western Australia; and

This amendment is the same as that moved by the member for Girrawheen in the other place on 5 September 2019, and would bring the Western Australian bill up to the standard of the Victorian legislation—specifically, section 9(1)(b) of the Victorian Voluntary Assisted Dying Act. The Victorian act contains a twofold residency test; that is, the person must ordinarily be resident in Victoria and, at the time of making their first request, must have been resident in Victoria for at least 12 months. As the Western Australian bill is currently worded, it requires only that the person must have been resident in Western Australia for 12 months at the time of making the first request. This amendment would discourage people living in states and territories where voluntary assisted dying has not been legalised from moving to Western Australia after having been diagnosed with a terminal illness, disease or condition for the express purpose of accessing voluntary assisted dying in the state. This is sometimes referred to as assisted dying tourism.

I note that the Northern Territory’s Rights of the Terminally Ill Act 1995 did not contain a residence requirement and, as such, people travelled to the territory from other Australian states to request assistance to voluntary terminate life, as it was described in that act. Members may be familiar with the publication in a peer-reviewed journal titled “Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia”. That article detailed the cases of seven patients who made formal use of the Rights of the Terminally Ill Act 1995. Two of those patients sought euthanasia but died before the act became law, four died under the act, and one died after the repeal of the act. I specifically want to draw members’ attention to case 1 in that study. Case 1 involved a 68-year-old woman who was not ordinarily resident in the Northern Territory, but who travelled there to seek euthanasia some months before the Rights of the Terminally Ill Act passed. The patient was diagnosed with a carcinoma of the caecum and, despite labelling herself as terminally ill, Dr Philip Nitschke understood her to know that there was potential for surgery to be curative and that her prognosis was good. It should be noted that although this patient moved to the Northern Territory to access voluntary assisted dying under the Rights of the Terminally Ill Act, this patient’s death was not brought about by voluntary euthanasia under the act. This particular person suicided in Darwin in September 1995, only weeks after an interview on national television in which she stated that she would suicide if the regulations necessary for the operation of the RTI act were not soon made law.

The other case out of the seven that I want to draw to members’ attention is case 6. Case 6 involved a woman who flew to Darwin from another part of Australia accompanied by her children. The patient in case 6 had advanced metastatic carcinoma of the breast. She had discussed euthanasia with her children, who agreed and organised her flight to Darwin. A week after arriving in Darwin, the patient in case 6 underwent euthanasia. Case 6 would be excluded under clause 15(1)(b)(ii) of the bill before us, because the patient was in the Northern Territory for only one week rather than one year. This case still serves to indicate that people are willing to travel interstate to access voluntary assisted dying where it is legally available. The fact that the Victorian act expressly requires the patient to have been ordinarily resident in Victoria makes the Western Australian regime a more liberal one, and more likely to attract people moving interstate to access voluntary assisted dying when diagnosed with a terminal illness. It is for those reasons that I have decided to move the amendment in the precise same language and words as moved by the member for Girrawheen in the other place.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: The government does not support this amendment. The proposed addition does not materially add to the clause, as the clause already contains the requirement for ordinary residence of 12 months. The residency requirement under section 15(1)(b) of the bill requires —

the person —

(i) is an Australian citizen or permanent resident; and

(ii) at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;

The types of things that may be considered when determining ordinary residence is the person’s physical presence with a degree of continuity, routine or habit; their social and living arrangements; and the maintenance and location of their assets et cetera. The Victorian act includes an additional limb in its residency requirement that the person be ordinarily resident in Victoria. This addition is not included in the WA bill as it is legislatively redundant; that is, to say that a person must be ordinarily resident and ordinarily resident for 12 months is essentially repeating the same requirement twice, because the test of ordinary residence necessitates that a time frame be built into it, specified or unspecified. For example, the Australian Taxation Office has a test of ordinary residence whereby the time frame is not specified. Nonetheless, the ATO generally accepts a time frame of six months for a person to be deemed ordinarily resident in Victoria, based on criteria I referred to previously. The test of ordinary residence differs across Australia dependent on the assessing party. To be clear, the WA bill specifies that at the time of making a first request, the person must have been ordinarily resident in WA for at least 12 months. The WA bill is not more liberal.

Hon NICK GOIRAN: Why was the period of 12 months selected?

Hon STEPHEN DAWSON: Recommendation 3 in the Ministerial Expert Panel on Voluntary Assisted Dying’s final report states —

For access to voluntary assisted dying, the person must have been ordinarily resident in Western Australia for 12 months at the time of making the first request.

That recommendation was considered. We felt it was an appropriate time period and included 12 months in the bill before us.

Hon RICK MAZZA: With all due respect to the mover of the amendment, I am struggling to find some relevance in the amendment before us about ordinary residence in WA. To me, 12 months is a fairly long time. My understanding of this legislation is that someone’s death will be imminent and if they need to be a resident here for 12 months, that is quite a considerable time. I do not think that there is any point in a person who is diagnosed with a terminal illness, who might have six months to live, moving to Western Australia if they have to wait 12 months to access voluntary assisted dying. If the mover of the amendment had also included deleting subclause (1)(b)(ii) and left “ordinarily resident in Western Australia” to some other definition, I could kind of understand it, but at the moment I am struggling somewhat to understand the relevance of this amendment.

The other issue is that someone could genuinely move to Western Australia and, after being here for three months, find that they have a terminal disease and are given only three to six months to live. At the moment, they would not be eligible; under this legislation, they would not be able to access VAD. With that, unless there is a plausible explanation for including this amendment, I am struggling with why I would support it.

Hon NICK GOIRAN: I indicate to Hon Rick Mazza that I find his comments to be fair and reasonable. I am committed to making sure that this house has an opportunity to consider all the amendments that were moved in the other place. We all know that the government’s attitude at that time was that no amendments be considered under any circumstance. Things have evolved; things have changed since then—for the better, I might add—and it is appropriate that this chamber also has the opportunity to consider all those amendments, including this one, of which the genesis was the member for Girrawheen.

Hon ADELE FARINA: Could the minister explain to me what sort of evidence the doctor would need to rely on to establish that the criteria in 15(1)(b) is satisfied?

Hon STEPHEN DAWSON: I believe I have provided this information previously, but I am happy to provide it again. The patient may demonstrate this with a range of documents such as a driver’s licence, rental or property agreement, employment records and registration to vote. They are some of the ways to do it.

Amendment put and negatived.

Hon MARTIN ALDRIDGE: Recommendation 3 of the ministerial expert panel’s final report is that in exceptional circumstances there should be a provision for application to the State Administrative Tribunal for relief on compassionate grounds from the strict requirement of residency for 12 months. I think that is what Hon Rick Mazza just went to with his hypothetical scenario of somebody who has legitimately moved to Western Australia, is three months into their residency in this state and for all other reasons would be eligible but for the fact that they had

Extracted from finalised Hansard
not been ordinarily resident in WA for 12 months. On that basis, and in my view, I think that the ministerial expert panel’s recommendation that a person can make an application to the SAT on compassionate grounds is reasonable. Why is it that the government has not accepted the ministerial expert panel’s recommendation in this regard?

Hon STEPHEN DAWSON: That recommendation was considered. The government felt that this was a liberal approach, and we respectfully declined that approach.

Hon MARTIN ALDRIDGE: I was hoping for a bit more thorough response, given the amount of advice the minister just took. I find it difficult to understand the government’s acceptance of its current position but not that of the ministerial expert panel. That could ultimately expose Western Australians to suffering—which is what we are trying to avoid through the passage of this legislation—because of the mere fact that they have not been ordinarily resident for 12 months, notwithstanding that they have legitimately lived here and have not moved here, as other members have outlined, simply to access the regime. Because they do not tick this box that requires residency for 12 months, there is no other option available to them. I do not understand the government’s opposition to allowing a Western Australian to apply to the State Administrative Tribunal to put a case for the exceptional circumstances that apply to them. It seems odd to me that the government would not accept this recommendation. I was hopeful the minister may have perhaps identified some practical implications. Obviously, one of those might be that the process of making an application to the State Administrative Tribunal is probably not an easy process to undertake, given the circumstances facing the person. However, if that is the only option the person has, they could weigh up the risks and the benefits of pursuing that course of action. The government has not accepted this recommendation from the ministerial expert panel. It is not clear to me why; I think that the panel’s recommendation is sound.

Hon STEPHEN DAWSON: I am not sure that the honourable member was looking for an answer. Again, I say the bill has necessary restrictions on limitations. Where we have landed with the bill is an area that we thought was appropriate. I take the member’s point of view on board, but that was not the reason for landing where we have.

Hon NICK GOIRAN: I move —

Page 12, line 9 — To insert after “progressive” —

and incurable

The CHAIR: I will mention that a new supplementary notice paper has arrived, with the regularity with which they have been arriving during the course of this debate. This is issue 10. We note one omission, but that will not affect us now and will be reinstated.

Hon NICK GOIRAN: For the sake of clarity, members, I seek to include here a provision that the disease needs to be incurable. This amendment is the same as the one moved by the member for Girrawheen in the other place on 5 September this year. Section 9(1)(d)(i) of the Victorian legislation requires that the patient’s disease, illness or condition be incurable in order for them to qualify for access to voluntary assisted dying. On 5 September in the other place, at page 6602 of Hansard, the member for Cottesloe noted —

… there are a range of absolutely treatable medical conditions that if left untreated, will result in death.

The member for Girrawheen in the other place offered the example of a person suffering from gangrene. In this example the person is told that if they do not have their leg amputated, they will die from the infection, but if they undergo the amputation, their life will be saved. On 5 September 2019, the Minister for Health responded to this scenario —

… 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-emasculation, 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.

In the words of the Minister for Health, it is unlikely that someone will choose death in situations in which they could have a higher quality of life. I think it is pertinent that the minister said it is “unlikely”; of course, that means it is possible under this bill, as it is currently drafted. My amendment, the genesis of which was the member for Girrawheen’s amendment in the other place, seeks to provide clarity for assessing practitioners while making it clear that it was the intention of this Parliament in drafting this law that voluntary assisted dying would not be available to people with lifelong medical conditions who, upon ceasing their medications, become terminally ill.

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Another medical condition that can be terminal if left untreated is diabetes. A patient with type 1 diabetes who ceases taking their insulin will become terminally ill. If it is left untreated, it can lead to diabetic coma and death. We know from the Oregon Health Authority’s 2018 annual report that 11 people with diabetes ended their lives through the voluntary self-administration of a lethal dose of medications expressly prescribed by a physician for that purpose under that state’s Death with Dignity Act; that is, diabetes is listed as the underlying illness that resulted in these 11 people ending their lives under the Death with Dignity Act. I hope members would agree with me that it is not the intention of this place for Western Australians living with chronic conditions, the symptoms of which are managed by medical treatment, to access voluntary assisted dying by ceasing their medical treatment and entering the terminal phase of their disease, illness or condition. It is for those reasons that I have moved this amendment, in the same words as the amendment moved by the member for Girrawheen on 5 September this year.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of this amendment. The term “incurable” has not been used, as it is largely a reiteration of the existing criteria. It would also unfairly exclude those for whom there is the right to refuse a treatment that may cause intolerable suffering or other adverse outcomes. The Victorian act requires that, in addition to the diagnosis criteria, the patient must also be diagnosed with a disease, illness or medical condition that is incurable. The exclusion of the requirement for a patient to have an incurable condition, illness or disease reflects the view of the Ministerial Expert Panel on Voluntary Assisted Dying. This criterion has not been included in the Western Australian bill for two reasons. Firstly, the WA bill already requires that the person has a disease, illness or medical condition that is advanced, progressive and will cause death within a time frame of six or 12 months, on the balance of probabilities. Secondly, 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 as a result of which the person would significantly compromise or lose 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 will lead to their 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.

Hon MICHAEL MISCHIN: That response surprises me because we are told that this is implicit in other criteria in the legislation. I would like that to be pointed out to me. I also refer to the second reading speech, and get back to what is and is not suicide. In introducing the bill, the minister stated —

> 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.

Now we are being told that that is going to be far too restrictive, so I would like to have that explained.

Hon STEPHEN DAWSON: The notion of incurability is implicit in clause 15, which refers to the illness being advanced and progressive and that it will, on the balance of probabilities, cause death. If we were to include “incurable”, as Hon Nick Goiran is seeking to do through his amendment, then, for example, should there be some sort of treatment available in some far-flung place around the world, this amendment could lead to the patient needing to travel overseas at great expense and difficulty, and potentially while very ill, to access the treatment. The bill does not require that the condition be incurable. What was meant in the second reading speech is that the patient has a terminal condition. I would not wish to say that a patient “must” get medical treatment.

Hon MICHAEL MISCHIN: So the government’s endorsement last week of the second reading speech, after I asked whether the government stood by it, remains, but we are not to read the second reading speech literally. Never mind about a patient who has to travel to the wilds of Tibet in order to obtain a cure for a condition; let us say there is one just around the corner. I have a disease, illness or medical condition that is advanced, progressive and will, on the balance of probabilities, cause death within six months. I am suffering discomfort or pain to the point at which I think it is intolerable. If I avail myself of treatment by going over to an appropriate specialist, I could be cured of the condition, but I just do not want to because I have gone to a doctor who specialises in my illness and has informed me that the option of voluntary assisted dying is available, and all my problems will be over. I will not have to suffer discomfort, pain and other inconveniences. Are we not throwing the net much wider than even the second reading speech policy contemplated and urged us to accept as one of the narrow confines within which this particular remedy would be available to patients? It seems to me that the amendment that has been suggested is entirely consistent with the policy of the bill as articulated by the government in the other place, and in here. Forget about my having to go halfway around the world—what if I am in the position that I have simply outlined and I say, “I’m just not interested in getting treatment”?

Hon STEPHEN DAWSON: It is always a question for the patient. It is unlikely that a patient who has access to an easy treatment that will not harm them will decide not to take it. As I have said previously, 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 will lead to their death.

Extracted from finalised Hansard
Hon MICHAEL MISCHIN: So voluntary assisted dying is now a treatment option? Is the minister saying that we should not make it too restrictive; that is, rather than having a state-sanctioned means of terminating someone’s life in restricted and narrow circumstances, cases of extreme suffering, with no prospect of living a life of any sort of quality, we are now throwing it open to a treatment option that the patient can accept or refuse, and then go to a doctor, tick the criteria, and have a state-sanctioned death, either by self-termination or through the agency of a medical practitioner? Is that what we have got to?

Hon STEPHEN DAWSON: No. Voluntary assisted dying is an option. It is not a medical treatment. I am saying that accessing voluntary assisted dying is not contingent on a patient first getting treatment.

Hon NICK GOIRAN: Is it the government’s intention that a patient with type 1 diabetes who does not take their medication should have access to voluntary assisted dying?

Hon STEPHEN DAWSON: It is not for the government to speculate about a decision that a medical practitioner might make in the future. There will be an independent assessment on a case-by-case basis as per the eligibility criteria. Each individual is able to exercise their right to accept or to refuse medical treatment. This is self-autonomy.

Hon NICK GOIRAN: If a Western Australian breaks their arm and goes to see a medical practitioner, a lack of treatment as a result of that will not lead to the death of the person. A person will not become terminally ill because they break their arm. So when the minister says that he will not speculate, I think that, as serious lawmakers, we can speculate and come to the conclusion that a Western Australian who breaks their arm will not be able to access voluntary assisted dying, because a broken arm will not qualify as an advanced progressive condition that will cause their death. I want to contrast the broken arm scenario with a Western Australian with type 1 diabetes who ceases to take their insulin. On the expert advice that has been provided to me, I am told that that person would become terminally ill, because they would develop diabetic ketoacidosis, which, left untreated, would lead to diabetic coma and death. It troubles me that we are opening the door for that scenario. I would like confirmation from the government that that is not its intention—it does not want to see Western Australians with type 1 diabetes cease to take their insulin and access this as an option.

Hon STEPHEN DAWSON: Of course we do not want to see people with type 1 diabetes accessing voluntary assisted dying. One would hope that such a person would access available medical treatments. I again say that I do not want to speculate about a decision that a medical practitioner might make in the future, because this will be an independent assessment on a case-by-case basis, as per the eligibility criteria in the bill.

Hon MICHAEL MISCHIN: I am exploring this rather than having had the opportunity to think it through, but perhaps rather than “incurable” in the second reading speech, what was meant in the speech was “not treatable with any reasonable prospect of cure or improvement” or “not being reasonably treatable with a prospect of cure or improvement” or some formulation to that effect. Is that what the government was driving at by saying “incurable”? If that is the case, it seems to me that an appropriately crafted amendment might fix some of the difficulties we have identified.

Hon STEPHEN DAWSON: I think the government’s intention is clear in the clauses of the bill, as set out before us. Honourable member, with the greatest respect, I am not going to go back to the second reading speech—the time to question that has passed. We are dealing with the amendment moved by Hon Nick Goiran at clause 15. I have indicated that we are not supportive of the amendment.

Hon NICK GOIRAN: Is it the minister’s intention to correct the statement that he made in the second reading speech, when he said —

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.

Does the minister intend to correct the record or leave it in that state?

Hon STEPHEN DAWSON: I am happy to state now that what I meant in the second reading speech was that it is terminal. That was my intention, and I make that clear to the house.

Hon MARTIN PRITCHARD: I do not want to participate too much in the debate, but treating type 1 diabetes does not actually cure it; it treats it and keeps it managed. It is a bit of a misleading point.

Hon NICK GOIRAN: I will just wrap up on this point. Member, is that not the point, that a person with diabetes can take insulin? I understand that the member is saying that there is perhaps a distinction. I think that is what Hon Michael Mischin was referring to—whether we are talking about something being untreatable or incurable. I think the point the member made is a good one. In that sense, diabetes is not able to be cured but it is able to be treated, and it is not treatable that people would describe as futile. It is a principle in common law, if not in statutory law in Western Australia—I would have to check—that a person has the right to refuse medical treatment. I am pretty sure that doctors have a statutory right—they certainly have the right at common law—to refuse to provide futile medical treatment. The government said, in its own second reading speech, that this bill is supposed to deal with incurable situations. It is no wonder the member for Girrawheen in the other place moved an amendment relating to circumstances in which that exact language is used in the Victorian legislation. For the government to say now, at the eleventh hour, that it did not really mean “incurable” is not a particularly satisfying response.

Extracted from finalised Hansard
Hon CHARLES SMITH: I draw the minister’s attention to subclause (1)(e). Short of someone saying it explicitly, how would coercion realistically be detected under this bill?

The DEPUTY CHAIR: Member, we are dealing with the matter before us at the moment, which is the amendment moved by Hon Nick Goiran. We will deal with that and then we will move on. The question is that the words to be inserted be inserted.

Division

Amendment put and a division taken, the Deputy Chair (Hon Robin Chapple) casting his vote with the noes, with the following result —

Ayes (11)
Hon Peter Collier  Hon Nick Goiran  Hon Simon O’Brien  Hon Colin Tincknell
Hon Donna Faragher  Hon Rick Mazza  Hon Robin Scott  Hon Charles Smith
Hon Adele Farina  Hon Michael Mischin

Noes (22)
Hon Martin Aldridge  Hon Stephen Dawson  Hon Alannah MacTiernan  Hon Dr Sally Talbot
Hon Jacqui Boydell  Hon Colin de Grussa  Hon Kyle McGinn  Hon Darren West
Hon Robin Chapple  Hon Sue Ellery  Hon Martin Pritchard  Hon Alison Xamon
Hon Jim Chown  Hon Diane Evers  Hon Samantha Rowe  Hon Pierre Yang (Teller)
Hon Tim Clifford  Hon Laurie Graham  Hon Aaron Stonehouse
Hon Alanna Clohesy  Hon Colin Holt  Hon Matthew Swinbourn

Amendment thus negatived.

Hon ADELE FARINA: I would like some clarification on this clause and, in particular, subclause (1)(c), which refers to —

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;

My understanding is that the person needs to be assessed as meeting the eligibility criteria at the time of making the request to access voluntary assisted dying. In the debate on this issue of the eligibility criteria, a number of people have indicated that, under this legislation, it is quite appropriate for people to obtain access to voluntary assisted dying before their suffering is intolerable on the basis that they will then be able to administer the drug at the point at which the suffering becomes intolerable. I would like some clarification, because my reading of this provision is that the suffering needs to be such that it cannot be relieved in a manner that the person considers tolerable at the time that the request is made and the assessment is made in order to meet the eligibility criteria. If the suffering is tolerable at that time, the person does not meet the eligibility criteria. I would like some clarification on that.

Hon STEPHEN DAWSON: When the person is assessed, they must meet all the eligibility criteria, including clause 15(1)(c)(iii).

Hon ADELE FARINA: Just to put that beyond doubt, at the time that someone makes the first request to seek access to voluntary assisted dying and they are assessed, the suffering that they are experiencing must be of the nature that the person considers intolerable.

Hon STEPHEN DAWSON: That is correct. It is when they are assessed. It is not at first request, but when they are assessed.

Hon ADELE FARINA: I now go to clause 15(1)(f), which requires that “the person’s request for access to voluntary assisted dying is enduring”. I do not know how the practitioner can assess whether that eligibility criterion is met on the first assessment, because the first assessment will follow the first request. It will be the first time a person has requested access to voluntary assisted dying. I do not know the basis on which we would assess whether that request is enduring. It seems to me that if that criterion were left in the eligibility criteria for the first assessment, every assessment would have to fail because there would be no way to establish that the person’s request for access to voluntary assisted dying is enduring.

Hon STEPHEN DAWSON: Endurance is demonstrated from the time of the first request. After that, endurance is assessed at several stages. The enduring nature of the request must be considered and demonstrated repeatedly throughout the process—that is, at the first request, at the written declaration, at the final request, at the final review, at the time of the administration decision, at the time of dispensing and at the time of administration if it is practitioner administered.

Extracted from finalised Hansard
Hon ADELE FARINA: I turn the minister’s attention to clause 23, which reads —

(1) The coordinating practitioner for a patient must assess whether the patient is eligible for access to voluntary assisted dying.

(2) For the purposes of subsection (1), the coordinating practitioner must make a decision in respect of each of the eligibility criteria.

On the first assessment, the coordinating practitioner needs to make a decision on the person’s request for access to voluntary assisted dying being enduring. Could the minister explain to me how the coordinating practitioner makes that assessment and decides that the eligibility criteria have been met on the first assessment?

Hon STEPHEN DAWSON: Endurance is assessed between the time of the first request and when the actual first assessment takes place; so this may be some time later.

Hon ADELE FARINA: It is also possible, is it not, for the assessment to be made at the same time that the request is made? The request needs to be made in a consultation, so there is no reason why that assessment could not be made during the course of that consultation, when that request is first made.

Hon STEPHEN DAWSON: As part of the assessment, the medical practitioner will be exploring the reasons why the patient wants to access voluntary assisted dying. If the medical practitioner has questions about the enduring nature of the request, they could make a finding that the patient is ineligible or does not meet the eligibility criteria.

Hon ADELE FARINA: With all due respect, I do not think the minister really answered my question. The question I asked was: how does a medical practitioner make an assessment on the first assessment that the eligibility criteria in clause 15(1)(f) has been met? The patient may have just received their diagnosis and prognosis and may be discussing treatment options, and the patient may say, “I want to put in a request now for voluntary assisted dying.” How does the doctor in those circumstances make a decision about whether the person’s request to access voluntary assisted dying is enduring? On any reasonable assessment of this, that criteria cannot be met on the first assessment. Keeping it in the eligibility criteria for the first assessment is currently creating a fundamental problem with this bill. It suggests that the eligibility criteria have no value at all because the criteria at paragraph (f) cannot be met on the first assessment, yet it is required under this bill that the medical practitioner be satisfied that it has been met. I would like an explanation about how the medical practitioner makes an assessment on the first assessment that the person has met the eligibility criteria that their access to voluntary assisted dying is enduring.

Hon STEPHEN DAWSON: The medical practitioner would use multiple ways to support a decision about a criterion—for example, discussion with the patient about their medical history and social history, and their perspectives on voluntary assisted dying. They would know when the diagnosis had been made, and clearly, if it was a while ago, the patient has had time to consider. If, at that very moment, they have not, the medical practitioner may determine that it is not enduring. In all scenarios the eligibility can be assessed. There may be a case, such as that described by Hon Adele Farina, in which a patient has just been diagnosed and then makes the first request, and then the first assessment takes place. Then the medical practitioner may say that the patient does not meet clause 15(1)(f). As such, at this stage, the patient may not meet the criterion at clause 15(1)(f).

Hon CHARLES SMITH: Clause 15(1)(e) states that a person must be acting voluntarily and without coercion. In the second reading speech, the minister referred to numerous inquiries, both internationally and in Australia. Is he in a position to table any of those inquiries?

Hon STEPHEN DAWSON: General practitioners are well placed to identify patients at risk of experiencing elder abuse. There are clinical screening tools suitable for use with older people that can be readily incorporated into assessment procedures, and this would form part of the mandatory training. The assessing medical practitioners will be required to assess whether a patient is acting voluntarily and without coercion. Furthermore, 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 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 to undergo voluntary assisted dying. The bill makes it a crime to unduly influence a patient in such a manner.

Hon NICK GOIRAN: I have some concern about the line Hon Charles Smith has brought to our attention—that is, the criterion in clause 15(1)(e), which states that a person is acting voluntarily and without coercion. In the minister’s second reading speech on 26 September, he stated —

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 that the vulnerable are being coerced into accessing voluntary assisted dying.

That being the case, why was it deemed appropriate to include the eligibility criterion in clause 15(1)(e)?

Hon STEPHEN DAWSON: It has been included to be clear that a patient must be free of coercion and must be acting voluntarily. It is a fundamental concept for voluntary assisted dying.

Hon NICK GOIRAN: In the second reading speech, the minister referred to numerous inquiries, both internationally and in Australia. Is he in a position to table any of those inquiries?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: I am not in a position to table information about those inquiries now. I am happy to take the question on notice, seek further information and hopefully provide it to the chamber at a later stage. Certainly, my advisers tell me that evidence from 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 of a person accessing voluntary assisted dying was typically someone with comparative social, economic, educational and professional advantage.

Hon NICK GOIRAN: It is very interesting that the minister should refer to Oregon. I draw to his attention the “Oregon Death with Dignity Act: 2018 Data Summary”, which indicates that burden on family, friends and caregivers was cited by more than half of the patients who died from ingesting a lethal dose of medication in Oregon in 2018. I look forward to the minister tabling those inquiries, which will substantiate the claim made in the second reading speech that there have been numerous inquiries, both internationally and in Australia, that have considered the issue of coercion and concluded that there is no evidence that the vulnerable have been coerced into accessing voluntary assisted dying. I particularly look forward to those inquiries being tabled, and the highlighting of the parts of the inquiries where the issue of coercion has been considered, and where the conclusion is drawn in those inquiries that there is no evidence. I look forward to that being tabled. While we are talking about matters that are to be tabled, the minister might recall that last week we discussed a document that might get tabled. Would this be a convenient time to deal with that issue?

Hon STEPHEN DAWSON: Although it is not related to clause 15, I did indicate to the honourable member last week that I would provide some further information about obligations on registered practitioners and penalties for contravention of the bill, so I am happy to table that document now.

[See paper 3435.]

Hon NICK GOIRAN: I am concerned about the eligibility criterion at clause 15(1)(e), which states that the person must be acting voluntarily and without coercion. I move —

Page 12, line 21 — To delete “without coercion;” and substitute —
not as a result of abuse, coercion, duress or undue influence;

The DEPUTY CHAIR (Hon Dr Steve Thomas): Do we have a written version of that? Honourable members, we are dealing with clause 15 and you should have before you the following amendment moved by Hon Nick Goiran —

Page 12, line 21 — To delete “without coercion;” and substitute —
not as a result of abuse, coercion, duress or undue influence;

The amended proposed subsection (e) would read —

the person is acting voluntarily and not as a result of abuse, coercion, duress or undue influence;

Hon NICK GOIRAN: This amendment strengthens the principle of voluntariness, which underpins the entire Voluntary Assisted Dying Bill. Members will note that a person’s request for access to voluntary assisted dying should not be impacted or influenced by coercion, as clause 15(1)(e) currently states. However, I trust that members would also agree with me that a person’s request should not be impacted or influenced by any abuse, duress or undue influence. The inclusion of these terms in this clause serves only to strengthen the protections afforded to patients by this bill. It is not onerous and it is not complicated, nor does it radically change the operation of the bill. When assessing the eligibility of a person to access voluntary assisted dying, a coordinating and consulting practitioner should have regard to more than just the absence of coercion. I note that the inclusion of “abuse” is consistent with the use of the term “abuse” in clauses 4(1)(i) and 158(c) and the inclusion of the term “undue influence” is consistent with the use of that term in clauses 99(2) and 100.

Hon STEPHEN DAWSON: The government is not supportive of the amendment standing in the name of Hon Nick Goiran. The current wording makes it clear that the consideration is in relation to the person’s action at the time of the assessment. We previously debated clause 4, “Principles”, for which similar words were sought to be included. I outlined at that stage significant reasons why we did not support the changes. Essentially, we do not wish to add unduly technical legalistic words that do not advance the broad effect of the provision as currently drafted, so we are not in support of it.

Hon NICK GOIRAN: The minister says it is unduly legalistic and technical, yet his own bill at clauses 99(2) and 100 use the words “undue influence”. I do not see any amendment in the minister’s name on the supplementary notice paper to indicate he is intending to delete those words from clauses 99 or 100. It seems to me that if it is good enough to use the phrase “undue influence” in clauses 99 and 100, it is good enough to use it in clause 15, given its significance, whereby we are saying to medical practitioners that we want them to assess a person against each and every one of the criteria. I draw to the minister’s attention that in clause 4, “Principles”, the chamber agreed—my recollection is that he agreed—to an amendment moved by Hon Martin Pritchard to include “coercion with abuse”, so the terms are consistent with the language used in the bill and I seek the support of members accordingly.

Extracted from finalised Hansard
Hon AARON STONEHOUSE: Just so that I have a clear understanding of what is sought to be changed, can the minister point me to what definition of “coercion” is being used for the purpose of this clause? A common understanding of coercion is the actual use of violence or the threat of violence to influence someone’s decision. Is there a different definition used here that we can refer to in the Criminal Code or some other statute?

Hon STEPHEN DAWSON: First of all, clauses 99 and 100 are offence provisions. As I have previously indicated, “undue influence” is legalistic terminology that is reflected in the offence provisions of the bill. It is a legal term that is understood by the legal profession; however, it is less familiar to the general community. Clause 15 provides for criteria that are assessed by medical practitioners. With regard to Hon Aaron Stonehouse’s question, in this case it is used to indicate voluntariness as a criterion of eligibility. The use of “coercion” and “abuse” in the principles is directed at protecting vulnerable persons. Under clause 15, “coercion” is used to underscore that a person’s decision must be voluntary. The level of abuse required to frustrate the clause is built into “coercion”.

Hon AARON STONEHOUSE: I am looking for a definition of “coercion” somewhere in Western Australian statutes, and I cannot really find one. There is “sexual coercion” under the Criminal Code, but it does not really go into detail about the coercion aspect. Instead, I am relying on a definition that is provided by the Department of Mines, Industry Regulation and Safety, which states —

Coercion involves force (actual or threatened) that restricts another person’s choice or freedom to act.

That is my understanding of coercion and I think it would be the common understanding of the word, but that implies force or violence; it does not cover abuse, which would capture more activity that might include physical injury or emotional or psychological harm. It is certainly true in other aspects of the law that when we talk about abuse, we cast a wider net. When we talk about things like domestic abuse, we do not limit it merely to violence or coercion; we also cover things like financial abuse, emotional abuse, psychological harm and things like that. When we talk about undue influence, there is certainly no violence involved there, so expanding clause 15 to include “abuse, coercion, duress or undue influence” would cover some of the ground that I think is missed by limiting it to merely “coercion”. I suppose the word “voluntarily” in the requirement under clause 15(1)(e) that the person is acting voluntarily and without coercion would imply some of those things, but it would certainly do no harm to spell them out in clearer language. I reject the idea that “undue influence” is too legalistic. Throughout the course of this debate, that is a topic that has been touched upon quite a lot, and it is a pretty well understood concept in contract and common law. The only thing I am a little unsure of is the inclusion of “duress” in Hon Nick Goiran’s amendment. I think that might be a bit redundant, as “duress” and “coercion” seem to overlap almost entirely. In any case, the inclusion of “abuse” and “undue influence” is, I think, absolutely necessary. We can discuss whether those are appropriate for inclusion in later clauses, keeping in mind that I do not think “coercion” covers abuse or undue influence. I think it is absolutely appropriate to include those terms in this clause, and therefore I support the amendment moved by Hon Nick Goiran.

Hon NICK GOIRAN: The other point I would make to members is that either we are going to get serious about elder abuse in our community or we are not. We had a select committee look into the prevalence of elder abuse in Western Australia, and here we have a situation in which at the end of life, a final decision is being made. Those members who are familiar with that committee’s inquiries will know that there is an issue with the identification of elder abuse in our community, even by professionals. It is entirely appropriate that we make sure that this issue is top of mind for medical practitioners when assessing someone’s eligibility to consider very clearly whether there is any undue influence, abuse, coercion or duress. I take the point made by Hon Aaron Stonehouse about the use of the word “duress”. I have included it for the reason that, unlike the word “coercion”, it appears in several of our Western Australian statutes, including the Adoption Act and the Surrogacy Act. The term “undue influence” appears later in this bill and in other statutes. Ironically, if any one of the three terms should not be there, it is probably “coercion”, which is in there anyway. It would certainly be consistent with good lawmaking practice to ensure that all these things have been captured, particularly in light of the recent inquiries into elder abuse.

Hon STEPHEN DAWSON: In answer to Hon Aaron Stonehouse’s question about coercion, the ordinary dictionary meaning of “coercion” applies. Coercion is the practice of persuading someone to do something by use of dishonesty, force or threat. With regard to the issues around elder abuse, it is not the intent of this bill to address issues relating to aged care or quality of life in older Western Australians. The bill sets out to provide choice for a small number of people nearing the end of their life on the timing and manner of their death. The mandatory training required under this bill to be provided to medical practitioners will include the identification of risk factors for abuse. I have previously indicated the government’s intentions in dealing with the issue of addressing elder abuse, including its prevention. I have made clear that we are not supportive of Hon Nick Goiran’s amendments to this clause, for the reasons that I have previously outlined.

Hon AARON STONEHOUSE: I would like to make one final point. I appreciate that this bill is not intended to address elder abuse, but it should absolutely be at the front of everyone’s mind as we progress through this debate. We should be doing whatever we can to mitigate those risks. In fact, the government has made great efforts in talking up whatever the quantum was of safeguards. We should do absolutely everything we can. We should be absolutely certain that we do whatever we can to mitigate whatever risks might be presented by the passage of this
bill. I think that ensuring that “abuse” and “undue influence” are covered under clause 15(1)(e) would be one way of doing that. I encourage everyone who is paying attention to give this amendment some thorough thought and to pass it. It certainly would not diminish the bill in any way or make it any more onerous; it will just ensure that those extra acts are covered and spelt out in black and white, rather than relying on a dictionary interpretation of the word “coercion”, which is not defined in statute elsewhere.

Division

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

Ayes (14)
Hon Jim Chown
Hon Donna Faragher
Hon Adele Farina
Hon Rick Mazza
Hon Simon O'Brien
Hon Martin Pritchard
Hon Robin Scott
Hon Tjorn Sibma
Hon Charles Smith
Hon Aaron Stonehouse
Hon Dr Steve Thomas
Hon Colin Trincknell
Hon Nick Goiran (Teller)
Hon Adele Farina
Hon Robin Scott
Hon Colin Trincknell
Hon Martin Pritchard
Hon Martin Aldridge
Hon Peter Collier
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Alannah Clohesy
Hon Martin Aldridge
Hon Ken Baston
Hon Jacqui Boydell
Hon Tim Clifford
Hon Alanna Clohesy
Hon Martin Co 1
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTiernan
Hon Michael Mischin
Hon Samantha Rowe
Hon Matthew Swinbourn
Hon Colin Holt
Hon Kyle McGinn
Hon Michael Mischin
Hon Samantha Rowe
Hon Matthew Swinbourn

Noes (21)
Hon Martin Aldridge
Hon Peter Collier
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Alanna Clohesy

Amendment thus negatived.

Hon CHARLES SMITH: I move —
Page 12, after line 23 — To insert —

(g) the person has considered the impact that the person accessing voluntary assisted dying may have on the person’s family.

Many residents of Western Australia have sent correspondence to many of us here. One of the concerns that was raised was how will family members know when a person has decided to access voluntary assisted dying. To that end, I want to add an additional eligibility criterion. This particular criterion comes from the Northern Territory Rights of the Terminally Ill Act, which seems to be a reasonable model that we can use. Section 7(1)(g) of that act states —

the medical practitioner is satisfied that the patient has considered the possible implications of the patient’s decision to his or her family;

As the bill is currently drafted, the patient’s family may not be aware of the patient’s voluntary assisted dying request until after the death of the patient. I hope members will agree that some people may end up with a nasty surprise if they were not expecting their relative to access voluntary assisted dying. Members may note that the amendment does not go so far as to mandate the request. It only asks the patient to confirm that they have considered the impact on their family of their accessing voluntary assisted dying. I think it is a reasonable amendment. It is a family-friendly amendment. I would not like a person to suddenly find out that their mother, brother, sister or daughter has accessed voluntary assisted dying. I commend the amendment to members for their consideration.

Hon STEPHEN DAWSON: It will not surprise the honourable member that the government does not support this amendment. We do not believe this is an appropriate eligibility criterion. The underpinning principle of voluntary assisted dying is that the patient will make the decision themselves about whether they wish to access voluntary assisted dying. It is likely that a dying person will have considered the impact of their death on their friends and family. Furthermore, it is likely that the dying person will also have considered the impact based on the fact that their death will be brought about by their accessing voluntary assisted dying. I think it is a reasonable amendment. It is a family-friendly amendment. I would not like a person to suddenly find out that their mother, brother, sister or daughter has accessed voluntary assisted dying. I commend the amendment to members for their consideration.

Hon RICK MAZZA: If someone accesses voluntary assisted dying, it will be a deeply personal decision. I do not know that requiring the person to consider their family in that case should be a test of whether they can or cannot access voluntary assisted dying. In fact, in some cases the person might not want anyone in their family to know about it. I would find it very difficult to support this amendment.

Hon ALISON XAMON: In an ideal world, when someone is facing imminent death, whether it be from their illness or because they access voluntary assisted dying, we would always hope that they would feel that they were able to reach out and get support from their loved ones, from family. However, I think it is a step too far to try to prescribe that desire within the legislation. Unfortunately, not everyone comes from a functional family. Sometimes, people are estranged, for good reason, from people who may feel that they have a vested interest in somebody else’s life, but the person who is dying may not feel that that is appropriate. It may also be the case, as has already been mentioned, that a person may decide to not tell their family that they are dying. We may have opinions about that.

Extracted from finalised Hansard
We may look upon such a scenario with sadness and reflect on how unfortunate that may be for those individuals, but, nevertheless, that is that individual’s choice. I do not think it is appropriate for us to try to prescribe within legislation the nature of family relationships.

**Hon AARON STONEHOUSE:** I have a question for the minister around this. I am leaning towards the position that was expressed by Hon Rick Mazza and Hon Alison Xamon in that it might be a step too far to prescribe this. However, can the minister advise me whether any consideration has been given to including in the training provided to medical practitioners how patients might discuss with their family their choice to access voluntary assisted dying, or their end-of-life choices, and whether those discussions are a healthy thing and whether they should be promoted or avoided? How might that fit into the scheme and the material or training that is provided and that will be prescribed in regulation? There is not much in the primary legislation that deals with family. Family is a very important institution in our society, and it should be preserved wherever possible, although I draw a line at prescribing it and having statutory obligations to family. In the development of the training material and the support that will be provided to medical practitioners that will be prescribed in regulation, what weight will be put on discussion with family? What promotion of discussion with family will be included in the material that is provided to medical practitioners or patients?

**Hon STEPHEN DAWSON:** I am told that it is good clinical practice for practitioners to have those types of conversations with patients, so it is reasonable to think that that issue will be canvassed as part of the training that takes place. I think the likelihood is that medical practitioners will encourage people to have a conversation with wider family members if appropriate. As others have indicated, it is not always appropriate. It is a personal decision at the end of the day.

**Hon NICK GOIRAN:** Is the amendment that has been moved by Hon Charles Smith consistent or inconsistent with clause 4(1)(g)?

**Hon STEPHEN DAWSON:** Clause 4(1)(g) is a patient-centred principle. The amendment that stands in Hon Charles Smith’s name is obviously very family focused.

**Hon NICK GOIRAN:** I will support the amendment moved by the honourable member because there is nothing in it that forces the patient to have any conversations with family members; it simply ensures that the doctor will ask whether the person has considered the impact of their decision on their family. I go back to the example that I gave the minister when we last had this debate. As a father of two teenage daughters, I am mindful that it is possible for an 18-year-old to access this regime without having had any conversation with their family. The amendment moved by Hon Charles Smith will not change that; an 18-year-old will still be able to access this regime without telling their family. However, the thing that I like about the amendment moved by the honourable member is that it will at least ensure that the doctor has some conversation with the patient, which is consistent with 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;

It will ensure that the practitioner has at least had a conversation with the patient about that. What the patient wants to do after all of that is, of course, entirely a matter for them.

**Hon Alannah MacTiernan:** It sounds like it is putting undue pressure on them, really.

**Hon NICK GOIRAN:** Hon Alannah MacTiernan should remember that she has no concerns about that, because she just voted against an amendment that would have ensured that an eligibility criteria was that a person was not under duress or undue influence. We already know her position on that. I obviously hold a very different position on that from Hon Alannah MacTiernan—I take the issue of influence very, very seriously. I think this amendment will ensure that a person has a conversation with at least a doctor about the impact on their family. For those reasons, I support the amendment.

**Amendment put and negatived.**

**Clause 16: Eligibility to act as coordinating practitioner or consulting practitioner —**

**Hon NICK GOIRAN:** There are some amendments on the supplementary notice paper to clause 16, but before we get to those, I have a number of questions. I also note that the first amendment on the supplementary notice paper is in the name of Hon Colin Tincknell, and deals with page 14 after line 2. I have an amendment that precedes Hon Colin Tincknell’s amendment, which I will deal with shortly. I should also indicate for the benefit of the clerks that the amendment standing in my name at 164/15 should remain on the supplementary notice paper because it is consequential on other matters.

Clause 16 sets out the eligibility criteria for a medical practitioner to be able to act as a coordinating practitioner or consulting practitioner. Would it be possible for the coordinating or consulting practitioner to be a family member of the patient?

**Hon STEPHEN DAWSON:** I am told that it is not considered appropriate under “Good Medical Practice: A Code of Conduct for Doctors in Australia”. Paragraph 3.14 of that guide of the Medical Board of Australia deals with this issue.
Hon NICK GOIRAN: So it is not good practice, but under the bill that is before us, would it be possible for the doctor to be a family member of the patient?

Hon STEPHEN DAWSON: I am told that it is not contemplated under the bill. Certainly, clause 16(2) refers to meeting the requirements approved by the CEO for the purposes of each paragraph there. I am told that the issue would be dealt with during the implementation phase, but it is certainly not contemplated by government.

Hon NICK GOIRAN: Members, when the minister says that it is not contemplated in the bill, it means that the bill is silent on this issue. Would it be possible for the coordinating practitioner or the consulting practitioner to be a beneficiary under the will of the patient?

Hon STEPHEN DAWSON: Yes, it is.

Hon NICK GOIRAN: I ask the minister to turn to clause 160 of the bill, which sets out criteria that deal with interpreters. We will get to clause 160 in due course, but it states that the bill will allow for interpreters to be used, which we discussed a bit under clause 1. I ask the minister to look specifically at clause 160(2), which states —

An interpreter for a patient —

...  
(b) must not —
    (i) be a family member of the patient; or
    (ii) know or believe that they are a beneficiary under a will of the patient or that they may otherwise benefit financially or in any other material way from the death of the patient ...

Why is it appropriate that we provide these prohibitions for interpreters, but not for medical practitioners?

Hon STEPHEN DAWSON: We do not believe that it is necessary because medical practitioners are bound by their professional code of practice.

Hon NICK GOIRAN: I move —

Page 13, line 19, to page 14, line 5 — To delete the lines and substitute —

(2) A medical practitioner is eligible to act as a coordinating 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 for the patient.

(3) A medical practitioner is eligible to act as a 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

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(b) the medical practitioner is not a family member of —
   (i) the patient; or
   (ii) the coordinating practitioner for 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 consulting practitioner for the patient; and

(d) the medical practitioner —
   (i) does not own a health facility or medical facility with the coordinating
       practitioner for the patient; and
   (ii) is not a supervisor of, or supervised by, the coordinating practitioner for the
       patient at a health facility or medical facility; and
   (iii) is not employed or engaged under a contract for services, or a consultant, at
       a health facility or medical facility where the coordinating practitioner for the
       patient is also employed or engaged or a consultant.

(4) The CEO must publish the requirements approved for the purposes of subsections (2)(a)(i), (ii)
and (iii) and (3)(a)(i), (ii) and (iii) on the Department’s website.

(5) In this section medical facility means a medical centre, medical clinic or similar facility.

The DEPUTY CHAIR (Hon Adele Farina): Members, Hon Nick Goiran has moved an extensive amendment.
I think we will just take a short hold while we wait for copies of that amendment to be distributed so that members
can read the amendment and understand what is currently being considered by the chamber.

Hon ALISON XAMON: Can I quickly ask a question to the member who moved the amendment?

Hon STEPHEN DAWSON: Can we wait until we have a copy of it? I would love to be able to follow the member’s
question, but until I have a copy of it, it is difficult.

Hon ALISON XAMON: It is about the form of the amendment, not the substance.

The DEPUTY CHAIR: Hon Alison Xamon, the minister has indicated that it would help him to follow the
discussion if he has a copy of the amendment before him and I think that is a reasonable position to hold, so I think
we will just hold for a few minutes while we wait for that amendment to be distributed to members.

Can members indicate whether they are happy to continue at this point with consideration of the amendment?
There has been an opportunity to peruse the lengthy amendment.

Hon ALISON XAMON: We have, of course, the quite comprehensive amendment in front of us. I note that the
amendment effectively has two different intents enshrined within the one amendment. The second intent is to make
sure that the medical practitioner does not have any sort of conflict of interest or any sort of capacity to benefit
from a patient’s death. It strikes me that that is an eminently sound and important provision that is probably worthy
of inclusion within the bill. I think that would improve the bill in its current form. I am interested that two different
components have been coupled into the one amendment. My question to the minister is specifically about the
provisions as outlined in clause 16(2)(a), which prescribes the professional requirements of a medical practitioner,
and their eligibility. Looking only at the provisions within subclause (2)(a), are they already implied within the
bill or will this in any way limit the current provisions within the bill?

Hon NICK GOIRAN: As the author of the amendment—with the benefit of parliamentary counsel, I should
add—I can perhaps assist by drawing to members’ attention that clause 16(2) at page 13 of the bill sets out those
professional requirements. The provision that the member has referred to in my amendment at clause 16(2)(a) is
identical to that at page 13 of the bill; it is simply the numbering that is different. Subclause (2)(a)(i) refers to
holding specialist registration, which is the same as subclause (2)(a) in the bill. My subclause (2)(a)(ii) equates to
subclause (2)(b) in the bill; and my subclause (2)(a)(iii) equates to subclause (2)(c) in the bill.

Hon ALISON XAMON: I thank the mover of the amendment. That is very helpful because, obviously, we have
only just seen this. Can I please confirm with the mover of the motion that the effect of the amendment is entirely
about ensuring there will be no conflict of interest from any practitioner who is assisting a person seeking access
to voluntary assisted dying?

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Hon NICK GOIRAN: The answer to that is yes, and it is done in two ways: one way is that there is no conflict between the practitioner and the patient; the second way it is dealt with is to make sure there is no conflict between the two practitioners involved—the consulting practitioner and the coordinating practitioner. That is why, for example, members will see the suggestion in my amendment at clause 16(3)(b)(ii) that the medical practitioner is the consulting practitioner—that is, the second practitioner involved—and they also should not be a family member of the coordinating practitioner. There should be no family relationship with the patient nor between the two doctors.

Hon COLIN HOLT: While the minister is considering his answer, I wonder whether the mover of the motion can define “family member” and how far it goes in that consideration?

Hon NICK GOIRAN: I draw to the honourable member’s attention clause 160(2)(b)(i) where the phrase “a family member” is used by the government in its bill, and so the same interpretation will apply. Whatever “family member” is intended to mean by the government in regard to interpreters will also apply to medical practitioners.

The DEPUTY CHAIR: I can add further clarification to that. There is a definition of “family member” at clause 5 of the bill.

Hon AARON STONEHOUSE: I thought I might as well take this opportunity to put my thoughts on the record. It seems an eminently sensible amendment put forward by Hon Nick Goiran. The policy intent of this amendment is something that everyone should agree with, regardless of their views on the policy of the bill at large. The intent of this amendment is to ensure there is no conflict of interest between medical practitioners, consulting or coordinating, or between a medical practitioner and a patient. It is something that I am certain everyone would agree with, if they understand properly what is being proposed. The question becomes, I think, whether or not such a prohibition already exists in the bill, whether implied or actual. If such a prohibition were implied, I think we would be on safer ground if we agreed to the amendment to at least spell it out clearly in black and white in the statute. I would rather not rely on implications or the penumbra of what the legislation says when we are putting in place safeguards to protect vulnerable people. If such a prohibition exists in the bill, that is good, because I would certainly be relieved to know that the government has not overlooked such a prohibition. But it would have to be explained by the minister where that prohibition exists in the bill. I would not want to rely on a prohibition existing somewhere else in some code of conduct or in some best clinical practice because I do not think that is sufficient in this case. We are discussing the contents of this bill and how this regime will be carried out. A code of conduct can always be changed and best clinical practice can also be changed over time. I think we should really be confident that the clauses of this bill that we agree to will provide adequate safeguards and not some other instrument that we have no control over here. With that, I absolutely support the amendment, but I look forward to hearing the minister’s response.

Hon STEPHEN DAWSON: I am going to ask you to leave the chair until the ringing of the bells, Madam Deputy Chair. I need to take further advice on the amendment, and what the practical implications will be. For example, I can see that proposed clause 16(3)(d) of Hon Nick Goiran’s amendment will cause issues for regional Western Australia. I ask you to leave the chair until the ringing of the bells, so that I can seek further advice to give the chamber a proper answer on this.

The DEPUTY CHAIR: The minister has asked me to leave the chair until the ringing of the bells, to seek further advice. I think that is eminently sensible, so I shall do so.

Committee interrupted, pursuant to standing orders.

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Martin Aldridge) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 16: Eligibility to act as coordinating practitioner or consulting practitioner —

Committee was interrupted after the amendment moved by Hon Nick Goiran had been partly considered.

Hon STEPHEN DAWSON: Advice is being handed to me now, so I am digesting it as we progress. We are not supportive of the amendment that stands in Hon Nick Goiran’s name. However, the government is amenable to the concept that a coordinating or consulting practitioner not be a family member of the patient or a beneficiary of their will. We do not accept the amendment as drafted and have drafted an alternative amendment. Furthermore, we reject the inclusion of the subclause that sets out the relationship between the coordinating practitioner—that is, the second practitioner involved—and they also should not be a family member of the coordinating practitioner. There should be no family relationship with the patient nor between the two doctors.

a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and palliative care as a person who lives in the metropolitan region.

Furthermore, logistically, a practitioner may be unaware in what capacity the other practitioner is employed or engaged.
**Hon ROBIN CHAPPLE:** This amendment rolled up fairly quickly; it was not even on supplementary notice paper issue 10. When an amendment like this is introduced, we should expect the chamber to address it in detail because it is fairly complex. There are elements of this amendment that are relatively good and elements that are ridiculous. It has been typed out, so this is not a spur-of-the-moment amendment. It should have been on the supplementary notice paper so that we could all deal with the matter in advance. I wonder how many more of these amendments Hon Nick Goiran has got up his sleeve.

**Hon RICK MAZZA:** I rise to say that I will support this amendment by Hon Nick Goiran. I am quite amazed that the bill does not provide that there should be no conflict between a medical practitioner and the patient, in the sense that the medical practitioner should not be a beneficiary of a will or a family member of the patient. I think, overall, this amendment will provide some integrity to the bill. I am quite surprised the government did not see that previously. The government has always said that this bill has many safeguards that make the process relatively safe. Not having this conflict issue embedded in the bill is an oversight or an omission. I will certainly be supporting the amendment in the form that has been put forward by Hon Nick Goiran.

**Hon ADELE FARINA:** I, too, think that there is a lot of merit to this amendment and that it is worthy of support. However, I also agree with the concerns expressed by the minister about paragraph (d) and how this might limit access to voluntary assisted dying in regional WA. Therefore, I intend to move an amendment to Hon Nick Goiran’s amendment. I move —

To delete —

subclauses (3)(d) and (5)

This should take care of the minister’s concern about the impact it might have in regional WA. It then strips it right back to the basics; that is, to ensure that there is no conflict of interest in the relationship between the medical practitioner and the patient.

**Hon PETER COLLIER:** Are we waiting for the minister’s amendment?

**Hon Stephen Dawson:** No. We are waiting for Hon Adele Farina’s amendment.

**Hon PETER COLLIER:** Hon Adele Farina is moving to delete proposed subclause (3)(d); is that correct?

**Hon ADELE FARINA:** I have moved to delete subclauses (3)(d) and (5). Subclause (5) provides a definition of a term that is used in subclause (3)(d), so I think we can get rid of both those. The minister did mention that the government might be moving an amendment, but I have not seen it.

**Hon PETER COLLIER:** That is what I want clarification on. I am receptive to this amendment, I have to say, particularly if we remove paragraph (d). It is up to the mover of the amendment, but I can understand why we would remove paragraph (d), particularly because of the implications it would have in some regional centres. I just want clarification on whether the minister intends to move his own amendment to this clause.

**Hon NICK GOIRAN:** By way of explanation, I understand the rationale behind the amendment to the amendment moved by my learned friend Hon Adele Farina. I indicate that I am not supportive of the amendment to the amendment because my desire to have paragraph (d) in the amendment is to stop what I see as two practitioners setting up shop together and effectively providing a clinic throughout Western Australia. That, to me, would undermine the independence of the practitioners. People referring constantly to each other and saying, “I’ll be the consulting practitioner; you be the coordinating one”, does not fill me with confidence. That is the reason I oppose the amendment to the amendment. I also recognise that it is unlikely that the will of the chamber is to defeat the amendment to the amendment. I acknowledge that the will of the chamber is what it is.

**Hon STEPHEN DAWSON:** I indicated—I know that the Leader of the Opposition was away from the chamber on urgent business at the time—that the government is amenable to the concept that a coordinating or consulting practitioner not be a family member of the patient or a beneficiary of a will, but we do not accept the amendment and we have drafted an alternative amendment.

I also indicate that although we support the intent of Hon Adele Farina’s amendment to the amendment—it is certainly consistent with the government’s view—it is our belief that it could be drafted better. We have drafted an amendment and can move that, but I seek your advice, Mr Deputy Chair.

**The DEPUTY CHAIR:** What are you seeking?

**Hon STEPHEN DAWSON:** I am seeking your advice.

**Hon Aaron Stonehouse** interjected.

**Hon STEPHEN DAWSON:** I am happy to provide it. Everybody will get a copy before we debate it. Do we have to vote down both the amendment to the amendment and the amendment before I move my amendment?

**The DEPUTY CHAIR:** There are other ways of dealing with this. The issue we have, minister, is that we are dealing with a number of amendments of which none have been given notice on the supplementary notice paper, including your intention to move one. One way to resolve this is for you to circulate your amendment. The attendants can photocopy it.

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and circulate it so that members can at least consider your amendment in the context of the amendment and the amendment to the amendment that are before the chamber. Essentially, minister, you are correct in that the amendment to the amendment and the amendment would need to be defeated so that you could then move your amendment.

Hon STEPHEN DAWSON: I am happy to circulate my proposed amendment so that members can consider all three.

Point of Order

Hon MARTIN PRITCHARD: I seek clarification. You mentioned, Deputy Chair, that the amendment to the amendment and the amendment have to be defeated. My understanding is that we would not necessarily have to defeat the amendment to the amendment, so long as the amendment was defeated. Am I correct in saying that?

The DEPUTY CHAIR (Hon Martin Aldridge): Hon Martin Pritchard, on your point of clarification, it would depend entirely on what the minister intends to move—whether that is an amendment to the substantive clause 16, or an amendment to the amendment of Hon Nick Goiran or, indeed, an amendment to the amendment of Hon Adele Farina. When that is circulated to the chamber, we will be in a better position to advise on the way forward.

Committee Resumed

Hon STEPHEN DAWSON: The amendment is being photocopied now. I can indicate that my amendment is to the substantive clause. It does not seek to amend Hon Nick Goiran’s amendment. I can further say that the difference between what will be circulated in my name and Hon Adele Farina’s amendment to the amendment is the split between coordinating and consulting practitioner into two subclauses. Hon Nick Goiran’s motion seeks to split those two; in mine, I have not. I do not believe it is necessary as the eligibility criteria for both is the same. That is the difference. The amendment is being circulated so people can consider it.

Hon NICK GOIRAN: To be clear, so that everyone understands—I have copped a fair amount of criticism over the course of this journey; some people will say rightly and others will say wrongly—the minister is suggesting that we spend a bit of time debating this and defeating the proposal by Hon Adele Farina, which, as I understand it, will substantively ensure that my amendment is the same as the minister’s, other than some formatting issues, and the minister would rather us spend time doing that and then deal with his amendment. Does the minister think that would be a good use of the time? I just want to make sure that we are all on the same page and we understand what is happening here.

Hon STEPHEN DAWSON: Just to be clear, I do not know whether the honourable member is trying to be smart. Certainly, the way I have worked throughout this debate has been to listen to those issues that have been raised by honourable members and to consider amendments as they have been raised and, if they do not destroy the intent of the bill, to take those issues on board when appropriate. That is what I have done so far and that remains what I will do as we continue through the passage of this bill. I am not supportive of Hon Nick Goiran’s amendment, for the reasons I have indicated. I have also indicated that what will be circulated in my name is, my advisers tell me, a better way of putting our intention than the amendment to the amendment in Hon Adele Farina’s name. People can play politics all they want. I am trying to make sure that we have a good bill and I am trying to ensure that I am taking on board the issues that are raised by honourable members as they are raised.

The DEPUTY CHAIR: Members, we are dealing with the amendment to the amendment moved by Hon Adele Farina. The question is that the words to be deleted be deleted.

Hon ROBIN CHAPPLE: Again, I raise the point that we are dealing with issues that can be resolved if we can see the minister’s amendment. I am not saying that the minister is at fault in this, but rather than dealing with things through the supplementary notice paper, we are dealing with them on the fly, and I do not think that is a good way to operate in a house of review.

The DEPUTY CHAIR: Members, I have given you a few moments to consider the document that has been circulated throughout the chamber by the attendants. The document foreshadows the intent of the Minister for Environment representing the Minister for Health to move an alternative amendment to clause 16. That will give members some guidance as to the minister’s intent once the question before the chamber is resolved. That question is, of course, the amendment of Hon Adele Farina to Hon Nick Goiran’s amendment to clause 16, to delete subclauses 3(d) and (5). The question remains that the words to be deleted be deleted.

Hon AARON STONEHOUSE: Comparing the two substantive amendments, obviously what is absent from the minister’s proposed amendment is anything dealing with the relationship between a consulting and coordinating practitioner. That is certainly the intention of the minister, although it leaves me a little concerned that there is nothing remaining in the bill or in the amendment we are likely to consider in a moment that would address that relationship and any conflicts of interest in that relationship. I appreciate what Hon Adele Farina has moved in trying to remove a roadblock for regional Western Australians accessing voluntary assisted dying that rules large sectors of medical practitioners ineligible to participate in this regime. It puts me in a difficult position in which I have two extremes. I have the option of the proposed amendment to the amendment, which would in no way regulate the relationship between coordinating and consulting practitioners; or I have the amendment proposed by Hon Nick Goiran which, on the face of it, does seem to go a little too far when we consider, as the minister pointed out, that there may be medical practitioners who work across the private and public sector and may have these relationships that are not necessarily a conflict of interest but will arise due to the nature of country health practice. It is difficult when faced
with these two choices. I would much rather have seen an alternative to paragraph (d) that would regulate, but not in a way that was too exclusionary for medical practitioners in the regions. I just point that out. I suppose it will be the will of the chamber whether we agree to the amendment to the amendment and then the substantive amendment after that, but it seems like we have two extremes here and not really an ideal middle place that leaves me comfortable that those relationships between consulting and coordinating practitioners will be regulated appropriately to mitigate risk without excluding too many practitioners or patients.

Hon NICK GOIRAN: I take the point raised by Hon Aaron Stonehouse and I think that perhaps it would be addressed by the deletion of paragraph (d)(iii). The question that is currently before the chair is the deletion of the entirety of subclause 3(d), but I wonder whether removing paragraph (d)(iii) would address the member’s concern, because it talks about whether somebody is under contract with another practitioner in the same sort of employment context, whether it be a health facility or medical facility. I would like to think that there would be some general agreement that proposed subclause (3)(d)(i) would be appropriate—that two medical practitioners who own a health facility or medical facility together should not be in cahoots or working in concert with regard to voluntary assisted dying. That is precisely the type of thing that I am concerned about.

If, for example, the infamous Dr Nitschke were to set up shop in Western Australia with another practitioner—there would be reasons why this might not happen, including that I am not sure whether he has medical registration anymore—and they were to call themselves the “WA One-stop VAD Shop”, I would find that distasteful. I would not want to see that happen here and I do not get the sense from other members that they want to see that happen either. Those who want to see this legislation pass are talking about an independent assessment done by one doctor and a referral to another doctor who does another independent assessment. I do not hear from members that we are talking about a one-stop shop. If the honourable member were to think that a one-stop shop is appropriate, they would want to see the entirety of proposed paragraph (d) defeated, but I wonder whether proposed paragraph (d)(iii) is the part that troubles the member.

Amendment on the amendment put and negatived.

The DEPUTY CHAIR: Members, we now return to the amendment moved by Hon Nick Goiran, which is to insert certain words at page 13, line 19 to page 14, line 5. The question is that the amendment be agreed to.

Division

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

Ayes (14)

Hon Jim Chown  
Hon Peter Collier  
Hon Donna Faragher  
Hon Nick Goiran  
Hon Jim Chown  
Hon Rick Mazza  
Hon Tjorn Sibma  
Hon Colin Tincknell  
Hon Peter Collier  
Hon Michael Mischin  
Hon Charles Smith  
Hon Ken Baston (Teller)  
Hon Nick Goiran  
Hon Michael Mischin  
Hon Charles Smith  
Hon Ken Baston (Teller)

Noes (20)

Hon Martin Aldridge  
Hon Jacqui Boydell  
Hon Robin Chapple  
Hon Tim Clifford  
Hon Alanna Clohesy  
Hon Stephen Dawson  
Hon Laurie Graham  
Hon Matthew Swinbourn  
Hon Colin de Grussa  
Hon Sue Ellery  
Hon Kyle McGinn  
Hon Dr Sally Talbot  
Hon Diane Evers  
Hon Martin Pritchard  
Hon Alison Xamon  
Hon Adele Farina  
Hon Samantha Rowe  
Hon Pierre Yang (Teller)

Amendment thus negatived.

Hon STEPHEN DAWSON: I move —

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

Extracted from finalised Hansard
(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.

I indicated previously when I spoke on Hon Nick Goiran’s amendment why it was my intention to move this amendment. Again, I have listened to the contributions of various members throughout this debate and the government has taken those on board. I stand by the amendment standing in my name.

Hon RICK MAZZA: I rise to say that I support the amendment that has been put forward by the government. In doing so, I would like to say that it is good to see democracy at work and the house of review doing its job. A very important area of conflict has been identified by members of this place. This amendment takes care of any financial conflict or beneficiary conflict that may occur between practitioners and the patient. It is very pleasing that this has been identified. It is democracy at work and the house of review has certainly done its job in this case.

Hon ALISON XAMON: I rise to indicate that I will also be supporting this amendment. I think it is an important improvement to the legislation and reflects the policy intention of Hon Nick Goiran’s previous amendment, which was defeated. It is essential to ensure that people who provide medical assistance for voluntary assisted dying can in no way personally benefit from their patient’s death.

Hon AARON STONEHOUSE: Contrary to comments in the press, democracy is not dead! It is alive and well through the process of amendments put forward and compromises reached and when, in this instance, legislation is enhanced and protections that were perhaps overlooked during the drafting have been included through amendment. We can now at least rest easy that conflicts of interest between patients and practitioners will be prohibited, which is something that I think everyone agrees to and everyone in the other place would agree to. I think this a vindication of members who have been interrogating this legislation in such detail. It is obviously frustrating for the public to look upon this process, as it may seem drawn out to the uninitiated, but this process is important. As I mentioned earlier, I am a little concerned that this does not address potential conflicts of interest in a relationship between consulting and coordinating practitioners. It is therefore not perfect in my eyes, but it is certainly an improvement over the status quo; therefore, I am happy to support this amendment.

Hon ROBIN CHAPPLE: I will certainly be supporting the amendment. These provisions were in both my bills and addressed this issue. The problem I have—it is something that we need to address and I repeat it again—is that if there are amendments out there, they should be on the supplementary notice paper so that it gives the government and members time to evaluate, come up with amendments or, as in this case, do what the minister has done and come up with a better alternative model. I support the minister’s position.

Amendment put and passed.

Hon STEPHEN DAWSON: As members can see, there is a second amendment standing in my name. It is consequential.

Hon NICK GOIRAN: I note that the further amendment proposed by the minister is at a later point in the clause than the one proposed by Hon Colin Tincknell, so it seems to me to be in order that he move his amendment at 4/16 first.

The DEPUTY CHAIR: Thank you, Hon Nick Goiran.

Hon COLIN TINCKNELL: I move —

Page 14, after line 2 — To insert —

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

(a) holds specialist registration covering either or both of the following —
   (i) palliative medicine;
   (ii) at least 1 disease, illness or medical condition with which the patient has been diagnosed and which the coordinating practitioner for the patient has determined meets the requirements of section 15(1)(c);

and

(b) has practised the medical profession for at least 1 year as the holder of specialist registration as referred to in paragraph (a); and

(c) meets the requirements approved by the CEO for the purposes of this paragraph.

My amendment to clause 16 is all about further safeguards for patients, especially vulnerable patients. People, especially those who want to access VAD, need qualified decisions from specialists. I am very concerned about
is a breath of fresh air, I have to say, coming from the government. Dealing with Roger was very, very heartening appreciation to the Minister for Health, Hon Roger Cook, for the manner in which he has dealt with this issue. He has sufficient specialists in the regions to cope with that situation, but unfortunately that is not going to happen. It means that people who are dying will be assured of the expertise that they need.

The clause in its current form, Hon Colin Tincknell, will inevitably have an adverse impact on those in the regions. To me, that is very, very important. It would be nice in a perfect, utopian world if that was not the case and we had access to people with expertise. However, I believe that when people are close to the end of life, they need that expertise and the reassurance it brings.

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Hon MARTIN PRITCHARD: At one point I would have been supportive of this amendment. I am sorry that I can no longer support it for a couple of reasons. Firstly, after a number of people spoke to me, I came to the realisation that before people access VAD, they will most likely have a number of specialist reports anyway, and trying to get specialists involved in the process by making them the consulting practitioner would severely limit the number of specialists available in not just the country, but also the metropolitan area. That came after a particularly enlightening briefing that Hon Colin de Grussa gave, in which we learnt that there are four motor neurone disease specialists in the state who look after 95 per cent of the patients in the state. We would need only a number of them to choose not to participate through either not receiving the training or conscientious objection or something along those lines. It would become problematic once we required a specialist to be involved in the process.

As I mentioned before, by the time people get to the point at which they have a prognosis and request VAD, they probably would have had a number of specialist reports anyway, without involving them in the process. I commend the sentiment. It would be great if we could get to a point at which this was possible, but, unfortunately, I think it is detrimental to the bill and, for that reason, I cannot support it at this stage.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of this amendment. The bill does not require that one practitioner is a specialist in the person’s illness, but has a requirement for further independent assessment if there is doubt about the eligible medical illness, disease or condition. The position is consistent with views of the joint select committee and the Ministerial Expert Panel on Voluntary Assisted Dying. Both supported the ability for the coordinating and consulting practitioner to refer on for assessment of particular eligibility criteria rather than having a requirement that either of them must be a specialist in the disease, illness or condition that the patient has. Further, this difference in requirement from that in the Victorian act also reflects the practicalities of responding to the geographic remoteness of many places in WA and distance from medical care. The requirement to refer for further assessment serves to ensure specialist expertise when required. 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.

Hon PETER COLLIER: This is an issue that I feel very strongly about and I thank Hon Colin Tincknell for putting forward this amendment. It pretty much mirrors the amendment that Hon Martin Pritchard initially put up and then withdrew. I have looked into it. I find it extraordinary that in this day and age we will have a situation in which one of the practitioners is not a specialist in the field. That, to me, is an oxymoron to this whole bill. Having said that, and I do not want Hon Colin Tincknell to take this personally, I cannot actually support this amendment. I will explain why. I was very, very insistent that in some shape or form we had sufficient safeguards so that the practitioners at least had access to information about someone who was going down the path of voluntary assisted dying. As a result, as a lot of us did, I worked very, very closely with the Australian Medical Association. I would like to put on record my appreciation to the AMA, particularly Dr Andrew Miller, who was exceptional. I spoke daily—constantly—with Andrew over the last two or three months. I would also like to put on record my appreciation to the Minister for Health, Hon Roger Cook, for the manner in which he has dealt with this issue. He is a breath of fresh air, I have to say, coming from the government. Dealing with Roger was very, very heartening to me. As a result of those negotiations that took place between the AMA and Hon Roger Cook in isolation and then collectively the three of us, we reached a point that assists in resolving the matter. That will come at clause 23, with an amendment from the government. Although it is not perfect—it is simply not perfect—the thing that got me across the line was that the AMA was very satisfied with it.

The clause in its current form, Hon Colin Tincknell, will inevitably have an adverse impact on those in the regions. To me, that is very, very important. It would be nice in a perfect, utopian world if that was not the case and we had sufficient specialists in the regions to cope with that situation, but unfortunately that is not going to happen. It would be nice in a perfect, utopian world if that was not the case and we had sufficient specialists in the regions to cope with that situation, but unfortunately that is not going to happen. It
would be nice, but it is not going to happen. Is that a reason, therefore, we do not support it? For me, I have not supported the second reading of this bill and at this stage I will not support the third reading, but I want to do all that I can to ensure that the bill is safer and that the safeguards that do exist are more stringent than those in the bill in its current form. With that said, I am comfortable, based on the negotiated agreement between the AMA and the health minister, and the discussions I have had with Hon Roger Cook and the AMA, that we have reached a landing point that I think goes a long way to improving those safeguards. I will have a bit more to say on clause 23; it will not be extensive. Suffice to say, I was really pleased with the manner in which those negotiations took place. I think that the health minister and the AMA were genuine in their desire to reach a landing point. I think we have done that with clause 23. For those reasons, and those reasons alone, even though in an ideal world I would support this amendment, I will not in this instance.

Hon COLIN TINCKNELL: I really appreciate the Leader of the Opposition’s words on this amendment. I was not privy to the meeting the Leader of the Opposition had with Hon Roger Cook. I have had meetings with the AMA, and it was very supportive of my amendment. I am aware that there is an issue with the country and that is one of the reasons the amendment is so important; it is something that the government should be addressing. It is a government-sponsored bill. It has chosen the time to put this bill through the house. The government needed to consider the geographical weaknesses in medical services in country regions before putting this bill to the house. This is something it has failed to do. The government has just wiped out of the Victorian bill. For me, it lacks protections for vulnerable people. I really have concerns that a patient may access voluntary assisted dying not knowing that there has been a breakthrough in his disease just recently—I know it happens all the time—and that person could possibly have been given another option. That is one of the main reasons we need to have up-to-date specialists involved in deciding whether someone is going to take their life.

I will continue to move this amendment. I am very, very happy to compromise and work with the government and anyone else in the chamber, because we all have a conscience vote and we can make very good decisions if we work together.

Hon TJORN SIBMA: I want to speak to this motion moved by Hon Colin Tincknell with perhaps a degree of specificity as I actually understood the intention to be. I must say that I probably started at the position the honourable member has landed at, but I have changed my mind over the course of time and through consultation with a variety of medical specialists in a range of domains. Although I recognise the purity of the intent here, I have tried to maintain a line of pragmatism around the realities of medical consultation. In my view, it is highly unlikely that a patient would arrive at this particular position without extensive prior consultation with a range of specialists in the particular disease that they are suffering from. I really think that there is capacity—room—for specialist involvement. Indeed, I would be utterly surprised if somebody embarked upon this process for themselves without spending extensive periods of time in waiting rooms and in consultation with particular medical specialists.

I want to reflect on the honourable member’s remarks about the disadvantage of people who live in rural and regional Western Australia. I completely concur with the sentiments that underlie the honourable member’s motivation there, but for me it is another reason perhaps not to support this motion, because I think there is very limited capacity for people who live in regional Western Australia to obtain this kind of final specialist certification. From that perspective of equity and also from reflection on the reality of consultation and the progression of somebody’s disease, although I recognise the intention behind the amendment, I cannot support it either.

Hon NICK GOIRAN: I am a little perplexed by what is happening here because I had understood that in an earlier part of the debate, members, the minister had given us an assurance—in fact, the word was a “guarantee”—that this government will ensure that if necessary, up to eight people will be flown out to regional Western Australia: the coordinating practitioner and if needs be an interpreter; the consulting practitioner and if needs be an interpreter; the administering practitioner and an interpreter; and, of course, because we are very concerned about regional Western Australia not being able to have the same level of access because of the inconsistency with commonwealth law, we will also make sure that there is a care navigator, an expert VAD steerer who will steer them down this whole path and if needs be with an interpreter. It is up to eight people. I asked the minister whether he would guarantee that the government would fly out those eight people if necessary. He said, “Yes. Cost is no issue to this government because we can’t allow money to stand in the way when people are suffering at end of life.” If what the government has said is true—I take it at its word that it will fly up to eight people out there—perhaps someone can explain to me how difficult it is to put a specialist on the plane to be one of those eight people. Because that is all Hon Colin Tincknell is asking for here. He is saying that it has to be either a palliative care specialist or a specialist in the disease that the person says that they have. I would have thought that it would make no difference who the human being is on the plane. If we are going to fly out eight people, is it not a good thing if one of them is a specialist? If we do not do that, then the outcome is that we give second-class service to regional Western Australians. We say to them, “Sorry; we’re not going to give you access to a specialist, because unfortunately you’re too remote, so you are going to have to put up with somebody with lesser qualifications.”

The Northern Territory experience informs us that this is exactly what happens. I encourage members to have a look at the seven deaths in Darwin, where on one particular occasion the specialist was an orthopaedic surgeon, despite the fact the person had a condition called mycosis fungoides, which is a cancer in the blood.

Extracted from finalised Hansard
that affects the skin. Dr Philip Nitschke ran around looking for a specialist, but he could not find one, so he kept doctor shopping and in the end it was an orthopaedic surgeon who had absolutely no qualifications in the underlying condition. That will not be a problem in Western Australia because this government will fly out the person—up to eight people if necessary. I do support the honourable member’s amendment; it is consistent with the Victorian provision. Our legislation will be more dangerous than the Victorian legislation on this significant issue.

Sitting suspended from 6.00 to 7.30 pm

Hon NICK GOIRAN: Prior to the adjournment, I had indicated that I would support the amendment moved by Hon Colin Tincknell. I note that the Australian Medical Association surveyed 1 500 doctors recently and revealed that 74 per cent of them believe that if neither of the doctors have a pre-existing therapeutic relationship with the patient, referral to a third independent specialist or the patient’s usual doctor should be mandated as a safeguard. Is there any provision in the bill that requires the doctor to have a longstanding doctor–patient relationship with the person requesting access to voluntary assisted dying?

Hon STEPHEN DAWSON: No, there is not.

Hon COLIN HOLT: I rise to say that I cannot support the amendment moved by Hon Colin Tincknell. I want to back up the views expressed by Hon Tjorn Sibma when he talked about the fact that this cannot be viewed as an isolated journey. As I think I pointed out in my second reading contribution, when people get to this point, they are going to have had multiple contacts with specialists and doctors. I think the minister touched on this. There is a provision in the bill that says that if there is any doubt, or words to that effect, by the coordinating or consulting practitioner because they cannot diagnose or there is doubt about the illness, they can refer the matter to a specialist. I think there are those provisions in the bill. There will be lots of occasions on which there is probably no doubt about where the patient is at in their illness journey or about the fact that they are very, very ill. There would not be in much doubt, as seen by those consulting and coordinating doctors, that this is where things were at after they had viewed all the medical records, taken them into account and worked with the patient. I think there will be many, many occasions on which there will be no doubt. When there is some doubt, under this bill there is the ability, or the requirement, to seek that specialist care or input. Therefore, I cannot support the amendment moved by Hon Colin Tincknell.

Hon NICK GOIRAN: I was delighted by a portion of Hon Colin Holt’s contribution just then. I might just draw to his attention the amendment standing in my name at 77/25, which deals exactly with that point the member raised.

Hon Colin Holt: Is it on the supplementary notice paper?

Hon NICK GOIRAN: Yes, it is.

The amendment seeks to insert the language, which Hon Colin Holt has just passionately spoken about, to indicate whether the specialist or the practitioner has any doubts about the situation. I look forward with enthusiasm, honourable member, to us walking together to the other side of the chamber when we get to clause 25!

Hon COLIN TINCKNELL: I will keep this brief. I thank everyone who has spoken on this important amendment. I know I possibly will not get it up, but I still think it is very important that it is something we debate. Whether we meet halfway or get an amendment that is close to it, this is what it is all about.

Division

Amendment put and a division taken, the Deputy Chair (Hon Matthew Swinbourn) casting his vote with the noes, with the following result —

Ayes (4)
Hon Nick Goiran Hon Charles Smith Hon Colin Tincknell Hon Ken Baston (Teller)

Noes (30)
Hon Martin Aldridge Hon Colin de Grussa Hon Rick Mazza Hon Aaron Stonehouse
Hon Jacqui Boydell Hon Sue Ellery Hon Kyle McGinn Hon Matthew Swinbourn
Hon Robin Chapple Hon Diane Evers Hon Michael Mischin Hon Dr Sally Talbot
Hon Jim Chown Hon Donna Faragher Hon Simon O’Brien Hon Darren West
Hon Tim Clifford Hon Adele Farina Hon Martin Pritchard Hon Alison Xamon
Hon Alanna Clohesy Hon Laurie Graham Hon Samantha Rowe Hon Pierre Yang (Teller)
Hon Peter Collier Hon Colin Holt Hon Robin Scott
Hon Stephen Dawson Hon Alannah MacTieman Hon Tjorn Sibma

Amendment thus negatived.

The DEPUTY CHAIR: Minister, you have an additional amendment following on from your previous amendment. Do you wish to move that amendment?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: Yes, I do have a consequential amendment on the special notice paper—not the supplementary notice paper, but the supplementary notice paper’s supplementary! I have a second amendment that is consequential, and changes need to be made as a result of the insertion of the clause in relation to the medical practitioner not being a family member of the patient and the other point in relation to the will of the patient. I move — Page 14, line 4 — To delete “subsection (2)(a), (b) and (c)” and substitute — subsection 2(a)(i), (ii) and (iii)

The DEPUTY CHAIR: The Minister for Environment has moved, at page 14, line 4, to delete “subsection 2(a), (b) and (c)” and insert “subsection 2(a)(i), (ii) and (iii)”. The question before the chamber is that the words to be deleted be deleted.

Amendment (deletion of words) put and passed.

Hon NICK GOIRAN: Clause 16 provides that an overseas-trained specialist —

Point of Order

Hon MARTIN PRITCHARD: Do we now have to move that the words to be inserted be inserted?

The DEPUTY CHAIR (Hon Matthew Swinbourn): You are correct. That is right; we have missed that point.

Committee Resumed

Hon NICK GOIRAN: Clause 16 provides that an overseas-trained specialist —

The DEPUTY CHAIR: Following on from that, the question now is that the words to be inserted be inserted. In my defence, I have a lot of Sudafed in me.

Several members interjected.

The DEPUTY CHAIR: No. The question is on the minister’s amendment, that the words to be inserted—that is subsection 2(a)(i), (ii) and (iii)—be inserted.

Amendment (insertion of words) put and passed.

Hon NICK GOIRAN: Clause 16(2)(a)(iii), as it now is, provides that an overseas-trained specialist who holds limited registration or provisional registration may be eligible to act as a coordinating or consulting practitioner. Given the concerns raised in the ministerial expert panel’s final report around language and cultural barriers in Indigenous and culturally and linguistically diverse communities, does the minister have any concerns that overseas-trained practitioners may not have the appropriate skills and training to assess people from diverse cultural backgrounds across Western Australia?

Hon STEPHEN DAWSON: I am advised that these medical practitioners are registered to work in Australia. The training requirements in the bill mean that they will receive further cultural competency training.

Hon MICHAEL MISCHIN: Apropos the circumstances that Hon Nick Goiran outlined in which a consulting specialist could prove to be an orthopaedic surgeon with no skill or expertise in the disease from which the patient is suffering, is that in accord with the policy of the bill and is it desirable?

Hon STEPHEN DAWSON: I am advised that although it may be possible, it is highly unlikely that a patient would make a first request to an orthopaedic surgeon or, indeed, that an orthopaedic surgeon would take a first request from a patient. However, all medical practitioners will need to undergo mandatory training to participate in voluntary assisted dying. I make the point that an orthopaedic surgeon is still a very experienced medical practitioner, but the bill contains clauses that allow for referral to a specialist if a determination cannot be made by that orthopaedic surgeon, if that were the case, which again is highly unlikely.

Hon MICHAEL MISCHIN: We are not talking about just the initial consultation. Basically, the consulting assessment can be done by a practitioner who has been shopped around for and who will give the opinion that the first physician and the patient want. Is that correct?

Hon STEPHEN DAWSON: In the context of voluntary assisted dying, there are circumstances in which it is entirely appropriate for the person to approach another medical practitioner with a first request—for example, if they are having 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. 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 also creates negative connotations of the integrity and skill of medical practitioners involved in the voluntary assisted dying process. Those practitioners are experienced doctors who must have undergone and passed mandatory education. That process requires also two independent assessments of eligibility, which is a further safeguard against the most perceived risk of doctor shopping.

Extracted from finalised Hansard
Hon MICHAEL MISCHIN: Hon Nick Goiran outlined the circumstances in which Dr Nitschke was having trouble finding someone prepared to give a second opinion and endorsement of the course that the patient and Dr Nitschke wanted to take. They looked around, found someone who had no experience in that particular disease, and that was the level of consultation and the consulting assessment. Can that happen under this bill? Is it possible that a doctor such as Dr Nitschke, with a patient who wants to terminate their life through a state-sanctioned mechanism like this, can find a practitioner who will endorse that course of action, even though they have no experience in that particular disease?

Hon STEPHEN DAWSON: I am not going to comment about Dr Nitschke, who operated in a territory under different legislation. If a medical practitioner, a coordinating practitioner, is unable to determine, the coordinating practitioner must refer the patient to a registered health practitioner who has the appropriate skills and training to make a determination on the matter.

Hon MICHAEL MISCHIN: The minister is assuring us that that situation cannot arise under this regime, having regard to the 102 safeguards that have been implemented to ensure the integrity of the model. Is the minister able to assure us that that cannot happen in Western Australia?

Hon STEPHEN DAWSON: I will answer it in this way: the bill provides a model for accessing voluntary assisted dying. We cannot make assurances about illegal or unethical acts.

Hon NICK GOIRAN: I was happy to move on to the next clause, but I was intrigued by the minister’s response to Hon Michael Mischin suggesting that doctor shopping is somehow a misnomer, notwithstanding the fact that the honourable member raises the example of the lived experience in the Northern Territory. I will give one further example of doctor shopping in Oregon. It is important to remember that the model before us is supposedly based on legislation in either Victoria or Oregon. The first known assisted suicide death in Oregon represents a clear example of doctor shopping. I draw members’ attention to the minority report from the yearlong inquiry of the Joint Select Committee on End of Life Choices. Paragraph 3.165—no doubt a paragraph that has not been read by anyone in government—states

This was a patient whose name is unknown, who was in her mid-eighties and who had been battling cancer for twenty-two years. Initially, two doctors, including her own physician who believed her request was due to depression, refused to prescribe her lethal drugs. Compassion & Choices in Oregon, then operating under the name Compassion in Dying, became involved in her case and referred the woman to a doctor willing to write the prescription.

Unfortunately, that is exactly what happens in those jurisdictions. There is no point asking the government about that because we already know from our interrogation under clause 1 that neither the government nor the joint select committee nor the ministerial expert panel has looked into any of the lived experiences in the international jurisdictions. A few people have spent a few cursory moments in time looking at the legislation in some of those jurisdictions, but never into the lived experiences. I am happy for us to move off clause 16, but any suggestion that doctor shopping is a misnomer can only be articulated by individuals who have not studied the experience in the other jurisdictions.

Clause, as amended, put and passed.

The DEPUTY CHAIR: There is an amendment on the supplementary notice paper in the name of Hon Charles Smith. Does the honourable member propose to move his amendment?

Hon CHARLES SMITH: Noting the similarity of this amendment and the amendment moved previously, and noting the chamber’s complete lack of interest in that amendment, I will not move my amendment to insert new clause 16A.

Clause 17: Person may make first request to medical practitioner —

Hon NICK GOIRAN: To what extent is a clause 17 first request made via clause 156(2)(a) restricted by sections 474.29A and 474.29B of the commonwealth Criminal Code Act 1995?

Hon STEPHEN DAWSON: If the patient makes the first request, it will not be an issue, because the patient is initiating the discussion with the practitioner.

Hon NICK GOIRAN: I think the minister moved an amendment earlier that was a variation on what has been referred to as the Buti amendment, which will allow the initiation by practitioners of this discussion. For discussions that are initiated by a practitioner, how will this be impacted by clause 17, clause 156 and the commonwealth Criminal Code Act?

Hon STEPHEN DAWSON: Discussions initiated by a practitioner would need to be made face to face.

I move —

Page 14, after line 11 — To insert —

(aa) made during a medical consultation; and

Extracted from finalised Hansard
This proposed amendment assures that a first request can be made by a patient to a medical practitioner only during a medical consultation. This paragraph has been included following consultation with the Australian Medical Association and the government considers it to be a good amendment. The proposed amendment will remove any obligation from a medical practitioner who is not in a medical consultation from having to report a request to access voluntary assisted dying to the board or provide information to a patient. Only when the first request is made—that is, a valid request under clause 17 of the bill—will the obligation to report to the board and give information to the patient be triggered. The effect of this proposed amendment is that medical practitioners who are not in the setting of a medical consultation, such as full-time researchers, medical administrators, retired doctors or doctors in a social setting, will not be required to lodge a first request form with the board nor to provide the patient with information about the VAD process. Thus, only eligible practitioners—those who meet the requirements under clause 16—or a practitioner who may be ineligible but is within a medical consultation scenario and to whom a first request has been made, will have to report to the board and provide information to the person making the first request. Clause 16 of the bill currently sets out the eligibility requirements for a medical practitioner to act as a coordinating or consulting practitioner. Clauses 16(2)(a) to (c) specifically require that in addition to meeting certain registration requirements, the medical practitioner must also meet requirements approved by the CEO. The very intent of this is to further narrow the types of medical practitioners who can act as the coordinating or consulting practitioner; that is, they cannot be working solely in management or research roles. The proposed amendment to clause 17(2) supports this.

**Hon NICK GOIRAN:** Given that “medical consultation” is not defined anywhere in the bill, does any other Western Australian statute use that term?

**Hon STEPHEN DAWSON:** I do not have an answer to that. My advisers cannot tell me whether it is used elsewhere. But it is a commonly used and understood term.

**Hon NICK GOIRAN:** I can tell the minister that it is not used in any Western Australian statute. In the absence of any statutory guidance, how will this term be interpreted?

**Hon STEPHEN DAWSON:** It will be the ordinary plain English meaning.

**Hon NICK GOIRAN:** Would a clause 17 first request made by clause 156(2)(a) constitute a medical consultation?

**Hon STEPHEN DAWSON:** I am advised that if the patient is in a medical consultation via telehealth, they may make a first request during it.

**Hon NICK GOIRAN:** Given that there will be serious consequences for medical practitioners in the event that they contravene any aspect of this legislation, I think it is appropriate that the medical practitioners in Western Australia understand how “medical consultation” will be interpreted. There is no definition in this bill, it is not a phrase used in any other statute and I am concerned that a medical practitioner may be found in contravention of the legislation simply by virtue of whether the circumstances in which they have a conversation with another person is defined as a “medical consultation”. What criteria can a Western Australian medical practitioner rely on to determine whether a dialogue between them and another person is or is not a medical consultation?

**Hon STEPHEN DAWSON:** I make the point that medical practitioners understand what a medical consultation is. It is a phrase used by medical practitioners and supported by the Australian Medical Association.

**Hon NICK GOIRAN:** Given that it is a phrase that medicos and the AMA use, is that commonly used phrase defined somewhere in some kind of code of conduct or in some other manuals? Is this something that medicos are taught at the University of Western Australia or the University of Notre Dame as they go about their training? It is so commonly used that all these medicos understand it, unlike members of the Legislative Council, so it must be recorded somewhere. Can the minister indicate where that is?

**Hon STEPHEN DAWSON:** I say it again: medical practitioners understand what a medical consultation is. It is a phrase used by medical practitioners and supported by the Australian Medical Association.

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**Hon STEPHEN DAWSON:** I say it again: medical practitioners understand what it is. It is certainly used by Medicare with rebates and billing.

**Hon AARON STONEHOUSE:** I am glad to see this amendment because it addresses something I raised when we discussed division 3 and the terms used. I raised some questions around the definition of “patient” and the broad definition used in clause 5, because on a first reading it seemed to me that a person could make a clear and unambiguous request for voluntary assisted dying in a very unofficial way. That would trigger obligations for a medical practitioner to record the conversation they had with that patient on their medical record and submit forms to the board. That may happen despite the fact that the medical practitioner has no idea who this person or patient is. It may be a casual passing, whereby somebody approaches someone who they know is a doctor, but the doctor has no idea who this person is. They could make an unambiguous request for voluntary assisted dying without the doctor having any idea who that person is, with no access to their medical records and, perhaps, depending on the setting, not being able to follow up with that person to fulfil their obligations under division 2. Can the minister confirm that this amendment addresses the concerns I have raised, that it is during a medical consultation it will ensure that in the scenario I described—somebody passing a doctor in the hall and making a request for voluntary assisted dying—the medical practitioner would not have those obligations triggered and the obligations under clauses 19 and 20 and so on would be triggered only if that request was made during a medical consultation?
Hon STEPHEN DAWSON: That is correct.

Hon AARON STONEHOUSE: I am glad to hear it. That addresses my concern, in which case I am happy to support the amendment put forward by the minister.

Amendment put and passed.

Hon NICK GOIRAN: The Victorian mandatory training for health practitioners involved in providing voluntary assisted dying notes red flags in the training module on the assessment of decision-making capacity. One of those red flags is that the patient can only communicate through gestures and appears to respond to questions inconsistently. Can the minister explain to the chamber how the bill can provide for non-verbal communication by the patient, while at the same time requiring the coordinating and consulting practitioners to ascertain that the patient has decision-making capacity in light of this red flag highlighted in the Victorian training module?

Hon STEPHEN DAWSON: If the medical practitioner cannot reliably determine decision-making capacity, the patient will not meet the criteria.

Hon NICK GOIRAN: Although the WA bill provides that a person may make a first request to a medical practitioner, as the minister knows, it does not contain the equivalent of the Victorian provision at section 8, which states that a VAD discussion cannot be initiated by the registered health practitioner. Our bill has been amended to mandate that any doctor-initiated VAD discussion must be accompanied with advice on treatment options, but could voluntary assisted dying be recommended to a patient by a medical practitioner, either pre or post a first request?

Hon STEPHEN DAWSON: I am advised that they can be informed about it as an option.

Hon NICK GOIRAN: I know they can be informed of it as an option; that is not my question. I want to know whether it can be recommended by a medical practitioner. That is a different thing altogether.

Hon STEPHEN DAWSON: The bill contains carefully considered neutral language in relation to a patient being informed or provided with information; it is not about making recommendations.

Hon NICK GOIRAN: Would the minister be willing to take it on notice—speak to the Minister for Health—and come back to us tomorrow about inserting a prohibition on a medical practitioner recommending voluntary assisted dying for a patient? I accept what the minister is saying about neutral language. I take it that the intent of government, and I would like to think of all members in this chamber, is that if we are going to have this scheme, it is quite one thing for a medical practitioner to initiate the conversation with a patient, but it is another thing for them to recommend it. I find really distasteful the idea that a medical practitioner could see a patient and say, “I recommend that you access voluntary assisted dying.” That is a very significant step. It is different from a patient saying to a doctor, “Doctor, I’m concerned. I’ve had enough and I want to access this voluntary assisted dying. Can you please inform me about my options?” and a conversation takes place or the doctor says to the patient, “These are all things that are available to you in Western Australia, including voluntary assisted dying, as a suite of options.” I think a doctor saying to a Western Australian patient, “I recommend you access voluntary assisted dying”, should be prohibited. I do not think there should be a place for that in our state. I do not expect the minister to be able to determine a position on that off the cuff, right now, but I would like an indication whether he would be willing to take that up with the health minister. If there was agreement in government that that is an appropriate prohibition, it might find a place in a later stage of the bill to put that in.

Hon STEPHEN DAWSON: I am happy to take the issue away and ask the question.

Clause, as amended, put and passed.

Clause 18: No obligation to continue after making first request —

Hon NICK GOIRAN: Why is it necessary to include clause 18 in the bill at all?

Hon STEPHEN DAWSON: This clause reflects the voluntary and enduring nature of requesting access to 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 in relation to accessing voluntary assisted dying.

Hon NICK GOIRAN: What mechanism in the bill ensures that the Voluntary Assisted Dying Board is notified if patients avail themselves of their clause 18 right?

Hon STEPHEN DAWSON: There is no formal process or time requirement to withdraw from the process. The patient may simply state that they do not wish to proceed. The request and assessment process ends if the patient decides not to continue the process. If the patient subsequently wishes to access voluntary assisted dying, they may begin a new request and assessment process by making a new first request.

Hon NICK GOIRAN: Do I take it from that that at the moment, if the bill is unamended, the board will never know whether a patient has accessed their right under clause 18 and requested the process to end?

Hon STEPHEN DAWSON: There is no requirement to notify the board.

Extracted from finalised Hansard
Hon NICK GOIRAN: Would the proposed amendment that inserts new clause 52A be a mechanism that would ensure that the board is notified in the event that a patient avails themselves of their rights under clause 18?

Hon STEPHEN DAWSON: It appears so.

Hon NICK GOIRAN: I congratulate Hon Charles Smith on his amendment to insert new clause 52A, because the minister has just indicated that that would be a mechanism that would ensure that the Voluntary Assisted Dying Board would be notified if a patient avails themselves of their rights under clause 18. Rightly so, I might add, because it troubles me that at the moment the bill is silent on this point, and, quite rightly, this clause states that a patient does not have to continue the process. Of course, they should not have to continue the process, but then it states at clause 18(3) that if they want to start the process, they have to begin again by making a new first request. The board would be none the wiser about any of that, particularly if the medical practitioner was unfamiliar or unskilled in the process that is set out in this particular bill. I look forward to consideration of new clause 52A when we get there.

Hon COLIN TINCKNELL: I refer to clause 18(3), lines 21 to 23. How many first requests, or new requests, can a person make? Is there a limit?

Hon STEPHEN DAWSON: There is no limit.

Clause put and passed.

Clause 19: Medical practitioner to accept or refuse first request —

Hon NICK GOIRAN: What information will be provided to the patient under clauses 19(4)(b) and 19(5)(b)? Will this information include a list of the practitioners who have undertaken the mandatory training and are willing to act as coordinating and consulting practitioners?

Hon STEPHEN DAWSON: No, it will not.

Hon NICK GOIRAN: I think the minister only heard the second part of my question. The first part of my question was: what information will be provided to the patient under those clauses?

Hon STEPHEN DAWSON: I did not hear that bit, sorry; I did only hear the second part. Standardised information regarding the voluntary assisted dying process—for example, eligibility criteria, access points, supports, and that a patient’s consent to assisted dying may be withdrawn at any time—will be developed during the implementation stage and made available to all health practitioners for provision to persons who make a request or require information regarding voluntary assisted dying.

Hon NICK GOIRAN: Will the information that the CEO will require medical practitioners to provide on pain of contravention of the act be tabled in Parliament?

Hon STEPHEN DAWSON: I do not think that the honourable member is asking for it to be made available and tabled now in Parliament, because it does not exist at this stage.

Hon Nick Goiran: No.

Hon STEPHEN DAWSON: It will be put together as part of the implementation phase. As to whether it could be tabled in the future, I cannot see why not.

Hon AARON STONEHOUSE: It is pretty fair to say, based on the answers the minister has just given, that the information to be provided under clauses 19(4)(b) and 19(5)(b) would be fairly comprehensive. It is not going to be something as simple as a URL or the telephone number of some hotline; it will be fairly comprehensive information. Can we expect that to take the form of a brochure or an information pack? What will it actually look like? How large will it be?

Hon STEPHEN DAWSON: That will be determined during the implementation phase, after consultation with the appropriate people.

Hon AARON STONEHOUSE: Under the newly amended clause 17, will there be an obligation for the information under clauses 19(4)(b) and 19(5)(b) to be provided only if a request for voluntary assisted dying is made during a medical consultation, or will there be an obligation for that information to be provided during a more casual conversation? For instance, if a person walked into a reception and asked the receptionist for that information, would there be an obligation for that information to be provided?

Hon STEPHEN DAWSON: The obligation exists only under the first point that the member made.

Hon AARON STONEHOUSE: The medical consultation?

Hon STEPHEN DAWSON: That is it.

Hon ADELE FARINA: Will the information include the potential risks associated with the administration of a voluntary assisted dying substance and the fact that the death may not be pain free and peaceful?

Hon STEPHEN DAWSON: That information will vary depending on the patient. The short answer is no; there will be a general information pack available, but what the honourable member is suggesting would be specific to individual patients. That information would not be included in the general information pack, but it may well be provided. That is provided for under clause 26.

Extracted from finalised Hansard
**Hon ADELE FARINA:** Could the minister please explain to me how the information that I have suggested should be provided is specific to different patients? I am asking about information on the general risks associated with the administration of the voluntary assisted dying substance.

**Hon STEPHEN DAWSON:** There may be general commentary about the risks, but that will be determined during the implementation phase. There will not be commentary on the specific risks associated with a patient taking a particular substance to access voluntary assisted dying.

**Hon AARON STONEHOUSE:** I will just ask the minister one more hypothetical question on this. Can we expect that information about palliative care will be provided in this information pack provided by the CEO to medical practitioners? One other point: will information for victims of elder abuse also be provided as part of that information pack? It sounds like it will be pretty comprehensive in covering the voluntary assisted dying aspect. Will it be comprehensive in providing people with more information about their alternative choices to voluntary assisted dying and, in fact, giving them information that might be useful if they are a victim of elder abuse?

**Hon STEPHEN DAWSON:** The content will be developed during the implementation phase. I will bring the member’s suggestion to the attention of the department; in fact, people from the department are here. But in relation to the specific palliative care information that is given to patients, clauses 26 and 37 deal with that.

**Hon AARON STONEHOUSE:** I would really appreciate it if consideration were to be given to providing information about palliative care in that information pack. I understand that there is an obligation to provide information about palliative care later in the process, at clause 26 and so on, and if the medical practitioner is the person who raises the question of voluntary assisted dying with the patient. However, proposed section 19(5)(b) is triggered only if a medical practitioner refuses to go through with the voluntary assisted dying request and refuses to become the coordinating practitioner. In that instance, when a medical practitioner refuses to carry out a request and they provide this information and send someone on their way, I think it would be very helpful for the patient who has taken this information home to digest to have everything relevant to their end-of-life care at hand. I think it would be very helpful for those people to be provided with information about palliative care in addition to voluntary assisted dying in that information pack. I would appreciate it if that is given consideration when the information is developed.

I have one more question for the minister. Is the obligation on medical practitioners in clause 19(5)(b) replicated in the Victorian Voluntary Assisted Dying Act 2017?

**Hon STEPHEN DAWSON:** I am advised that it is not.

**Hon AARON STONEHOUSE:** Is it replicated in the Oregon legislation, which I am told the Victorian regime and our regime is modelled on?

**Hon STEPHEN DAWSON:** Honourable member, I do not know. I am not sure whether my advisers have that information here. I am not sure what the relevance is. Perhaps the member wants to make his point and I can give an answer. But I do not know at this stage. I might be able to get it, but we do not know at this stage.

**Hon AARON STONEHOUSE:** That is okay, minister; thank you for that. The reason I ask is I am trying to see whether such obligations are replicated in similar jurisdictions to our own. Comparing us with the Netherlands or Belgium, I do not think is really helpful. But looking at Victoria—another Australian jurisdiction—or Oregon, which the Victorian legislation and our own legislation is modelled on, would be helpful in informing us whether such an obligation is included in their legislation and is necessary, how their voluntary assisted dying schemes operate in the absence of such an obligation and whether there are problems with patients being informed of the option for voluntary assisted dying in the absence of such an obligation. I will sit down for now because I think other members have questions along a similar line.

**Hon RICK MAZZA:** I will just step through this, minister. Someone has a medical consultation and they ask their doctor about voluntary assisted dying and the doctor is a conscientious objector. Does the doctor simply need to give the patient a pamphlet, or whatever the CEO-approved information is, and send the patient on their way? Is there a requirement for the medical practitioner to make a report to a board or anything? If they do not give the information, do any penalties apply?

**Hon NICK GOIRAN:** While the minister is finding the answer, the honourable member might like to know that earlier today the minister tabled a schedule as per a discussion we had last week, and it sets out all the different clauses, including the penalty if the practitioner has contravened anything. The schedule that was tabled earlier today refers to clause 19(5)(b), which provides for giving a patient information approved by the CEO. When the medical practitioner has a conscientious objection and does not provide the information, it will not constitute a criminal offence under the bill, but it will enliven clause 10 of the bill whereupon any associated penalties are determined by the Health Practitioner Regulation National Law (WA). Therefore, in other words, it will be some kind of misconduct. It will not be a criminal offence, but it is still a very significant penalty imposed on a medical practitioner who says, “I don’t want to be involved in this”, and suddenly we say to them, “You’ve now committed misconduct.”

**Hon COLIN TINCKNELL:** Further to that question, what if the medical practitioner is not a conscientious objector but he believes that the patient is making a mistake by seeking to access VAD?

*Extracted from finalised Hansard*
Hon STEPHEN DAWSON: If the medical practitioner refuses the first request, they still have the responsibility to provide the information.

Hon NICK GOIRAN: Therein lies the problem in which we have a medical practitioner who says, “Look, I’m very concerned about this particular patient. I don’t think they should be accessing voluntary assisted dying”, for example, “because I think that this particular individual is depressed, so I’m not going to facilitate this process. I’m going to choose, under clause 19(2), to say that I’m unwilling to perform the duties of a coordinating practitioner. I’ve done the training, but I’m not going to perform it with regard to this person because I believe this person is depressed”, yet we as legislators are now going to say to that doctor that they have to provide this information approved by the CEO. That troubles me.

It brings me to a question I have. Why is it that under clause 19(5), we oblige a practitioner who has a conscientious objection to immediately inform the patient, whereas everybody else has two business days? Under clause 19(2)(a), a person might be unwilling to perform the duties; under subclause (2)(b), a person might be unable to perform the duties; or under subclause (2)(c), a person may refuse the request because they are not eligible to act. In any of those scenarios, we give the practitioner two business days to inform the patient. But if they are a conscientious objector, we really punish them and make sure that they have to inform the patient “immediately”. Why was it decided that the conscientious objector has to inform the patient immediately, but everybody else, including the person who is unable or unwilling or does not even qualify to participate, has two business days?

Hon STEPHEN DAWSON: First of all, it is not about punishment, it is about the best interests of the patient. Subclauses (4) and (5) create a positive duty on the medical practitioner to inform the patient of their acceptance or refusal of the first request. This reflects the position that a medical practitioner is professionally obligated to not unduly delay a patient’s access to voluntary assisted dying. They should make a decision and inform the patient as quickly as possible. If the medical practitioner is a conscientious objector, they must inform the patient of the refusal immediately after receiving the first request. For other reasons, as Hon Nick Goiran pointed out, the medical practitioner must advise the patient within two business days of the request. This provision takes into consideration that a person who conscientiously objects to voluntary assisted dying will refuse a patient’s request as a matter of course. Thus, this medical practitioner does not require a length of time to come to that decision and there is no reason to delay notification to the patient. However, other medical practitioners may require time to consider whether they are available or able to provide this service to the patient—for example, the medical practitioner cannot schedule the patient in, or they do not meet one or more of the minimum requirements to be a coordinating practitioner.

Hon NICK GOIRAN: What absolute rubbish, minister, because a practitioner who has not fulfilled the training requirements knows instantly that they are not able to participate. I draw the minister’s attention to subclause (3). It states —

The medical practitioner must refuse the first request if the practitioner is not eligible to act as a coordinating practitioner.

The medical practitioner knows that immediately; they have either done the training or they have not. The suggestion that somehow the conscientious objector is the only type of medical practitioner who understands instantly and then has to tell the patient makes no sense in light of subclause (3). It is not at all clear to me why we are—in my language—punishing the conscientious objector. Nevertheless, could it be the case that a conscientious objector has not done the training and is therefore not eligible to act as a coordinating practitioner? In that instance, they qualify under subclauses (2)(a) and (3). Do they get two business days to inform the patient or do they have to inform them immediately?

Hon STEPHEN DAWSON: 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 first request and prior to undertaking the first assessment.

Hon AARON STONEHOUSE: I would like to pick up on something that was raised by Hon Nick Goiran—that is, the obligation for a medical practitioner to provide the information laid out by the CEO in instances when they are not necessarily conscientious objectors, but they are unwilling to perform an assessment and become a coordinating practitioner because they know, perhaps for a fact, that a patient is ineligible. Maybe they know that a patient has severe depression or some cognitive impairment, or perhaps they know that the patient is under the age of 18. It seems to me that we are creating an obligation here by which a 16-year-old or even someone younger could walk into a medical practice and during a medical consultation make a request for voluntary assisted dying, and there would be an obligation on the medical practitioner to provide the information pack laid out by the CEO. Am I wrong in that reading of the obligations in clauses 19(4)(b) and 19(5)(b), or have I got that right?

Hon STEPHEN DAWSON: They are required to provide the information. It does not mean that the patient can access it straightaway. It is our belief that the doctor should communicate his or her concerns to the patient. The patient would still have to undergo the assessment process with relevant practitioners. I think the member also alluded to people under 18. Can I just make the point that if someone is under 18, they are not eligible.

Hon Aaron Stonehouse: But there would be an obligation to provide information.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: Let me clarify that. Yes, they would be under an obligation to provide it.

Hon AARON STONEHOUSE: Madam Deputy Chair (Hon Adele Farina), I am sure you can understand why I am deeply concerned about this. There could be a situation of someone under the age of 18 making inappropriate requests for voluntary assisted dying and a medical practitioner would have an obligation to provide information about it to that person. There may also be an instance of a medical practitioner knowing that their patient has suicidal ideation. That patient could make a request for voluntary assisted dying and the medical practitioner would have an obligation to provide information about voluntary assisted dying. I think that is grossly inappropriate, and it could lead to some serious harm. Without adequate protection for medical practitioners who refuse to provide that information, vulnerable people at serious risk of harm could be provided information about voluntary assisted dying. I know we have gone to pains not to use the word “suicide” in this instance, but providing that kind of information to somebody who suffers from suicidal ideation or has a severe mental illness is going to put those people at great risk of harm, and I am very, very concerned about that. It is something I do not think we have really appreciated until we have had the chance to interrogate this clause, but I think all members should be concerned about that obligation on medical practitioners in this instance. Without a way to opt out, without any discretion afforded to medical practitioners, we will be putting them in a horrible situation in which even if they know it will cause harm, they will still be obliged to provide information. They will be compelled to do so, and if they do not, there will be professional misconduct. They may be potentially stripped of their ability to practise for refusing to participate and provide the information they are compelled to.

Hon ALISON XAMON: I respectfully disagree with the concerns being raised by Hon Aaron Stonehouse on the basis that if a medical practitioner is faced with this situation that has been described by the honourable member, in theory they may be obliged to provide the basic information, but that basic information would make it very clear that the person who may be experiencing suicidal ideation is simply not eligible to avail themselves of this. What it does do is open an opportunity with a clinician to talk to that person about their mental health issues and the fact that they are experiencing suicidal ideation. Fifty per cent of mental health presentations first occur with general practitioners. It is a very, very common occurrence, and one that general practitioners have to deal with at least weekly, sometimes on a daily basis. Part of their training is to learn how to respond to people who are experiencing deep mental health stress and then to address the issues accordingly. I do not think that the supply of the information is going to pose the sort of risk that is being contemplated by the honourable member. I think it clarifies that voluntary assisted dying is not the appropriate course of action, or even available in this instance. It opens up the opportunity for a therapeutic response to deal with serious mental health issues.

Hon NICK GOIRAN: I am reminded of a case that was shown in the documentary Fatal Flaws. A young lady in the Netherlands continued time and again to try to have access to voluntary euthanasia as it is in the Netherlands. There is a very sad scene in which the filmmaker, Kevin Dunn, is in this dialogue with this lady, and he continues to follow up with her afterwards, but she is insistent that she wants to access this. She acknowledged, and I think it was obvious from the documentary, that she suffered from some form of mental illness, and that was the reason that she wanted to access euthanasia. It is true that under the eligibility requirements we agreed to earlier under clause 15(2), a person is not eligible to access VAD only because they have a disability or have been diagnosed with mental illness. That is true, but Hon Aaron Stonehouse’s point is that in the meantime the practitioner, knowing this, still has to provide information. I would have thought that the only circumstances in which a doctor should have to provide this information for a patient would first of all be if the doctor knows that the person is over 18 years of age. If the person is not 18 years of age, the doctor should not have to provide this information. If the doctor knows that the person has not been ordinarily resident in Western Australia for the last 12 months, they should not have to provide information. If they know the person does not have a terminal illness because they are in a longstanding therapeutic relationship with the person, they should not have to provide the information.

Above all else, even if members do not agree with me on all of those points and say that practitioners should still provide the information, surely to goodness if the practitioner has a longstanding relationship with the person and they can see that this person has been coerced by a family member, that should be enough for the practitioner to say, “I am hitting the pause button here. I cannot provide you with this information. Why? Because I am going to exercise the right that is available to me under clause 19(2), which says that I am otherwise unwilling to perform the duties.” That should be enough. I do not see why we then create this mandatory requirement upon this clinician, who in all good faith says that they are not going to provide this and that they are not going to participate, but they still have to steer the person in the other direction. I, like Hon Aaron Stonehouse, am concerned about this provision. I note that unlike clause 19(5), by which we in Western Australia are going to force our practitioners to provide information, in Victoria not only are practitioners not forced to do that, but they have a statutory right to say that they will refuse to provide information about voluntary assisted dying. Victoria basically does the exact opposite of us. Victoria says, “Medicos, if you do not want to provide information about voluntary assisted dying, you have a statutory right not to provide it.” In Western Australia we say, “Forget that, you do not have any such right. In fact, you have an obligation under this law to provide information.” I am grateful that I am not a medical practitioner. I think we are doing the wrong thing here.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: While I have it at hand, referring to the Oregon legislation and the member’s earlier question, Oregon legislation requires the patient to make an informed decision; however, it does not include provisions such as found at clause 19(5)(b). That is in relation to that issue.

It is important to note that mature minors can currently make their own medical decisions. That happens today. As we have said, the bill requires that for someone to access voluntary assisted dying, they must be a minimum of 18 years of age. If a doctor were not to give that information because they thought that a person was under age or mentally unwell, what could happen? Under clause 10 of the bill, the patient could potentially report the doctor, 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 for the purposes of the Health Practitioner Regulation National Law (Western Australia).

The reality is that if it were reported and investigated, it is likely that no breach would be found because the people investigating it would recognise that the patient was underage and that the doctor had made a legitimate decision by not providing it. Further, in relation to the residency issue, a person who ordinarily may be resident or have a condition just outside the criteria should be able to avail themselves of information before they make a valid first request.

Hon AARON STONEHOUSE: I thank the minister for providing that information on Oregon. I appreciate the reassurances provided by Hon Alison Xamon. I understand, I suppose, the view that the information provided to medical practitioners by the CEO would ideally address concerns about people with mental illness who are seeking appropriate help and not going down the avenue of voluntary assisted dying. I remain concerned, however, that someone in a very vulnerable state who is provided with information about voluntary assisted dying may pose a harm in some instances, especially in the case of someone under the age of 18 who is very vulnerable and very susceptible to suggestion and would, perhaps, not have the same powers of reason that a fully formed adult might have. They might read that information and it might plant in their mind the seed of an idea about causing their own death. I remain concerned about that. We do not know at this time what will be in the information pack provided by the CEO. I certainly hope that it is comprehensive information that points people to mental health services, and provides information to victims of elder abuse and information about palliative care. But at the moment I am concerned that it may not, and I am concerned about what seems to be a lack of discretion for medical practitioners who may know what best information to provide to their patients at the time, but would be obliged to provide the information that the CEO tells them to provide.

Originally, my interest in this clause was around conscientious objectors, but on closer reading and seeing that subclause (2)(a) refers to “otherwise unwilling to perform the duties of a coordinating practitioner”, I took more of an interest in the issue around medical practitioners who may know that their patient is ineligible or may have some perhaps not conscientious objection, but ethical objection to providing information that sits outside the bounds of their religious, cultural or moral beliefs about voluntary assisted dying. It is that lack of discretion that I think will do the most harm. Depriving medical practitioners of the ability to assess their patient’s situation, perhaps even their patient’s mental state at that time — although they may not be the best placed clinically to do so, they do have that longstanding relationship and, as was pointed out by Hon Alison Xamon, they are on the front line to assess the mental health of the public in a lot of ways because they do provide referrals to mental health services — I fear may cause harm, if they are not able to exercise their judgement appropriately in those instances. In any case, Mr Chairman, I have an amendment that I hope addresses these problems. I move —

Page 15, lines 19 to 26 — To delete the lines and substitute —

(5) If the medical practitioner refuses the first request under subsection (2)(a), the practitioner must, immediately after the first request is made, inform the patient that the practitioner refuses the request.

As I pointed out a moment ago, the Victoria legislation contains no such obligation, and, as was pointed out by the minister, neither does Oregon. Oregon is the basis for the Victorian legislation and our legislation. We have obviously borrowed a lot from the Victorian legislation in the drafting of this bill. It is worth recognising that section 7 of the Voluntary Assisted Dying Act 2017 in the Victorian regime, under the heading “Conscientious objection of registered health practitioners”, states —

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) to provide information about voluntary assisted dying;
(b) to participate in the request and assessment process;
(c) to apply for a voluntary assisted dying permit;
(d) to supply, prescribe or administer a voluntary assisted dying substance;
(e) to be present at the time of administration of a voluntary assisted dying substance;
(f) to dispense a prescription for a voluntary assisted dying substance.

Extracted from finalised Hansard
Victoria’s legislation not only is lacking in obligation for medical practitioners to provide information, but also expressly provides them the right to not do so. Why it is missing in the case of the Western Australian bill is somewhat of a mystery to me. It had always been my impression that Victorians were a little more progressive than we were here. However, we have pursued a slightly different regime that will place upon medical practitioners the obligation to provide information; that is, members, despite the principles of the bill. I refer members to division 2, clause 4, “Principles”, and subclause (1)(j), which reads —

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

In fact, later in division 4, clause 9 states —

(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;
(b) prescribe, supply or administer a voluntary assisted dying substance;
(c) be present at the time of the administration of a voluntary assisted dying substance.

(2) Subsection (1) is not intended to limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in that subsection.

Clause 9 of the Western Australian bill is essentially section 7 of the Victorian bill; however, clause 9 of the Western Australian legislation is absent a protection and a right for medical practitioners to refuse to provide information about voluntary assisted dying. I pointed out previously that I think it is undesirable that in a bill in which we have gone to great pains to ensure that there is no coercion, and that the bodily autonomy and the sovereignty of patients is respected and that patients will be free to make their own choices about their own health care, and in which the options at the end of life are paramount and central to this bill, we are also placing upon medical practitioners obligations that will violate their conscience and take away their right to conscientiously object. Clause 4, “Principles”, and clause 9—the quite overt reference to the right of medical practitioners to be conscientious objectors—are contradicted by clause 19(5)(b). Medical practitioners who have a conscientious objection to voluntary assisted dying will be forced—compelled—to provide information in contravention of perhaps deeply held religious or cultural beliefs.

My amendment addresses not just this infraction but also the concerns I raised earlier—that a medical practitioner who is otherwise unwilling to perform the duties of a coordinating practitioner will still be obliged to provide information. It is my belief that that will cover medical practitioners who know that their patient is ineligible or know that it would be inappropriate if their patient were to seek voluntary assisted dying in the instance that their patient is under the age of 18 years or is suffering from a mental illness or some other cognitive impairment. By deleting lines 19 to 26 on page 15 and inserting a new clause 19(5) that reads, “If the medical practitioner refuses the first request under subsection (2)(a)”, rather than the current reference to conscientious objectors, my amendment will ensure that any medical practitioner who objects or refuses under subclause (2)(a)—that being conscientious objectors or medical practitioners otherwise unwilling to perform the duties—will be protected from the obligation to provide information to a patient. There is still an obligation for them to inform the patient immediately of their refusal to carry out those duties. The patient is to be advised that the medical practitioner will not carry out the duties, but there is no obligation to provide the information. This amendment will ensure that medical practitioners are not put in that difficult situation of having to violate their conscience or provide information that they think may be harmful to a patient. It is consistent with the Victorian legislation. It is consistent with the Oregon legislation. It is consistent with the principles of liberalism. It is consistent with the principles of this bill as stated in clause 4—that autonomy should be respected, the religious and cultural views of individuals should be respected and people should not be coerced. I commend this amendment to the chamber.

Hon ALISON XAMON: In response to the amendment that has been presented, I go back to clause 19(2)(a) of the bill. It is important that we note that subclause (2)(a) is split into two different parts; one part refers to conscientious objection and the other part refers to being otherwise unwilling to perform the duties of a coordinating practitioner. The reason that is important to note in relation to this amendment is that subclause (5) refers only to the requirement to give information in the event of a conscientious objection. It is important to note that the bill currently refers to a scenario in which a practitioner is otherwise unwilling to perform the duties of a coordinating practitioner. That could well be a situation in which a practitioner is of the view that someone is at risk, is experiencing psychosis, is six years old or is clearly not dying. We could envisage a whole range of scenarios in which it would be not only inappropriate, but also potentially patently absurd for the GP to be obliged to supply that information. As I understand the minister’s response previously, if someone were to issue a complaint that the information had not been issued in those circumstances, that complaint would be unlikely to be upheld. It is important to make that distinction, because then the existing provision that the amendment seeks to amend would apply only to people who are unwilling to supply the information because they have a conscientious objection. I think the conscientious objection provision within this legislation is an important one and one that we should be absolutely prepared to protect and uphold. It is reasonable. In fact, I have not heard anybody argue against the capacity for a medical

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practitioner to exercise a conscientious objection to this piece of legislation. However, it says that the medical practitioner cannot just advise that they object and leave it at that, with no capacity for a patient to have any idea about where they might be able to go after that. This is not an uncommon provision in other conscientious objection regimes. For example, with teenage pregnancies and those sorts of things, people are not obliged to engage in particular procedures if they do not wish to, but nor should people be left without any idea about the options that are potentially available to them if they go elsewhere.

It is important to note that the amendment refers to the medical practitioner refusing the first request under subclause (2)(a), and that is broader than the current requirement in the bill to provide information. I wanted to at least make sure that members were aware that it is potentially imputing a requirement to give information that I am not sure currently exists within the entirety of subclause (2)(a).

Hon AARON STONEHOUSE: In response to the remarks by Hon Alison Xamon, I point members to clause 19(4), which states —

Unless subsection (5) applies, —

That is the conscientious objector provision —

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.

Under subclause (2)(a), if the medical practitioner is otherwise unwilling to perform the duties of a coordinating practitioner, subclause (4)(b) will come into effect and they will have to provide that information. My amendment focuses on subclause (2)(a) in its entirety, rather than just the conscientious objector provision, which is currently referred to in subclause (5). The reason I have done that is that although I originally intended to protect the rights of conscientious objectors, as I have teased out this issue of objections under subclause (2)(a), I have become concerned about the lack of discretion afforded to medical practitioners who are unwilling, for some ethical reason rather than a conscientious objection, to carry out the duties of a coordinating practitioner because they know that their patient is vulnerable, at risk of harm, patently ineligible or things of that nature. I am providing a broader protection for all objections under subclause (2)(a). It is intentional and I think it is appropriate.

I am mindful of the comments made by the minister about a breach of obligations under subclause (4)(b) if a six-year-old walked into a medical practice and asked for access to voluntary assisted dying and the doctor said, “Get out of here; that’s silly.” If that were taken to the professional board that oversees the conduct of medical practitioners, the board would assess the circumstances and a reprimand would probably not be involved. In an example like that, it probably would not involve a reprimand, but I am very uncomfortable with the idea of leaving it to some external body to determine the circumstances in which it may be appropriate or inappropriate for a medical practitioner to refuse to provide information under subclauses (4)(b) or (5)(b). There may be situations that are not so black and white and are quite nuanced. It is essential that we provide clear protection to medical practitioners in this instance and make it very clear to them what their rights and obligations are. If we say to medical practitioners, “Use your discretion and maybe your oversight board will determine whether you acted appropriately”, I do not think that is an appropriate way to legislate. I do not think that will provide adequate comfort to medical practitioners in the future when they are trying to determine what their obligations are. My amendment very clearly states that any refusal under subclause (2)(a) will not trigger an obligation to provide information. I think it is very appropriate.

By retaining the obligations under subclause (5)(b), we are saying to people who have deeply held religious or cultural beliefs—they may be Christian, Muslim, Sikh or what have you—that even though they have a moral objection to voluntary assisted dying, they will be compelled by the state to participate in that regime. I know that members will say that they do not have to be the coordinating practitioner, but providing comprehensive information about how people can access voluntary assisted dying is being involved in the regime. I am sure that it is not hard for members to imagine a scenario in which there is something that they find morally objectionable that they would not do or facilitate themselves, but if they were forced to provide information to somebody who asked them about it, they would find that a breach of their conscience—something that gets them involved in a process that they find morally objectionable. Are we willing to compel medical practitioners to do that? I do not think we should. In a western, liberal democracy, in which we are passing a bill central to which is the autonomy and rights of an individual to make choices for themselves about their own health care at their end of life, it would be reprehensible to include in that legislation obligations that violate the conscience of medical practitioners.

I really want members to think carefully about that. If that is what they want to do, I guess I cannot convince them otherwise, but they should not be kidded. This will involve putting an obligation on medical practitioners with conscientious objections to voluntary assisted dying to provide information.

Hon MARTIN PRITCHARD: As a side point, in a previous clause we debated and allowed for doctors to be able to initiate the discussion on VAD. During that debate, I raised the concern that it did not mandate that the doctor had to raise it, so many patients would be unaware of voluntary assisted dying and many doctors would not

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raise it because of their conscientious objection or other reasons. I said at the time that during the implementation stage, the department would need to put together a strategy for people to learn about voluntary assisted dying. I make that point again. I am sympathetic to the amendment and think it behoves the department to make sure that people are aware of voluntary assisted dying and can access information.

Hon JACQUI BOYDELL: I will not be supporting the amendment for a couple of reasons. I think it comes with the premise that providing information is participating. I do not agree with that principle or that that is the case. I have always believed that doctors have an obligation to inform patients of their options. A medical practitioner who is a conscientious objector simply provides information to a patient who asks about voluntary assisted dying, and that does not mean that they are participating in the potential voluntary assisted dying plan for that patient. If doctors want to be conscientious objectors, they will have no role, apart from handing over information to patients. I do not believe a medical practitioner who is a conscientious objector will be in a position to be able to make an assessment about whether a patient is or should be eligible for voluntary assisted dying because they have decided to opt out. It is not their call to make. If doctors want to be conscientious objectors, I completely respect that, but that means that they do not get to make any assessments about whether patients should be eligible. They get to hand over information to the patient, allow the patient to read the information, determine whether they may be eligible and seek further consultation. Just because patients have the information does not mean that they will continue the process or will participate in any way. If patients get the information and determine that they want to seek out a medical practitioner who may be able to assist them, they will still have to go through the process and at that point the assessment of their eligibility will be made. That they got the information from a doctor who was a conscientious objector has nothing to do with the fact that they may access the scheme.

From a regional perspective, if the bill should pass the house, regional patients will need a process to protect them and give them access to voluntary assisted dying, because if the one doctor in their town is a conscientious objector, they will still have to go through the process and continue the process or will participate in any way. If patients get the information and determine that they want to seek out a medical practitioner who may be able to assist them, they will still have to go through the process and at that point the assessment of their eligibility will be made. That they got the information from a doctor who was a conscientious objector has nothing to do with the fact that they may access the scheme.

Hon RICK MAZZA: I have been weighing up two things when thinking about this amendment. The first is the idea of someone going to their medical practitioner and that medical practitioner having a conscientious objection or being unwilling to discuss voluntary assisted dying with them and being sent away with no pamphlet or information. The second is that if the medical practitioner does not provide information and a complaint is made to a standards board, they will be at the mercy of the standards board as to whether they will be prosecuted, for want of a better word. That seems a little open-ended to me as a legislator. What the penalty would be for that medical practitioner is not clear enough. If they were to be suspended or have a severe penalty put on them, it could impact them greatly. Weighing those two things in my mind—a patient being sent away without information, or a medical practitioner having a complaint made against them and, I think, unjustly, receiving a penalty for that—I err on the side of supporting this amendment. It is a little concerning to me in some ways that this clause does not cover off situations in which medical practitioners do not provide the information clearly. If it did, I would probably be likely not to support the amendment and think that the patient should be given some information before being sent away. On that basis, I will be supporting the amendment.

Hon NICK GOIRAN: This bill refers to a request and assessment process. That is referred to a few times in the bill, including under clause 8, which tells us when the request and assessment process is completed. Is a medical practitioner’s decision to accept or refuse a first request part of the request and assessment process?

Hon STEPHEN DAWSON: The honourable member asked the very same question at clause 9. In fact, a lot of what has been raised in this clause this evening was raised under clause 9. We had quite an extensive debate at clause 9, so I do not propose to re-answer questions that were asked at clause 9 now. I do not propose to go into the same level of detail we went into at clause 9, but I will comment on some things that have been raised. I draw members’ attention to the report of the Ministerial Expert Panel on Voluntary Assisted Dying. On page 52, under the heading “Personal objection”, it states —

If legislation is passed to enable voluntary assisted dying in Western Australia the panel noted the relevance of the principle that a person should not be impeded in accessing what would be a legal option at end of life. In the Panel’s view however, it is not sufficient to simply not impede access.

A little later it continues —

... the Panel determined that the most appropriate option was to recommend that practitioners and services that have a conscientious objection have an obligation to provide information to people seeking voluntary assisted dying but are not obliged to refer on. This would appear to be an acceptable ‘middle ground’.

The provision of information balances the right of a doctor to conscientiously object and the right of a patient to be properly informed. The bill reflects that this balance should favour the patient in these circumstances. It is also consistent with current professional obligations. I have already given reasons for the different timing requirements for practitioners, so I am not going to go over that again. I reiterate that this is in line with the

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Australian Medical Association’s position on conscientious objection. I have read that before, but I will bring it to members’ attention again. Its position statement states —

A doctor with a conscientious objection should inform the patient of their objection, preferably in advance or as soon as practicable, and inform the patient that they have the right to see another doctor. The doctor must ensure the patient has sufficient information to enable them to exercise that right, and take whatever steps are necessary to ensure the patient’s access to care is not impeded.

Hon NICK GOIRAN: For starters, minister, that is talking about care being provided to a patient, not a pathway to death. There is a very big difference between a medical practitioner who has a conscientious objection being required to send information to a patient to care for them and sending them on a pathway to death. I find it appalling to try to use that as the justification for that. By the way, the reason I asked that question earlier—as to whether this is part of the request and assessment process—is that Hon Jacqui Boydell has just passionately put to us that this has nothing to do with participating in the process. According to the minister’s own bill, providing information is part of the first request, and the first request is part of the request and assessment process. I was just trying to clarify that for the honourable member, who seemed to be under the misapprehension that by providing information, one is not actually participating in the process. That is not what the minister’s bill says, but I understand that he is not willing to answer that question. I am not at all persuaded by the non-answers that have been provided this evening. I hold the view that if it is good enough for the Victorian doctors, it should be good enough for the Western Australian doctors. I do not see why our Western Australian doctors should be treated like second-class citizens. I also find it quite ironic that we 36 members have a conscience vote, but we are not prepared to provide the same conscience right to medical practitioners in Western Australia.

Division

Amendment put and a division taken, the Chair casting his vote with the ayes, with the following result —

Ayes (7)
Hon Nick Goiran  Hon Simon O’Brien  Hon Aaron Stonehouse  Hon Ken Baston (Teller)
Hon Rick Mazza  Hon Charles Smith  Hon Colin Tincknell

Noes (26)
Hon Martin Aldridge  Hon Stephen Dawson  Hon Colin Holt  Hon Matthew Swainbourn
Hon Jacqui Boydell  Hon Colin de Grussa  Hon Alannah MacTiernan  Hon Dr Sally Talbot
Hon Robin Chapple  Hon Sue Ellery  Hon Kyle McGinn  Hon Darren West
Hon Jim Chown  Hon Diane Evers  Hon Michael Mischin  Hon Alison Xamon
Hon Tim Clifford  Hon Donna Faragher  Hon Martin Pritchard  Hon Pierre Yang (Teller)
Hon Alanna Clohesy  Hon Adele Farina  Hon Samantha Rowe
Hon Peter Collier  Hon Laurie Graham  Hon Robin Scott

Amendment thus negatived.

Clause put and passed.

Clause 20: Medical practitioner to record first request and acceptance or refusal —

Hon AARON STONEHOUSE: Clause 20 deals with an obligation on medical practitioners to record the first request and acceptance or refusal. Just to be absolutely clear, that obligation exists regardless of whether a medical practitioner has refused a request under clause 19(2)(a), (b) or (c); is that correct?

Hon STEPHEN DAWSON: Yes.

Hon AARON STONEHOUSE: I assume that if it is during the course of a medical consultation, as amended clause 17 now reads, a medical practitioner would presumably have access to a patient’s medical record; is that correct?

Hon STEPHEN DAWSON: Each patient has their own medical record. They do not have access to the medical records of another practitioner.

Hon NICK GOIRAN: Under clause 20(d), why is it assumed that the practitioner might not have given the patient the information referred to? It seems to indicate that they might have provided it, but they might not have provided it, yet at clause 21(2)(g), it is assumed that the patient has been provided the information. Why the distinction?

Hon STEPHEN DAWSON: At the time of the medical consultation at which the first request has been made and has been documented, under the clause, the practitioner may not have given them the information yet, as they may have two days to give it to them, as per clause 19(4). Clause 20(d) can be a reminder to the practitioner about what they have to do.

Hon ADELE FARINA: Could the minister clarify whether the medical practitioner is required to record in the My Health Record for the patient any of this information that they are required to record?

Hon STEPHEN DAWSON: The bill does not require it.

Clause put and passed.
Clause 21: Medical practitioner to notify Board of first request —

Hon NICK GOIRAN: Is a conscientious objector obligated to comply with clause 21?

Hon STEPHEN DAWSON: The answer is yes.

Hon NICK GOIRAN: How so, in light of clause 9?

Hon STEPHEN DAWSON: They need to fulfil the requirements of the first request. This includes reporting to the board. I think that this point has been canvassed at an earlier stage of the debate.

Hon NICK GOIRAN: When we supposedly had a discussion at an earlier part of the debate, the minister indicated that the specific overrides the general. I think the minister said that to the chamber. Clause 19 is very specific about conscientious objection, whereas clause 21 is entirely silent. In those circumstances, given that there is no specific requirement for conscientious objectors under clause 21, on what basis are we now saying that there is a specific requirement that overrides the general provision at clause 9, specifically when clause 9(2) states —

Subsection (1) is not intended to limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in that subsection.

Hon STEPHEN DAWSON: There is operational continuity between clauses 19, 20 and 21. It clearly applies to practitioners under clauses 19 and 20.

Hon AARON STONEHOUSE: The obligation in clause 21 for a medical practitioner to notify the board of a first request would apply in those circumstances that I described earlier when we discussed clause 19—that being a situation in which a child may make a request to a medical practitioner. A medical practitioner would be obliged to fill out the first request form and record information such as name, date of birth, the contact details of the patient, the name and contact details of the medical practitioner, the date when the request was made and so on. That same obligation would exist for other people who may be, on the face of it, potentially eligible, but it seems to me to be a little absurd that in those instances in which a patient is clearly ineligible—one under age—a medical practitioner would still be obliged to fill out that form. That is not a question; it is merely an observation. Some of these obligations might be a little too rigid and do not allow medical practitioners to use their discretion in these instances.

If it is helpful to clear it up for other members, there is an amendment to clause 21 in my name on the supplementary notice paper. That is a consequential amendment to the amendment I moved to clause 19. As my amendment to clause 19 was unsuccessful, I do not intend to move my amendment 14/21.

Hon NICK GOIRAN: Is the amendment on the supplementary notice paper at 14/21 consistent with clause 20(d)?

Hon STEPHEN DAWSON: Sorry, honourable member, but we were having a debate about the question. Would you mind asking the question again, please?

Hon NICK GOIRAN: Is the amendment standing on the supplementary notice paper at 14/21 consistent with clause 20(d)?

Hon STEPHEN DAWSON: I am advised it is not consistent, but it does not need to be, because the obligation to provide the information should have been complied with before notification to the board.

Hon NICK GOIRAN: If the minister looks at clause 21(2)(g), he will see that it refers to the practitioner needing to provide —

the date when the medical practitioner informed the patient of the practitioner’s decision and gave the patient the information referred to in section 19(4)(b);

Could that not happen on two different dates?

Hon STEPHEN DAWSON: Yes, it could be two different dates.

Hon NICK GOIRAN: Would the amendment standing in the name of Hon Aaron Stonehouse at 14/21 not be superior to the current provision at clause 21(2)(g), which conflates the two requirements into one date, whereas Hon Aaron Stonehouse’s amendment separates them out?

Hon STEPHEN DAWSON: I am advised that Hon Aaron Stonehouse’s amendment does not include the date requirement; our clause does, and allows for different dates to be recorded. This will be provided for at implementation.

Hon NICK GOIRAN: I move —

Page 16, lines 24 and 25 — To delete the lines and substitute —

patient of the practitioner’s decision;

(ga) the date when the medical practitioner gave the patient the information referred to in section 19(4)(b);

The DEPUTY CHAIR: That is slightly different from the amendment on the supplementary notice paper. We will get that distributed.

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Hon STEPHEN DAWSON: The government is of the view that the current provision in the bill is clearer. As I have said, if the date is different, this will be recorded, and the change is not required.

Hon NICK GOIRAN: The provision currently reads —

the date when the medical practitioner informed the patient of the practitioner’s decision and gave the patient the information referred to in section 19(4)(b);

Is the minister saying to the chamber that that provision is clearer than a provision that separates out the two and specifies that there is a possibility that there will be different dates between the two? I am staggered if it is seriously the advice to the chamber that clause 21(2)(g) is clearer than the amendment that I have proposed.

Hon AARON STONEHOUSE: I have been convinced of the importance of the amendment that I had on the supplementary notice paper, albeit now with slightly different wording—it does seem to provide some clarity. However, I am interested to hear what the minister has to say in response to the point just made by Hon Nick Goiran. At this point, I view the amendment favourably.

Hon STEPHEN DAWSON: My advice stands. I am advised that, as it reads, the date applies to both limbs.

Division

Amendment put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the noes, with the following result —

Ayes (7)
Hon Martin Aldridge  Hon Martin Pritchard  Hon Aaron Stonehouse  Hon Nick Goiran (Teller)
Hon Rick Mazza  Hon Charles Smith  Hon Colin Tincknell

Noes (28)
Hon Ken Baston  Hon Jacqui Boydell  Hon Robin Chapple  Hon Tim Clifford  Hon Alanna Clohesy  Hon Peter Collier  Hon Stephen Dawson  Hon Colin de Grussa  Hon Sue Ellery  Hon Diane Evers  Hon Donna Faragher  Hon Adele Farina  Hon Laurie Graham  Hon Colin Holt  Hon Alannah MacTiernan  Hon Kyle McGinn  Hon Michael Mischin  Hon Simon O’Brien  Hon Samantha Rowe  Hon Robin Scott  Hon Tjorn Sibma  Hon Matthew Swinbourn  Hon Dr Sally Talbot  Hon Dr Steve Thomas  Hon Daren West  Hon Alison Xamon  Hon Jim Chown  Hon Dr Steve Thomas  Hon Jacqui Boydell  Hon Colin de Grussa  Hon Sue Ellery  Hon Diane Evers  Hon Donna Faragher  Hon Adele Farina  Hon Laurie Graham  Hon Colin Holt  Hon Alannah MacTiernan  Hon Kyle McGinn  Hon Michael Mischin  Hon Simon O’Brien  Hon Samantha Rowe  Hon Robin Scott  Hon Tjorn Sibma  Hon Matthew Swinbourn  Hon Dr Sally Talbot  Hon Dr Steve Thomas  Hon Daren West  Hon Alison Xamon

Amendment thus negatived.

Clause put and passed.

Clause 22: Medical practitioner becomes coordinating practitioner if first request accepted —

Hon NICK GOIRAN: Can a medical practitioner refuse to continue to participate in the assessment process once the practitioner has accepted the patient’s first request and formally become the coordinating practitioner under clause 22?

Hon STEPHEN DAWSON: The answer is yes, but they would need to transfer the role according to clause 155.

Hon NICK GOIRAN: Clause 155 refers to the transfer of a coordinating practitioner’s role. Is that based upon— no; the minister will tell me to discuss that at clause 155! That is fine; I will rephrase the question. Will a medical practitioner face disciplinary or legal action if they refuse to continue to participate in the assessment process after being recognised as the coordinating practitioner under clause 22?

Hon STEPHEN DAWSON: The answer is no; they would not be sanctioned.

Hon NICK GOIRAN: The minister indicated that if a medical practitioner wants to refuse to continue to participate in the process, they could transfer under clause 155. However, clause 155 allows only for the transfer of the coordinating practitioner to happen if the consulting practitioner consents. Does that mean that a coordinating practitioner is stuck and forced to continue to be a coordinating practitioner even if they have some concerns for some reason? Maybe the patient says that their request is enduring but the coordinating practitioner does not think that it is enduring, or maybe the patient develops a new condition that the patient did not suffer at the time. It could be for any reason. Maybe the practitioner suddenly has a change of heart and has a conscientious objection, or is unwilling to participate in any way. Will coordinating practitioners be stuck, with no capacity to refuse to continue to participate?

Hon STEPHEN DAWSON: I am advised that they can object at any stage of the process, but it may mean that the patient will need to find another coordinating practitioner.

Hon NICK GOIRAN: That is indeed good news. What part of the bill makes it clear that the practitioner can object at any stage?

Hon STEPHEN DAWSON: It is under clause 9.

Clause put and passed.
Clause 23: First assessment —

Hon NICK GOIRAN: Clause 23 is silent on the time frame within which the first assessment must be made by the coordinating practitioner. Must the assessment be made in one consultation or can the coordinating practitioner make their assessment over several consultations with the patient?

Hon STEPHEN DAWSON: It can be over several consultations.

Hon NICK GOIRAN: What evidence can the coordinating practitioner take into account in assessing whether the patient meets all the eligibility requirements under clause 15? Members will see at clause 23(2) —

… the coordinating practitioner must make a decision in respect of each of the eligibility criteria.

What evidence can they take into account in making that assessment? For example, will the coordinating practitioner have access to all the patient’s medical records?

Hon STEPHEN DAWSON: It is any relevant information such as medical history, and they can seek specialist reports or other reports from other health practitioners.

Hon NICK GOIRAN: I move —

Page 17, line 12 — To delete “criteria.” and substitute —

criteria and take into account the medical history of the patient.

This amendment proposes to mandate in clause 23 that a coordinating practitioner must take into account a patient’s medical history when making the decisions about each of the eligibility criteria set out in clause 15 of the bill. Unfortunately, we cannot legislate to cover every issue that will arise as this legislative scheme becomes operational in medical practice in our state. As serious legislators, with foresight we can anticipate when issues might arise and address them as best we can. It is instructive to consider the debate that took place in the other place on 4 September 2019 when the member for Cottesloe and the member for Darling Range identified an issue in the bill that we now have an opportunity to address. The dialogue took place as follows —

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.

We can see from the debate in the other place that this issue was identified by those members in that dialogue with the Minister for Health. Unless something has changed or the position of government has evolved, it is clear that that particular provision is not in the bill. It is my proposition to members that rather than leaving it to best clinical practice, it would be superior for us to mandate that a practitioner should take into account the medical history of the patient; not the least of which because we know from the lived experience in the Northern Territory, during the short time that that legislation was in place there, that there were patients who had a history of depression and the like and Dr Philip Nitschke ran around making voluntary euthanasia available for those patients notwithstanding that medical history. I think it would be a superior provision to mandate it in the legislation rather than simply leaving it to best clinical practice on the bold assumption that every medical practitioner in Western Australia is going to adhere to best clinical practice.

**Hon STEPHEN DAWSON:** I indicate to honourable members that the government is not supportive of the amendment that stands in Hon Nick Goiran’s name. I draw the chamber’s attention to an amendment standing in my name is that it requires the practitioner to take into account the medical history that took place with the AMA with regard to this amendment, the president of the AMA will be part of the
implementation board and he will have input into the guidelines that will be established, which will have a direct impact on the information that will be available to practitioners? That will go a long way towards assisting in the information that will be available. Can the minister confirm that? I do not want to verbal the minister at all, but as I understand it, that was part of the discussions that took place between the minister and the AMA.

Hon STEPHEN DAWSON: Thank you, honourable member. I can confirm that the AMA WA president, or their nominee, will be part of the group responsible for developing the guidelines and processes for voluntary assisted dying.

Hon NICK GOIRAN: Will it be a requirement in those guidelines that the practitioner needs to take into account the medical history of the patient?

The DEPUTY CHAIR: Noting the time and the consideration that is going on, I might allow the minister to consider that overnight. I will report progress.

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

Legislative Council
Wednesday, 27 November 2019

VOLUNTARY ASSISTED DYING BILL 2019

Clause 23: First assessment —
Progress was reported on the following amendment moved by Hon Nick Goiran —

Page 17, line 12 — To delete “criteria.” and substitute —
criteria and take into account the medical history of the patient.

The DEPUTY CHAIR: I draw members’ attention to supplementary notice paper 139, issue 11, dated Wednesday, 27 November 2019. If members do not have a copy of that, I am sure that one of the attendants will be happy to provide it to them.

Hon STEPHEN DAWSON: Last night, Hon Nick Goiran asked me whether there will be a requirement in the guidelines that the practitioner take into account the medical history of the patient. The answer is yes; it is reasonable to consider that this would be in the guidelines, and I note that this would be done in a manner consistent with section 2, “Providing good care”, of the Medical Board of Australia’s “Good Medical Practice: A Code of Conduct”.

Hon NICK GOIRAN: Given it will be in the guidelines, there should be no problem having it in the statute.

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

Ayes (5)
Hon Adele Farina
Hon Simon O’Brien
Hon Nick Goiran (Teller)
Hon Martin Pritchard
Hon Charles Smith

Noes (28)
Hon Martin Aldridge
Hon Stephen Dawson
Hon Alannah MacTiernan
Hon Aaron Stonehouse
Hon Ken Baston
Hon Colin de Grussa
Hon Rick Mazza
Hon Matthew Swinhoun
Hon Jacqui Boydell
Hon Sue Ellery
Hon Kyle McGinn
Hon Dr Sally Talbot
Hon Robin Chapple
Hon Diane Evers
Hon Michael Mischn
Hon Colin Timcknell
Hon Tim Clifford
Hon Donna Faragher
Hon Samantha Rowe
Hon Darren West
Hon Alanna Clohesy
Hon Laurie Graham
Hon Robin Scott
Hon Alison Xamon
Hon Peter Collier
Hon Colin Holt
Hon Tjorn Sibma
Hon Pierre Yang (Teller)

Amendment thus negatived.

Hon STEPHEN DAWSON: Honourable members will recall that last evening, in speaking against the amendment that has just been voted down, I indicated that I had an amendment standing in my name on the supplementary notice paper. At that stage, I indicated the reasons I was not supporting Hon Nick Goiran’s amendment and why
I was obviously supporting the amendment standing in my name. I do not propose to go over that again, but I will point out again that this amendment has been included following consultation with the Western Australian branch of the Australian Medical Association, and the government considers it to be a good amendment. I move —

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.

Amendment put and passed.
Clause, as amended, put and passed.

Clause 24: Coordinating practitioner to have completed approved training —

Hon NICK GOIRAN: Is the reference in clause 24 to “approved training” intended to be a reference to the training approved by the chief executive officer at clause 158?

Hon STEPHEN DAWSON: Yes, that is correct.

Hon NICK GOIRAN: Why does clause 24 not say this, given that the mandatory requirement here is subject to a discretionary power under clause 158?

Hon STEPHEN DAWSON: Under the definitions at clause 5, “approved training” is defined as meaning “training approved by the CEO under section 158”.

Hon NICK GOIRAN: The Victorian training module on capacity assessment and screening for undue influence is seriously deficient. I have been advised that the Victorian training module on assessment of decision-making capacity comprises a two minute and 10 second video and a series of slides that take less than three minutes to read, while the training on voluntariness, including assessing the absence of coercion, comprises a two minute and 20 second video and a series of slides that, again, take less than three minutes to read. Given the brevity of the Victorian training, is the government committed to providing a greater level of training in Western Australia?

Hon STEPHEN DAWSON: The government is committed to providing robust training in Western Australia. Although the Victorian model may inform some of the training, the training that will be designed in Western Australia will be designed for Western Australia and our specific circumstances. I further add that we will consult with the Royal Australian College of General Practitioners and the Western Australian branch of the Australian Medical Association on the training that we provide in this state.

Hon NICK GOIRAN: Will the training for Western Australian health practitioners include training on the approved poison to be used, including risks of adverse consequences and what a health professional, layperson or, indeed, a patient should do in the event of any adverse consequences, should they occur?

Hon STEPHEN DAWSON: I am advised that all those things will be considered during the implementation phase.

Hon CHARLES SMITH: Will this training be subject to scrutiny by the Parliament?

Hon STEPHEN DAWSON: No, it will not.

Clause put and passed.

Clause 25: Referral for determination —

Hon NICK GOIRAN: Clause 25 provides for self-referral on the part of the coordinating practitioner. Can the minister explain to us what is meant by the term “unable” in subclause (1)?

Hon STEPHEN DAWSON: I am told it is the ordinary English meaning. If they are unable, they are not able—so, if it is not clear, and if further information is needed.

Hon NICK GOIRAN: Would the use of the word “unable” include the circumstance in which the practitioner has doubts about whether the patient meets the required eligibility criteria?

Hon STEPHEN DAWSON: Yes, it would.

Hon NICK GOIRAN: Would the use of the word “unable” also cover the situation in which the practitioner does not have the appropriate qualifications themselves to make the assessment?

Hon STEPHEN DAWSON: Honourable member, would you repeat that, please?

Hon NICK GOIRAN: We are talking about the use of the word “unable”, and the minister has indicated that it would in his view capture the circumstance in which the practitioner has doubts about whether the patient meets the required eligibility criteria. Separate to that, would it also cover the situation in which the practitioner does not have the appropriate qualifications themselves to make that assessment?

Hon STEPHEN DAWSON: The coordinating practitioner has the qualification as per clause 16 of the bill. This would not come down to whether the coordinating practitioner has or does not have formal qualifications. It is about the practitioner’s judgement as to whether they are unable to do something.

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Hon NICK GOIRAN: If a practitioner does not feel that they are sufficiently skilled, qualified, experienced or trained, would that not be an example of them being unable to determine whether the patient has a particularly rare disease, and would that then be a circumstance in which a referral would be appropriate under clause 25?

Hon STEPHEN DAWSON: If they said for that reason they were unable to make the determination, that is a legitimate reason.

Hon NICK GOIRAN: At clause 25(2), the phrase “appropriate skills and training” is used. Why are these appropriate skills and training not required of the coordinating practitioner? Why is it that under clause 25(2), they are able to proceed as the coordinating practitioner notwithstanding the fact that they do not have the appropriate skills and training?

Hon STEPHEN DAWSON: As I have indicated, what the coordinating practitioner has to demonstrate is in clause 16. This could relate to a coordinating practitioner making the judgement that they are unable to make a determination, and they can refer to somebody with appropriate skills and training for a particular medical condition. That may well be a specialist in rare neurological conditions, for example.

Hon NICK GOIRAN: If the practitioner themselves recognises that they do not have the appropriate skills and training, should they not bow out at that point and transfer the role to somebody else who does have the appropriate skills and training?

Hon STEPHEN DAWSON: The referral is for one eligibility criterion, not for the whole coordinating practitioner role. It relates to a specific element of the person’s eligibility.

Hon NICK GOIRAN: Minister, I agree, albeit that it is not true to say that it relates to only one eligibility criterion, because the minister will see at clause 25(1)(a) and (b) that there are two limbs. They can refer if they are not sure whether the person has a disease that meets the requirements—in other words, are they terminal, do they have only six months to live or not; and, secondly, do they have decision-making capacity? They are two distinct and very different things. In fact, a practitioner might decide to refer to two different practitioners about that. A practitioner might not really be sure whether the person has terminal cancer, so they might send the patient to a particular specialist. With regard to decision-making capacity, they might send them to a psychiatrist for expert determination. I do not think it is quite right for the minister to suggest that there is only one circumstance in which that would apply when clause 25(1) clearly indicates that there are two things. Nevertheless, it troubles me. A coordinating practitioner might recognise, or at least have the self-awareness to realise, that they are out of their depth, yet clause 25(2) says they must refer the patient to another practitioner. I would much rather this subclause say that they must transfer the role to another practitioner who has appropriate skills. That sounds to me like a far stronger and more stringent safeguard than leaving somebody who is ill-equipped to continue to play a role. A coordinating practitioner might say that they do not want to participate anymore. I think the minister said yesterday that because of clause 9, they can pull out at any stage. Would the patient then have to make a new first request to a separate practitioner?

Hon STEPHEN DAWSON: Yes, they would.

Hon NICK GOIRAN: I want to compare and contrast the language in clause 25(2) and (3). Subclause (2) talks about the practitioner referring the patient to another practitioner, whereas subclause (3) talks about referring the patient to another person. That is a much broader category. The context of my question, particularly with regard to subclause (3), is that we are looking here at the issue of coercion. The minister may be aware that the Select Committee into Elder Abuse produced and tabled a report entitled “I Never Thought It Would Happen to Me”: When Trust Is Broken” in this fortieth Parliament. The report noted, particularly at page 15, that elder abuse is often hidden, associated with shame and underreported. At page 16, the report went on to say —

The fact that elder abuse (mostly) occurs within a family may mean that parents or spouses are inhibited or reluctant to disclose its existence or severity.

There were several pertinent findings in that report that are relevant to clause 25(3). Finding 8 states —

The majority of people who perpetrate elder abuse are likely to be close family members, including children, grandchildren or spouses of the older person who is experiencing abuse.

Finding 18 of the report states —

Carer stress or carer fatigue is a risk factor for elder abuse and symptoms of carer stress can be early indicators of an increased risk of elder abuse in a relationship.

Finding 19 of the report states —

Elder abuse that occurs as a result of carer stress can be a result of not having the necessary skills or support services to provide effective care for an older person.

Finding 20 of the report states —

Carer stress can arise due to factors related to an older person being cared for, including the person’s behaviour, mental or physical health or other circumstances.
Finding 23 of the report states —

The community in general is not well-educated on the specific signs of elder abuse, nor of the extent of the problem in the community.

At finding 25, the report states —

There is insufficient training for Western Australian police officers to learn to identify and respond to elder abuse effectively.

Two recommendations were made as a result of that particular finding. Recommendation 10 of the report recommends —

Western Australia Police develop a separate training module for all police officers that specifically covers the forms, signs and risk factors of elder abuse and how to respond effectively.

Recommendation 17 of the report states —

Specialist elder abuse units should be created within Western Australia Police.

In light of all those findings and recommendations made by the Select Committee into Elder Abuse in this fortieth Parliament, who does the minister think would be an appropriate “other person” who has appropriate skills and training to make a determination under clause 25(3) in the event that the medical practitioner is concerned about whether the patient is acting voluntarily and without coercion?

Hon STEPHEN DAWSON: This may include experienced registered health practitioners, healthcare workers including social workers, and police officers with the 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 WA police if they believe that the patient is being coerced to undergo voluntary assisted dying. The bill makes it a crime to unduly influence a patient in such a manner.

Hon NICK GOIRAN: Is not the coordinating practitioner, by the very definition in this bill, an experienced health practitioner?

Hon STEPHEN DAWSON: Yes, they are, but they may not be able to make the assessment.

Hon NICK GOIRAN: Clause 25(4) does not require that the determination made by the person with appropriate skills and training be adopted by the coordinating practitioner who made the referral. Why is the adoption of the determination optional? For example, can the coordinating practitioner continue to seek as many referrals as necessary until they are satisfied with the determination that has been made?

Hon STEPHEN DAWSON: That is correct, honourable member.

Hon NICK GOIRAN: Section 18(4) of the Victorian legislation requires that when a patient has a disease, illness or condition that is neurodegenerative, referral to a medical practitioner who has appropriate skills and training in that particular disease, illness or medical condition is mandatory. Section 18(5) of the Victorian legislation requires that the determination made by the specialist under section 18(4) must be adopted by the coordinating practitioner. Why is there not a similar provision at clause 25?

Hon STEPHEN DAWSON: We are just checking the Victorian act. Can the honourable member just tell us the sections he referred to again, please?

Hon NICK GOIRAN: It is section 18(4) and (5) of the Voluntary Assisted Dying Act 2017 of Victoria.

Hon STEPHEN DAWSON: The coordinating practitioner may not be satisfied with the advice, so the clause as it stands allows them the opportunity to seek a further opinion.

Hon NICK GOIRAN: On the supplementary notice paper is an amendment standing in my name at 76/25. I indicate that it is consequential on an amendment standing in my name to insert new clause 29A. For those reasons, I do not seek to move it now, but I seek to have it left on the supplementary notice paper in the event that there is a recommittal of the bill.

The DEPUTY CHAIR: That is noted.

Hon MARTIN PRITCHARD: This debate has been edifying for me. It has made me realise that the coordinating practitioner does not necessarily need to be an expert in each area, but should draw together information that, as I have previously said, is probably available to them already. Most people would avail themselves of special advice before they make their first request. The coordinating practitioner would then coordinate that. I note the amendment in the minister’s name which was passed at clause 23 and which encourages that.

I have an amendment in my name at 17/25. For those reasons and also because it may, I think, be seen as derogatory to the coordinating practitioner and their expertise, it is not my intention to move it unless the minister believes that my wording at 17/25 improves the bill. Could the minister indicate whether he is in favour of that amendment?

Hon STEPHEN DAWSON: I can indicate that we are not in favour of the amendment.

Hon MARTIN PRITCHARD: It is my intention not to move 17/25.
Hon Nick Goiran: Members will be aware that at several points on clause 25 I have taken the time to propose amendments to expand the language so that rather than it simply being a case of whether the practitioner is able or unable to make the determination, the standard would be lifted to make it clear that they should refer in circumstances in which they have any doubt. This picks up on concerns raised by Hon Colin Holt yesterday about the need to refer if there is any doubt in the mind of the practitioner. To that extent, I draw to members’ attention the amendment standing in my name at 77/25. The amendment standing in my name at 76/25, not to be confused with 77/25, also uses that same language—whether the practitioner has any doubt whatsoever. Noting that I have asked for my amendment to remain on the supplementary notice paper until another occasion, it may well be the case that my new clause 25A will not be successful in due course, but I would not want to lose that language because I share the view of Hon Colin Holt that there should be a referral any time that the practitioner has any doubt. In light of that, I move —

Page 17, line 20 — To insert after “determine” —

or has any doubt as to

The Deputy Chair (Hon Adele Farina): I ask that the attendants collect that amendment from Hon Nick Goiran, make copies of it and distribute it to members in the chamber. A hard copy of the amendment is being distributed. I will wait until all members have had an opportunity to read that amendment.

Hon Stephen Dawson: I indicate that we do not support this amendment. My advisers tell me that Hon Nick Goiran’s addition does not add any value to the clause. As I have already espoused, the term “has any doubt” is subjective on the part of the medical practitioner. The term “unable to determine” is objective and more appropriate in both the legislative and operational context. From a policy perspective, “unable to determine” is appropriate because it retains an outcome focus, which is the whole purpose of assessment, and will be readily understood by medical practitioners.

Hon Nick Goiran: This amendment seeks to strengthen the referral policy contained in clause 25. I was particularly guided by the remarks of the Minister for Health in the other place on 4 September this year, at page 6464, when he said —

... 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 …

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.

In this instance, the consequence of a bad decision, to use the phrase of the Minister for Health in the other place, by a general practitioner or any medical practitioner about whether the patient has decision-making capacity in relation to voluntary assisted dying would obviously be fatal for the patient. The minister in the other place admits that decision-making capacity assessments come before the State Administrative Tribunal regularly and that this is a difficult area of medical assessment. This type of concern was raised in the debate in the other place, including by the member for Cottesloe, about errors in assessing a patient’s decision-making capacity. Those remarks were made on 5 September this year. Dr Honey’s concerns related to the appropriateness of assessment of decision-making capacity, particularly via audiovisual means such as telehealth, and the risk of making an error in such a crucial assessment without a face-to-face consultation. That particular concern was responded to by the member for Morley, who said, “They are dying anyway.” That was said on 5 September 2019. If anyone wants to see that particular remark in its context, they can find it at page 6642 of the Hansard. I find that quite astonishing. I would have thought that the decision-making capacity of all patients, especially ones applying for this particular scheme, should be of concern to every member of Parliament whether or not they support this bill. That somebody may already be dying does not, in my view, reduce the need for an accurate decision-making capacity assessment.

In fact, Dr Gibson, the Chief Psychiatrist in Western Australia, gave evidence on this particular issue to the Joint Select Committee on End of Life Choices on 14 December 2017. He said that the stakes are higher in this particular instance. The correct assessment of the decision-making capacity of a person with a terminal illness who requests access to voluntary assisted dying under this bill is of the utmost importance. The entire policy of the bill is founded upon the patient’s autonomy and decision-making capacity. This amendment seeks to make it clear that if a medical practitioner has “any doubt” about the patient’s decision-making capacity, they should refer. Likewise, if the coordinating practitioner has any doubt about whether the patient has a disease, illness or medical condition that meets the requirements, they should refer.

As I said earlier, it was instructive to me that in the other place the Minister for Health said that a referral should occur if the medical practitioner has any inkling whatsoever that the person does not have decision-making capacity. I absolutely agree with the health minister: if there is any inkling at all in the mind of the medical practitioner, they

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should refer. My clause would put beyond doubt that that is when a referral should occur. The minister indicated that my amendment will not add anything. If it does not add anything, it will do no harm. We can certainly agree that it will not undermine the operation of the bill. In my respectful submission to members, it seeks only to strengthen the specialist referral requirements at clause 25.

The CHAIR: I give the call to Hon Rick Mazza. Members, if you are seeking the call, sing out.

Hon RICK MAZZA: Thank you, Mr Chairman. I will sing out next time.

The CHAIR: Thank you. Singing, incidentally, is a turn of phrase or an expression; you just need to attract the Chair’s attention by some sort of audible signal.

Hon Stephen Dawson: And orderly.

The CHAIR: And orderly, if possible.

Hon RICK MAZZA: Through the Chair, the mover of this amendment, Hon Nick Goiran, might be able to help me establish what he is trying to achieve. We are considering “unable to determine”, which is what is in the bill, and “or has any doubt”. To me, that means the same thing. I am struggling to establish why I would support this amendment when it does not materially change the operation of clause 25. There has been a lot of debate. I have been listening very closely to this debate about clause 25. Hon Nick Goiran has predominantly homed in on the difference between “has any doubt” as opposed to “unable to establish”. From the outset, I have been on the record as not supporting the bill. Whether members support this bill or not is not the question during committee; it is about how this bill will operate at the end of the day. I am unable at this point to establish why I would support this amendment because I do not see it making any material difference to improving the operation of this particular clause.

Hon NICK GOIRAN: To the member who raises a legitimate query: the issue is that the minister says that whether the practitioner has any doubt is captured under the expression “unable to determine”. Can I put it to members that “unable to determine” something can also be interpreted in a different way. If I am unable to do something, it is not necessarily the same as my having doubts about something. I interrogated the minister about a few different scenarios. If a medical practitioner says, “I don’t have the skills to deal with this particular patient; this patient is beyond my level of expertise and experience; I am unable to make the decision”, that is different from a medical practitioner saying, “I have the experience, qualifications and training, but you know what? I’m just not sure. I’ve got some doubts about whether this person qualifies or not.” To me, they are two different things. I am concerned that is not definitively captured in this phrase in the bill before us at clause 25(1). If we add the amendment standing in my name, it will put beyond doubt that it is both. I referred earlier to a scenario in which the medical practitioner simply does not have the capacity; they are not sure, they do not have the experience and so forth, but this one here is if they have some doubts, we want them to refer. Members of this chamber would be saying, “If you, medical practitioner, have any doubts about the decision-making capacity of the person, we want you to refer. Sure, you might be able to make a determination, but how sure are you about this determination? Until you’re sure, don’t proceed. Let us take the cautious approach.” The minister said that my scenario is captured. I think Hon Rick Mazza also said that it is already captured in the expression. Both the honourable member and the minister may well be correct and a court of law may determine it in that way, but rather than leaving it at that, I think it is safer that we put in the clear words that we intend at this time.

Amendment put and negatived.

Hon CHARLES SMITH: Winding back to clause 25(1)(a), does that include referral to a mental health expert for mental health issues?

Hon STEPHEN DAWSON: Yes, it could.

Hon CHARLES SMITH: Is there any particular reason it is not mentioned specifically in paragraph (a)?

Hon STEPHEN DAWSON: There could be a variety of persons to whom the reference could be made, so we did not pick on one.

Hon NICK GOIRAN: I would like to move the amendment standing in my name at 63/25. I move — Page 17, line 24 — To delete “section 15(1)(d).” and substitute — section 15(1)(d), for example due to the patient’s past or current mental illness.

This amendment seeks to bring clause 25 up to the standard of section 18 of the Victorian legislation. Section 18(1) of the Victorian legislation states — If the co-ordinating 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 co-ordinating 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.

This amendment complements a further amendment standing in my name at 64/25, which seeks to insert — matter, such as a psychiatrist if the matter to be determined involves mental illness.

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The current amendment, together with the amendment at 64/25, would bring clause 25 up to the Victorian standard found in section 18(1) of that legislation. The amendment makes explicit reference to a patient’s past or current mental illness in clause 25(1)(b), making it clear that the coordinating practitioner should turn their mind to the fact that a patient’s past or current mental illness might have an impact on that person’s decision-making capacity in relation to voluntary assisted dying. If the coordinating practitioner is aware that the patient has a mental illness, or is aware from the patient’s medical history that they had previously had a mental illness, that would likely be a circumstance in which it would be proper for that practitioner, who is likely to be a general practitioner, to refer to a psychiatrist for further assessment of the impact of that mental illness on the decision-making capacity of the patient to request voluntary assisted dying. I suggest that there is nothing controversial about this amendment. It does not change the function of clause 25; it simply makes it clearer for coordinating practitioners when a referral under clause 25 might be considered necessary.

We can take some lessons from the experience in some of the international jurisdictions at this point. In Oregon, research commissioned by Linda Ganzini found that, among terminally ill Oregonians who participated in the study and received a prescription for a lethal drug, one in six had clinical depression. The prevalence of depression and anxiety in patients requesting physicians’ aid in dying was considered by this study. It is appropriate for the chamber to note that Oregon allows for a similar optional referral for psychiatric assessment as we have in the bill before us. Interestingly, as recently as 2016, fewer than one in 25—that is, 3.75 per cent—people who died by self-administering a lethal drug under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation. That information can be found in the Oregon Public Health Division’s own data summary. We have the lesson from Oregon, where one in six patients had clinical depression, but only one in 25 were referred for psychiatric evaluation. If we compare and contrast the experience in Oregon with that in Washington, examination of data from that state’s own health department—the Death with Dignity Act annual report as recently as 2019—reveals that in 2018, only 10 of 251 patients were referred for psychiatric and psychological evaluation. In 2017, the number of patients referred was so low in Washington that the figure was redacted.

I dare say that, given that that is the experience in Oregon and in Washington, we can expect a similar low rate of referral for psychiatric assessment in Western Australia, should we legalise the regime set out in the bill. The amendment before us seeks at least to mitigate against those low referral rates by asking practitioners to turn their minds to the presence of current or historical mental illness, and the impact of this upon the patient’s decision-making capacity. For those reasons, I seek the support of members for the amendment.

The CHAIR: Members, Hon Nick Goiran has moved his amendment, which is shown as number 63/25 on the supplementary notice paper. I gather, though, from his remarks that this is closely related to proposed amendment 64/25, which, although not formally moved, I think he has been debating cognately.

Hon NICK GOIRAN: Mr Chair, just to clarify that for members, the two amendments complement each other, but they are standalone amendments, and so one can survive without the other.

The CHAIR: Very well. In that case, we are focusing on the amendment formally moved, but if members and the minister feel the need to canvass the other matter as a related one to deal with it more expeditiously, they may do so.

Hon STEPHEN DAWSON: Thank you for that advice, Mr Chair. I am not supportive of the amendment that we are dealing with at the moment; nor am I supportive of the next amendment that stands in the name of Hon Nick Goiran. I am not supportive for the same reasons, so I will indicate now my opposition, and I will give the reasons now, but I will not do it again when we get to the next amendment. The addition of an example is not required. There may be a number of reasons for which a medical practitioner may be unable to make a determination on a patient’s decision-making capacity in relation to voluntary assisted dying. Practitioners are already aware that a variety of matters may impact decision-making capacity, such as the impact of certain medications, mental illness, the impact of certain diseases, acquired brain injuries and intellectual impairment. The specific inclusion of the past or current mental illness may create the unwanted effect of limiting the application of the clause. Furthermore, the proposed amendment could imply that persons with a mental illness may not have decision-making capacity. A wide range of conditions and states of being amount to mental illness, and to apply a broad brush, stating that those with mental illness do not have decision-making capacity, is quite a prejudiced view. The Royal Australian and New Zealand College of Psychiatrists has noted that the capacity test is not diagnosis-specific, but rather focuses on a person’s ability to make the decision at hand in the situation.

Hon NICK GOIRAN: The minister indicated that the inclusion of an example is not required. Is an example included in the Victorian legislation?

Hon STEPHEN DAWSON: The answer is yes, but obviously that is a different bill from our own.

Amendment put and negatived.

Hon NICK GOIRAN: I move —

Page 17, line 27 — To delete “matter.” and substitute —

matter, such as a psychiatrist if the matter to be determined involves mental illness.
Similar to, but separate from, the previous amendment just considered, this amendment would lift our legislation to the level of the Victorian statute, specifically section 18(1). The amendment seeks to insert the phrase “such as a psychiatrist if the matter to be determined involves mental illness”, and I make explicit reference to psychiatrists, making it clear, as the Victorians do, that referral should be made to a psychiatrist to assess the patient’s decision-making capacity when the patient has a mental illness or a history of mental illness that may impact upon their decision-making capacity on voluntary assisted dying.

The efficacy in explicit reference to a psychiatrist in clause 25 is perhaps best understood by this evidence given by Western Australia’s Chief Psychiatrist to the Joint Select Committee on End of Life Choices on 14 December 2017 when he said —

The question is: are GPs good at doing capacity? That is one question. The answer is that it is extremely variable. The nature of GP practice is that they often do not have the appropriate time to do this, and they will acknowledge that. They are the people seeing people in nursing homes. They are seeing lots of individuals who are incapacitous or may have capacity or not. So, they are seeing lots of it but they are not always thinking in that paradigm; they are thinking in more broad, holistic paradigms. In the situation where a GP is treating mental illness, assisting with the palliative care and making potential capacity assessments that are not leading to the potential death of the person, that may be reasonable. But the stakes go up when you are saying that someone is going to die.

I think the position of Dr Gibson, Western Australia’s Chief Psychiatrist, in the committee hearing was that general practitioners should not be making decision-making capacity assessments for voluntary assisted dying. I think his words remain relevant to this amendment and I seek support for it from members.

**Hon AARON STONEHOUSE:** I support the amendment put forward by Hon Nick Goiran. From what I can see, it at least makes clearer the obligation on medical practitioners to refer when mental illness may be present. From reading clause 25, without it, there is certainly reference to an obligation on coordinating practitioners to refer. It does not spell out clearly in simple language an obligation for a referral when mental health is in question. In that case, it makes it eminently clear to practitioners and to the public the obligations for referral. For that reason, I support the amendment. It does not seem to interfere in any way in the operation of this scheme or make it any more onerous, but merely clarifies something that should be done anyway; therefore, I support it.

**Hon ALISON XAMON:** I have a question about how it would be interpreted. Clause 25(2) states that the coordinating practitioner “must” refer the patient, so can I confirm whether the effect of the amendment would be that there is not a requirement to refer someone to a psychiatrist if they have a mental illness or a history of mental illness? Is it still intended to be a discretionary option?

**Hon STEPHEN DAWSON:** My advice is that it would be mandatory. It would be a requirement.

**Hon ALISON XAMON:** In that case, I am very concerned about the amendment in front of us. I would like to remind members that it is estimated that throughout the course of their life, 50 per cent of people will experience some sort of mental illness and that at any given point, 20 to 25 per cent of us are experiencing a form of mental illness. Depression and anxiety can often be the most common. However, by no means suggests that people have impaired capacity or, indeed, that they have a desire to die. It is not necessarily the case that suicidal ideation follows from depression and anxiety, although certainly it can be very serious. I also want to point out that for the majority of people who live with or experience mental illness during their lifetime, most never see a psychiatrist. Other health practitioners may assist them or they may have other tools to assist them with their mental health issues.

I am really concerned about anything that requires someone who has a history of mental health issues to see a particular type of mental health professional—to prescribe that—when it may be well beyond the regime of how they deal with their mental health issues. I think it is too prescriptive. It is one thing to have an amendment that, basically, encourages people when they have doubt to look at referring to an appropriate practitioner. However, I do not believe it is appropriate to refer someone to a psychiatrist specifically, considering that half of us at any given point would be subject to a mandatory referral to a mental health practitioner who may not be appropriate.

**Hon NICK GOIRAN:** The minister has just given advice to Hon Alison Xamon that this would be a mandatory requirement. Can he point to us the language in either the amendment or the clause that makes it mandatory?

**Hon STEPHEN DAWSON:** My advice is that because 25(2) states “must refer the patient”, the amendment would then mean that it must be done—the patient must be referred to a psychiatrist. I have indicated, Mr Chair, on the last amendment that we would not support this amendment, and I have given the reasons for it. We had an extensive debate on this general issue at clause 6 when we addressed the issue of a psychiatrist not being the only person to determine decision-making capacity. At that stage, on 20 November, I tabled some correspondence from the Chief Psychiatrist, Dr Nathan Gibson, that showed a different view from the Chief Psychiatrist from the one Hon Nick Goiran read out from December 2017. I will say again that to suggest that only psychiatrists can assess decision-making capacity mischaracterises the role of psychiatrists. A psychiatrist treats mental illness; they are not general experts on decision-making capacity.

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Hon STEPHEN DAWSON: To confirm, we are dealing with amendment 64/25, the amendment before the chamber at the moment. That refers to line 27. Clause 25(2) states that “the coordinating practitioner must refer” and the amendment would take effect at the end of that sentence.

Hon NICK GOIRAN: The minister is quite correct. I was out of order, and I apologise for that.

Hon AARON STONEHOUSE: In relation to what is mandatory in this proposed amendment, it is worth bearing in mind that it is triggered only if clause 25(1)(b) comes into play in this instance. It is not saying that anyone suffering from mental illness must be referred to a psychiatrist. Amended clause 25(2) would read —

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, such as a psychiatrist if the matter to be determined involves mental illness.

What is the matter to be determined? The matter to be determined is whether the patient has decision-making capacity in relation to voluntary assisted dying as required by clause 15(1)(d). There is a mandate there for referral, but it comes into play only if the coordinating practitioner is unsure of the patient’s decision-making capacity and if the matter to be determined involves mental illness. I think in those instances it is appropriate. I believe that because of the letter that was sent by Dr Nathan Gibson, the Chief Psychiatrist of WA, to Malcolm McCusker, and tabled in this place. He stated —

- Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

I think in this very specific circumstance, in which capacity cannot be determined and there is the intersection of mental illness, it is appropriate to require medical practitioners to refer to a psychiatrist. That is why I support this amendment.

Hon ALISON XAMON: I am still trying to get to the bottom of this. The one thing I think everyone in this chamber will possibly agree with is the idea that if a coordinating practitioner is not confident that the person making the request is competent, they will need to refer them on. Likewise, I suspect everyone would agree that if the coordinating practitioner is not confident that the request is not coming as a substantive result of someone’s mental illness, as opposed to the physical illness that is killing them, we would want the practitioner to refer them on to ensure that the person’s motivations for wanting to avail themselves of voluntary assisted dying are not substantially due to mental illness. I suspect we agree on that. However, I do not see how the way the bill is currently written precludes referrals in those instances—that if a coordinating practitioner is concerned about someone’s capacity and that their wish to die is substantively because of their mental illness and not their physical illness, referral can be pursed. That is the whole point of clause 25(2). Again, I am concerned about including in the bill something quite prescriptive about the appropriate practitioner for referral in particular instances. For example, if I have a longstanding relationship with a clinical psychologist whom I have been seeing since I was 11 years old, perhaps they would be best able to make an assessment as to whether my motivation for dying is substantively because of my mental illness or that I am actually mentally okay, as opposed to some psychiatrist whom I have never seen before in my life, with whom I have no relationship and who knows nothing about my history. I am concerned about prescribing a clinical relationship to that degree within the legislation. But as I say, as I read the bill, if there is a genuine concern, that referral can—in fact, must—occur anyway. I would like to know whether I have misunderstood that.

Hon STEPHEN DAWSON: The honourable member is correct, and was reading it correctly.

Amendment put and negatived.

Hon MARTIN PRITCHARD: I do not propose to move the amendment standing in my name at 18/25.

The CHAIR: We have contemplated a matter dealt with in proposed amendment 77/25 and dispensed with it.

Hon NICK GOIRAN: There is an amendment standing in my name at 77/25 on which we have had a preliminary discussion. It all revolves around the use of the word “unable” and whether that includes the phrase “has any doubt as to”. The minister indicated that it did and Hon Rick Mazza earlier indicated that he could not see a need to include it because he shared the minister’s view that it incorporated the two. I know there will be an 18-month implementation phase, but will the guidelines that are being developed for provision to medical practitioners ensure that they understand that “unable” includes whether they have any doubts?

Hon STEPHEN DAWSON: I am told yes, they will.

Extracted from finalised Hansard
Hon NICK GOIRAN: In light of the view of the chamber on the earlier amendment and the fact that the minister has indicated that the guidelines will include that, I see no need to move amendment 77/25.

Hon MARTIN PRITCHARD: I move —

Page 18, line 5 — To delete “may adopt” and substitute —

must take into account

There has been quite a bit of discussion on this matter already, and I have received a number of briefings on it. As I understand it, the reason it reads “may adopt” is to allow the medical practitioner the right, as he should have, to receive one bit of advice from a specialist, maybe not accept it, and then seek further advice from another specialist—or, indeed, two, three, four or five specialists, if he so wishes. Is that correct?

Hon STEPHEN DAWSON: The honourable member is correct.

Hon MARTIN PRITCHARD: I think they have every right to do that, but my concern is about situations in which a medical practitioner accepts that they are unable to make a determination and seeks advice from a specialist. Given that they have the opportunity to get advice from multiple sources, it would seem to me unreasonable for coordinating practitioners to not at least take into account all the advice they receive. My amendment does not seek to limit the advice that coordinating practitioners get, but to ensure that they take into account all the advice they receive. I have an amendment further on in the bill that would provide for all that information to be passed on to the board, so that the board has some oversight of the advice that is received. It does not, in my view, negate the coordinating practitioner’s opportunity to seek advice from multiple sources, as is currently the case under clause 25; it mandates that they take all that advice into account. I seek the minister’s support for my amendment.

Hon STEPHEN DAWSON: I indicate that the government does not support this amendment. The clause, as currently drafted, provides that the coordinating and consulting practitioners may adopt the determination obtained from the referral. To state that the practitioner “must” take it into account, as this amendment provides, reflects the same meaning as the current wording because the practitioner, when deciding whether to adopt the determination obtained from the referral, would have to consider the referral report before them.

Hon MARTIN PRITCHARD: Could that also then, for example, open the possibility, however remote it might be, that the coordinating practitioner may admit that they are unable to make a determination and seek advice from a specialist? The specialist might suggest that they are not eligible to advise, for whatever reason, and on that basis the coordinating practitioner could continue, because they would not have to take the advice that they sought from the specialist; is that right?

Hon STEPHEN DAWSON: Yes, that is correct.

Hon ADELE FARINA: I would like to draw the minister’s attention to section 18 of the Victorian legislation, which actually uses the word “must”. It states —

(6) If the co-ordinating medical practitioner refers the person to a specialist registered medical practitioner under subsection (4), the co-ordinating medical practitioner must adopt the determination of the specialist registered medical practitioner in respect of the matter in relation to which the person was referred.

I would like to come to some understanding about why we are taking a different approach. I would have thought that if a coordinating practitioner formed the view that they do not have the skills or the knowledge or are unable to form a decision, they would refer the case to a specialist, and if the specialist came back with a decision, they would simply adopt that decision, because, after all, the practitioner referred the matter to that particular specialist—they could have chosen whichever specialist they wanted—seeking that specialist advice, so why would they then not adopt the advice from that specialist? In addition to that, if the practitioner did not adopt the advice of that specialist, could they be legally liable if, at some future time, there was some question about the decision that they had made?

Hon STEPHEN DAWSON: Could the member please ask the second question again, about the liability?

Hon ADELE FARINA: I just think that if the coordinating practitioner refers the case to a specialist, the specialist comes back with his or her opinion, and the practitioner then chooses to ignore his or her opinion and forms a different decision, they are potentially exposing themselves to liability should that become known down the track. It just seems to me that the Victorian legislation makes it very simple. They refer it to the specialist of their choice. Once they get that advice, they adopt that advice. That seems to me the simplest way of dealing with this issue, rather than continuing to go to specialist shopping.

Hon STEPHEN DAWSON: Again, it is not about specialist shopping or, indeed, doctor shopping. What “must adopt” would do is that even if the opinion is —

Point of Order

Hon MARTIN PRITCHARD: Chair, the amendment does not say “must adopt”. We are talking about my amendment, which is “must take into account”.

The CHAIR: There is no point of order, but I am sure the minister appreciates the interjection.

Extracted from finalised Hansard
Committee Resumed

Hon STEPHEN DAWSON: I was actually responding to the question of Hon Adele Farina, when she referred to the Victorian legislation. As I have answered Hon Martin Pritchard’s questions on various topics, I propose to answer Hon Adele Farina’s question on this topic now.

What I was saying is that if it were to read “must adopt”, that would indicate that even if the opinion was patently an error, the practitioner must adopt it; it does not give them the option of seeking a further opinion. I will make the point, too, that doctors refers to specialists all the time. They then receive reports back from specialists, and they make their assessment based upon consideration of the referral report. The coordinating practitioner needs to be given the option to decide whether to accept the opinion. To go with a different decision is not ignoring the referral report. The coordinating practitioner will consider the report and form their own view based on the information in front of them.

Hon RICK MAZZA: The amendment moved by Hon Martin Pritchard is very sensible. Rather than say that the practitioner “must adopt” the report, he says they “must take into account” the report. There might be some aspects of that report or determination that the coordinating practitioner does not want to consider. It is not a matter of adopting it. I think “must take into account” is a very sensible and practical amendment.

The DEPUTY CHAIR: Members, the question is that the words to be deleted be deleted. All those of that opinion say aye, to the contrary no. I think the ayes have it.

Hon Martin Pritchard: Divide.

The DEPUTY CHAIR: Division called. Ring the bells.

Point of Order

Hon SIMON O’BRIEN: I think the prerogative to call for a division rests with the member whose view has not prevailed, but, if the ayes have it, the honourable member should be well satisfied with that and not call for a division.

The DEPUTY CHAIR (Hon Martin Aldridge): Members, the point of order from Hon Simon O’Brien went to the calling of a division. I draw members’ attention to standing order 78, which states —

(1) After the President has declared an opinion on the resolution of a question (Standing Order 77), a Member may challenge that opinion by calling for a division immediately.

(2) A Member who calls for a division shall not leave the Council, and shall vote with those Members who, in the opinion of the President, were in the minority.

(3) If the President determines that an absolute majority is required, the President shall advise the Council accordingly and conduct a division.

There is not a point of order, because any member can call a division, regardless of the call of the Chair. However, the member calling a division would be obliged to vote with the minority. The Chair called the question with the ayes. I said that the ayes have it, and then a division was called, and I gave the instruction to ring the bells, at which time the point of order was made.

I also draw members’ attention to standing order 80, “Division May Be Cancelled”, which states —

At any time before the Tellers are appointed, a call for a division may be withdrawn by leave of the Council, and the division shall not be proceeded with. The decision of the President which was challenged shall then stand.

Committee Resumed

Hon MARTIN PRITCHARD: Mr Deputy Chair, may I seek leave of the chamber to withdraw my call for a division?

The DEPUTY CHAIR: Hon Martin Pritchard has sought leave. Is leave granted?

Several members interjected.

Hon STEPHEN DAWSON: Mr Deputy Chair, I seek some clarification. If the chamber were to give Hon Martin Pritchard leave to withdraw his call for a division, would it still be open to me or another member of the chamber to call for a division at that stage; or, if leave was given to withdraw, would we then move on from that issue totally?

The DEPUTY CHAIR: Members, might I suggest to the chamber that the easiest way to resolve this matter is for the chamber to reconsider giving leave to withdraw the division, at which point I will put the question again, and we can then resolve the matter with certainty. If there is no dissenting voice, that will be the course of action that I will take. The question is that Hon Martin Pritchard seeks leave to withdraw his call for a division. Is leave granted?

Leave granted.

The DEPUTY CHAIR: The question is that the words to be deleted be deleted.
Division

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

Ayes (12)
Hon Martin Aldridge
Hon Nick Goiran
Hon Charles Smith
Hon Colin Tincknell
Hon Donna Faragher
Hon Rick Mazza
Hon Aaron Stonehouse
Hon Dr Steve Thomas
Hon Adele Farina
Hon Simon O’Brien
Hon Martin Pritchard (Teller)

Noes (23)
Hon Ken Baston
Hon Peter Collier
Hon Colin Holt
Hon Tjorn Sibma
Hon Jacquie Boydell
Hon Stephen Dawson
Hon Alannah MacTiernan
Hon Matthew Swinbourn
Hon Robin Chapple
Hon Colin de Grussa
Hon Kyle McGinn
Hon Dr Sally Talbot
Hon Jim Chown
Hon Sue Ellery
Hon Michael Mischin
Hon Darren West
Hon Tim Clifford
Hon Diane Evers
Hon Samantha Rowe
Hon Pierre Yang (Teller)
Hon Alanna Clohesy
Hon Laurie Graham
Hon Robin Scott

Amendment thus negatived.

Hon NICK GOIRAN: I move —
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.

This amendment really flows on from the discussion we had yesterday. Members will recall that we had quite a detailed debate as to whether a consulting or coordinating practitioner should be able to be a beneficiary under a will—that is, whether they should be able to profit from the death of the patient—or be a family member of the patient. We had quite an extensive discussion about that. I moved an amendment. Hon Adele Farina moved an amendment to my amendment. In the end, that was defeated and some wording was provided by the government. Members may recall that we had an extra recess yesterday to enable the government to provide its preferred wording, and members facilitated that. I have used the government’s preferred language in my amendment.

The purpose of this amendment is to support the argument that a practitioner obviously should not be able to refer to another practitioner who can benefit under the will or is a family member of the patient. Obviously, if we are going to put these protections in the bill for interpreters, as per clause 160, and coordinating and consulting practitioners, as per clause 16, then plainly we should do the same with regard to medical practitioners or persons who will be referred to under clause 25. I seek the support of all members.

Hon STEPHEN DAWSON: I indicate that the government is not going to support this amendment. The coordinating practitioner will make the referral to a registered health practitioner. It would be unreasonable to expect the coordinating practitioner to screen those referrals. Furthermore, I am advised that this requirement might create operational problems, so we are not supporting it.

Hon ALISON XAMON: What sorts of operational problems would arise from this? It strikes me that this amendment simply enshrines current requirements in many regards, certainly in terms of being a family member of the patient. Secondly, we have already agreed that we do not want people who are involved in this process to potentially be able to benefit financially from a patient’s death. I am a little concerned as to why this provision would not be supported.

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

Hon ALISON XAMON: I asked a question.

Hon Stephen Dawson: And I intend to answer; I am seeking advice.

Hon SIMON O’BRIEN: While the minister is receiving advice, like a lot of members in this place I want to see some progress made on this bill, so I will seek to offer the following right now. Members, if we look back to yesterday’s uncorrected Hansard, we can see in our contemplation of clause 16 that we held an almost identical debate and, if we are to be consistent, it was resolved in a way that I believe would have us all vote for the amendment that is before the Chair. I say that not to be argumentative, not one bit. In fact, I would like to see the chamber adopt this amendment now unanimously. I think there is merit in it, and indeed the chamber saw merit in the same argument when we contemplated clause 16 yesterday. Clause 16 related to, colloquially, other medical practitioners

Extracted from finalised Hansard
in the chain, but at an early stage. I refer to yesterday’s uncorrected Hansard at page 15. I have lost track of which of the 11 previous supplementary notice papers I had this written down on, but it is in our uncorrected Hansard—God bless Hansard! At page 15, we see words that appear to me to be identical, intended in the same spirit and as the same sort of safeguard.

I have been making these remarks as the minister is receiving advice, because it needs to be placed on the record, but I do not want to unnecessarily extend our time dealing with this bill. I think I have faithfully encapsulated the gist of an argument, which gives a compelling case in support of the amendment that is before us now as moved by Hon Nick Goiran. With all that in mind, I hope that the minister will see that there is great merit in adopting it for these reasons. Firstly, it is a highly desirable safeguard and one which by its own construction will shoot down some elements of opposition to this bill. It will not shoot them all down, including mine. It would certainly deal with this matter decisively. Of course the medical practitioner involved in a referral should not be a beneficiary in the will of the intended deceased. That is self-evident. It was self-evident when we contemplated clause 16 less than 24 hours ago, and it is thoroughly the case now. The next reason is that it is important to the integrity of the proposed act. A very wise Chairman of Committees once said not long ago that there is no law in the Constitution or the standing orders or anywhere else that says that anything that comes out of this place needs to make sense.

Hon Donna Faragher interjected.

Hon SIMON O’BRIEN: He was a very sage person. Perhaps it will come to Hon Donna Faragher shortly. The horrible thing is that person, who borrowed the phrase from a previous Chairman of Committees—Hon George Cash, back in the day—is absolutely right. However, there is a rider to that. For all members from all eras in the life of this chamber, we also subscribe to the view, which is also not written down, that it is highly desirable that things do come out of here making sense. In many cases, they make a hell of a lot more sense and are far better ordered than the condition in which we perhaps received them from the other place. That is something we also like to underscore and wear as a badge of pride. Warming to the theme that what comes out of this house of review should be legislation that is in good nick, it should also appear to be in good nick. It should have loose ends tied up, it should have frayed ends detected for attending to, and all the rest of it.

It would create a gaping hole if, after having adopted the amendments to make clause 16 what it is now, we failed to amend clause 25 in a near identical and sympathetic fashion. Having been confronted with all that argument and having had that pointed out—I thank Hon Nick Goiran, the mover of this amendment—it would be remiss of all of us if we were not to recognise that, when it is presented in front of us in the terms that I have just outlined, we failed to take the action that we took previously. Those are the two broad reasons that support for this amendment has a compelling basis. I do not intend to continue my remarks any longer, but I know that the minister has been carefully considering what I have had to say just now as he receives advice. Whatever the government decides to persevere with, this is a conscience vote, so members on all sides might like to bear in mind what I have just said.

Hon STEPHEN DAWSON: Back to the question asked by Hon Alison Xamon, I am advised that the operational issue is that it places unreasonable onus on the coordinating practitioner to check these matters before referring. In saying that, I have had the time to consult and I indicate that we will support the amendment that stands in Hon Nick Goiran’s name.

Amendment put and passed.

Clause, as amended, put and passed.

New clause 25A —

Hon CHARLES SMITH: I move —

Page 18, after line 8 — To insert —

25A. Referral to psychiatrist

(1) The coordinating practitioner must refer the patient to a psychiatrist for a psychiatric assessment to determine whether the patient is suffering from treatable clinical depression or another psychiatric condition that may affect the patient’s decision-making capacity in relation to voluntary assisted dying.

(2) In determining whether the patient meets the requirements of section 15(1)(d), the coordinating practitioner must take the psychiatric assessment required by subsection (1) into account.

We have heard today that psychiatrists are not required, in the VAD process, to determine whether the patient is eligible to access voluntary assisted dying. We also heard from Hon Aaron Stonehouse today that the Chief Psychiatrist in Western Australia, Dr Nathan Gibson, in his email to Mr Malcolm McCusker stated that “psychiatrists are by far best placed to assess”. In light of that, members, new clause 25A will amend the bill to require a patient to be assessed by a psychiatrist as part of the assessments required in order to determine whether the patient is eligible to access VAD. The purpose of the psychiatric assessment is to ensure the patient is not suffering from any treatable clinical depression or other psychiatric condition that may, in turn, affect their decision-making capacity in relation to VAD.
I have quoted that email correspondence from the Chief Psychiatrist of WA. I will quote some more by way of further explanation. The Chief Psychiatrist said the following to the Joint Select Committee on End of Life Choices —

... if you look at the Mental Health Act, it requires a psychiatrist to determine capacity to make someone involuntary under the Mental Health Act. My feeling would be why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

Further, he said —

The issue is around when someone actually wishes to accelerate and end their life actively. Then, I think, there is an ethical and professional requirement to really make sure that we exclude mental illness in that situation.

It is a very simple additional safeguard to ensure that a safe decision is made on the patient’s journey through VAD.

Hon STEPHEN DAWSON: Hon Charles Smith started to quote correspondence from Dr Nathan Gibson, but let me place on the record exactly what Dr Gibson said. He said —

- Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

I think it is important to put that whole comment on the record.

I indicate that the government is not supportive of this amendment. To require all patients who wish to participate in voluntary assisted dying to first see a psychiatrist is contrary to the voluntary nature of participating in the process and may be seen as quite offensive to some patients. Hon Charles Smith’s proposal fundamentally breaches the legal principle that an adult is presumed to have decision-making capacity. In addition, it does not reflect the policy of the bill and would significantly impede access.

Under the bill, decision-making capacity must be independently assessed by two experienced medical practitioners. If they are unable to make a determination, they are obliged to refer the patient to a health practitioner with appropriate competency to make the assessment. The appropriate health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate; if the concern is decline due to ageing, a geriatrician may be preferable; or maybe a neuropsychologist in the case of an acquired brain injury. The ability to refer the patient to a health practitioner with appropriate skills and training is consistent with the legislative framework of the Joint Select Committee on End of Life Choices. 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, 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. 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 that capacity assessment is not solely in the domain of psychiatrists. Psychiatrists are rarely the most appropriate clinicians to undertake capacity assessments. For those reasons, I indicate we are not supportive of the amendment.

Hon NICK GOIRAN: I also have an amendment standing in my name that seeks to do a similar thing to Hon Charles Smith’s amendment that is before us; that is, to mandate a psychiatric referral. The comments that I am about to make are supportive of the amendment moved by the honourable member. I indicate that I will be supporting it, albeit that the model I have proposed in the amendment standing in my name at 78/NC25A is different. It is different to this extent: Hon Charles Smith’s amendment is a general referral whereas mine is more prescriptive and is based upon the provisions in the Mental Health Act. I will speak to that, if we get to that amendment.

I am supportive of the thrust of the amendment moved by Hon Charles Smith, which is to mandate psychiatric referral. To me, it strengthens the gatekeeper role that the coordinating practitioner has to make, particularly when we know there have been a number of issues across the various jurisdictions in respect of this issue. But apart from the lived experience in those jurisdictions, I am guided by some of the evidence that was taken by the Joint Select Committee on End of Life Choices. I was the only member of the committee who attended every meeting and every hearing during that yearlong inquiry. I draw to members’ attention submission 391, which was given by the Western Australian branch of the Royal Australian and New Zealand College of Psychiatrists. It stated in evidence to the committee —

In situations where a patient has a terminal condition causing suffering, there is a risk that symptoms of mental ill health may be mistaken by a doctor not trained in psychiatry for an ‘understandable’ reaction to their condition.

Furthermore, treatment for mental health issues can help to relieve the experience of physical pain, due to the interaction of biological and psychological systems …

Extracted from finalised Hansard
That was from the submission provided by the Royal Australian and New Zealand College of Psychiatrists to the Joint Select Committee on End of Life Choices during its one-year inquiry.

In addition, Dr Lisa Miller noted in her evidence to the Joint Select Committee on End of Life Choices that she runs the only specifically funded cancer liaison psychiatry clinic in Western Australia and has a month-long waitlist. St John of God Health Care also noted in its evidence to the committee that rapid access to psychological and psychiatric services is limited outside the context of inpatient specialist palliative care. It noted that in the absence of adequately addressing psychological distress, requests for assisted dying may be more likely. I refer members to the information provided by St John of God Health Care to the joint select committee in response to questions taken on notice.

In addition, a similar warning was issued to the parliamentary inquiry by the Western Australian branch of the Royal Australian and New Zealand College of Psychiatrists. In its submission, submission 391, it states at pages 4 and 5 —

> Adequate support for consultation–liaison services is essential in ensuring people with chronic and terminal illnesses are able to alleviate or manage psychological suffering. It is arguable that patients are currently able to fully exercise choice regarding end of life care where such services are unavailable or poorly understood.

Despite all of this evidence, from the best experts, given to the Joint Select Committee on End of Life Choices, obviously there has been a continuing push to legislate the scheme that is before us. The amendment that I moved to clause 4, “Principles”, to include a reference to consultation–liaison psychiatry and psycho-oncology, failed. Apparently, relieving patient suffering through the provision of consultation–liaison psychiatric services and psycho-oncology services is not a priority. Instead, the priority is to relieve patient suffering by allowing doctors to terminate the lives of their patients through the administration of a voluntary assisted dying substance. Since this is apparently the priority, it is appropriate that we have mandatory psychiatric assessment before a patient is assessed as eligible to access voluntary assisted dying under this bill. I note that the submission made by the Western Australian Chief Psychiatrist to the Joint Select Committee on End of Life Choices, submission 655, stated —

> While individuals with mental illness must be afforded the same rights as other individuals within society, they are implicitly vulnerable in the potential context of seeking end of life because of issues of stigma, the inherent nature of mental illness (the complexity of determining remediable drivers and the influences on these), and the complexity of determining capacity.

In addition, the Royal Australian and New Zealand College of Psychiatrists gave this evidence during the yearlong inquiry — People suffering from mental disorders may manifest significant fluctuations in their cognitive function over short periods of time and may also vary in decision-making capacity depending on the matter being addressed …

For a person with co-existing physical and mental illnesses, ensuring adequate decision-making capacity in the context of PAS may therefore pose significant challenges.

That was submission 391 to the yearlong inquiry. It appears that the issue of comorbidity as a complicating factor in the assessment of capacity has been raised on multiple occasions during the yearlong inquiry, but it is also well documented in the research papers in this area. I draw to the attention of members a paper written by Dr C.J. Ryan, a consultation–liaison psychiatrist from the department of psychiatry at Westmead, that appeared in a peer-reviewed journal and states —

> Sadness and despair are normal responses to the news that one is gravely ill. However, as many as one in five seriously ill people go beyond this normal response to develop major depression … Major depression is far more than a disorder of emotion; its effects on reason and the intellect may be just as profound.

At page 411 of the article in the Medical Journal of Australia, he goes on to state —

> Unfortunately, the diagnosis of major depression in the gravely ill is very difficult. Low spirits are to be expected in serious illness, and many of the other features of major depression (such as weight loss and sleep disturbance) are also common in physical illnesses. The difficulty of diagnosis is reflected in studies that reveal that non–psychiatrist trained doctors miss up to half of cases of major depression in the medically ill.

Another witness who gave evidence during the yearlong inquiry was Dr Best, a palliative care physician and academic. She noted that the incidence of depression is high in terminally ill patients, and up to 80 per cent of depressed patients with cancer are not diagnosed or treated. I encourage members interested in that transcript to look at that session on 1 May 2018. We also heard during the yearlong inquiry from Dr Khorshid, who was at the time the president of the Australian Medical Association in Western Australia. He gave this evidence on 18 May 2018 —

> … the discussion around diagnosis of depression and other mental illnesses that are comorbid with terminal illnesses is very difficult for the average doctor and very difficult for a palliative care physician or any non-psychiatrist, and, in fact, is probably difficult for psychiatrists as well.

*Extracted from finalised Hansard*
This is the AMA evidence to the yearlong inquiry. He continues —

Our strong recommendation is that a psychiatric assessment be completed for everybody accessing this option, partly around competence … but mainly to exclude significant mental illness. We know those rates of mental illness are extremely high in this population and we would not countenance access to euthanasia because someone is depressed. We feel that would be an inhumane treatment.

This is the advice of the AMA to the yearlong inquiry. In addition, Dr Miller, the only dual trained consultation–liaison psychiatrist in cancer and palliative care in Western Australia, advised the inquiry on 13 December 2017 that around 40 per cent of people in a general hospital setting may be experiencing some degree of significant mental health comorbidity along with their physical health morbidity.

The DEPUTY CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: She also noted that comorbid depression with cancer or other advanced illnesses is common. I will conclude by referring again to the evidence given by Dr Nathan Gibson, Western Australia’s Chief Psychiatrist, in his submission to the yearlong inquiry. In submission 655, at page 3, he states —

While there are robust, internationally-recognised classifications systems, including the ICD-10 and the Diagnostic and Statistical Manual Version 5 (DSM 5), the diagnosis of mental illness still requires an expert clinician to assess for the criteria. While the classification systems seek to objectify this process as far as possible, the assessment of criteria for mental illness will still have components of subjective weighting and analysis based on the skill and experience level of the individual clinician. It is not uncommon for clinicians to disagree on the nature of an individual’s mental illness.

I will just conclude, if I have it readily available, by referring to the letter that was tabled earlier this week, or recently, by the minister, which was the exchange between the government special adviser, Mr McCusker, and the Chief Psychiatrist on 14 November 2019. I had previously encouraged members to take a look at that letter. It was clear from an earlier exchange that Hon Aaron Stonehouse has done that. If members take a moment to look at that exchange, it is quite clear what he is saying, rather than how he was verballed by the government. I have been quite disappointed during this debate to see the number of occasions on which the Chief Psychiatrist has been verballed by the government. His response to Mr McCusker on 14 November speaks for itself. He ends by stating —

- Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

We have the option now to either support the amendment moved by Hon Charles Smith, which is consistent with the expert advice given by the Chief Psychiatrist in Western Australia, that psychiatrists and geriatricians are by far best placed to assess capacity, or we can ignore the Chief Psychiatrist’s evidence. That is okay—we can do that; there is an option for members to do that. I err on the side of supporting the evidence given by the Chief Psychiatrist, who has repeatedly given this evidence to the Joint Select Committee on End of Life Choices. I thank the government’s special adviser for reconfirming that in this exchange on 14 November.

Division

New clause put and a division taken, the Deputy Chair (Hon Robin Chapple) casting his vote with the noes, with the following result —

Ayes (4)
Hon Nick Goiran Hon Aaron Stonehouse Hon Colin Tincknell Hon Charles Smith (Teller)

Noes (30)
Hon Martin Aldridge Hon Ken Baston Hon Jacqui Boydell Hon Robin Chapple
Hon Jim Chown Hon Tim Clifford Hon Alanna Clohesy Hon Peter Collier
Hon Stephen Dawson Hon Colin de Grussa Hon Sue Ellery Hon Colin Holt
Hon Alannah MacTiernan Hon Rick Mazza Hon Kyle McGinn Hon Robin Scott
Hon Dr Sally Talbot Hon Michael Mischin Hon Simon O’Brien Hon Samantha Rowe
Hon Tjorn Sibma Hon Matthew Swinbourn Hon Dr Sally Talbot Hon Pierre Yang (Teller)
Hon Alanna Clohesy Hon Laurie Graham Hon Martin Pritchard Hon Tjorn Sibma
Hon Alanna Clohesy Hon Samantha Rowe Hon Dr Sally Talbot Hon Tjorn Sibma

New clause thus negatived.

The DEPUTY CHAIR: Members, we will be dealing with another new clause 25A, proposed by Hon Nick Goiran, to insert certain words after line 8 on page 18. If you will excuse me, I will not read in the whole insertion. I leave it to Hon Nick Goiran to move the motion in his name.

Hon NICK GOIRAN: Noting the length of the amendment, with the minister’s concurrence, I will make some general remarks about proposed new clause 25A standing in my name at 78/NC25A, rather than move the entirety of the amendment. I propose to do that because it would be fair to say that if the chamber is not willing to support the amendment moved by Hon Charles Smith —

Extracted from finalised Hansard
The DEPUTY CHAIR: Member, I think you need to move the new clause before you start.

Hon NICK GOIRAN: Mr Deputy Chair, I am making general comments under new clause 25A.

The DEPUTY CHAIR: I am advised that you need to put the new clause.

Hon NICK GOIRAN: I indicate to the chamber that I will not move the new clause standing in my name at 78/NC25A. By way of brief explanation, given the chamber was not supportive of the good amendment moved by Hon Charles Smith, it would be impossible to gain support for the new clause standing in my name. I indicate to members that the brief distinction between the two is that this amendment at 78/NC25A sought to mirror the provisions in the Mental Health Act, as I asked parliamentary counsel to try to do. The history of that is simply some evidence provided by the Chief Psychiatrist during the yearlong inquiry. To paraphrase the exchange that took place between him and me, we were both of one mind that the stakes are higher here. I draw to members’ attention this one piece of evidence provided by the Chief Psychiatrist on 14 December 2017, when he said —

… if you look at the Mental Health Act, it requires a psychiatrist to determine capacity to make someone involuntary under the Mental Health Act. My feeling would be why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

He went on to say —

… obviously we have said, again in the Mental Health Act, that anyone who is made involuntary has to be seen by a psychiatrist. It is so serious that a psychiatrist must see them to determine capacity, mental illness et cetera. What I would not like to see is a watered down version that would not apply the same rigour to individuals seeking to end their life, notwithstanding that palliative physicians are good at screening for mental illness. Palliative physicians would not call themselves psychiatrists. They would not say that they can, hand on heart, make diagnoses of mental illness in every case. They would screen for it. Except if you are Lisa Miller, you can do both, but most palliative physicians would say that they screen for it but they would ask for specialist advice if it was a complex situation, hence, I am trying to —

The DEPUTY CHAIR: Hon Nick Goiran, I just remind you that we are not talking to any particular clause at this time, so I ask you to keep the debate truncated.

Hon NICK GOIRAN: Indeed. Thank you, Mr Deputy Chair. To conclude the evidence from the Chief Psychiatrist, he continues —

not have a lesser standard for individuals who are seeking to end their life, even in the case of terminal illness, than we apply already within the Mental Health Act.

It is for those reasons that I asked parliamentary counsel to prepare an amendment that would try to mirror the provisions in the Mental Health Act. However, given the response to the amendment moved by Hon Charles Smith, I think it is prudent at this time not to move the amendment standing in my name at 78/NC25A.

The DEPUTY CHAIR: That takes us to the next amendment from Hon Charles Smith.

Hon CHARLES SMITH: I seek leave to withdraw that amendment.

The DEPUTY CHAIR: We now move to new clause 25B proposed by Hon Nick Goiran.

Hon NICK GOIRAN: I indicate to members that amendment 79/NC25B was a consequential amendment associated with the amendment that I had proposed at new clause 25A. In light of the fact that I have not moved that one, it follows that this one should also not be moved.

Clause 26: Information to be provided if patient assessed as meeting eligibility criteria —

Hon RICK MAZZA: I have an amendment on the supplementary notice paper at 416/26, which is a consequential amendment, and it can remain on the supplementary notice paper.

Hon NICK GOIRAN: I refer to clause 26(1)(a), (b) and (c). How can a medical practitioner who is not required to be a specialist in the patient’s disease, illness or medical condition, nor required to be a specialist palliative care practitioner, be expected to deliver the correct information to the patient required under clause 26?

Hon STEPHEN DAWSON: I make the point that palliative care is not just specialist palliative care. It is well recognised that GPs and other practitioners provide palliative care at end of life. Specialist palliative care advice is most usually provided in the most complex cases.

Extracted from finalised Hansard
Hon NICK GOIRAN: What are the potential risks of self-administering, or being administered, a voluntary assisted dying substance that is likely to be prescribed under this legislation for the purposes of causing the patient’s death, as referred to under clause 26(1)(d)?

Hon STEPHEN DAWSON: Risks would depend on the medical protocol that is appropriate for the patient. That information will be provided to doctors undergoing training. A possible risk may well be the medication not taking effect because it is regurgitated by the patient.

Hon NICK GOIRAN: Would one of the potential risks of self-administration be that the voluntary assisted dying substance is consumed by someone other than the patient?

Hon STEPHEN DAWSON: I am advised that that risk exists with any medication that is dispensed in Western Australia.

Hon NICK GOIRAN: There is reference under clause 26(1)(f) to the method by which the substance referred to is likely to be self-administered. What is the method that is likely to be used?

Hon STEPHEN DAWSON: I am advised that the method will be discussed between the patient and the doctor, and it will depend on the patient’s particular circumstances.

Hon NICK GOIRAN: What would be some examples of the methods that are intended to be used in this provision? I can think of several methods that surely would not be intended to be used. There have been some harrowing stories of suicide from members as reasons for their support for this legislation, to avoid some of those harrowing circumstances. I would imagine that those types of methods are not intended to be used under clause 26(1)(f). What are some of the methods that are intended to be used?

Hon STEPHEN DAWSON: In cases of patient self-administration, it would be oral medication in a liquid or tablet form. In relation to practitioner administration, it would be via liquid, tablet, injection, oral tube, nasal tube, intravenous line and stomach peg.

Hon NICK GOIRAN: Why would the patient not be able to have an injection for self-administration?

Hon STEPHEN DAWSON: I am advised that it depends upon the substance; these are just examples, so it could potentially be.

Hon NICK GOIRAN: To be clear, minister, for self-administration, is it the intention of the government to allow patients to take the substance home in the form of an injection, is it the intention of the government that the substance be taken in the form of a liquid to be consumed, or is it the intention of the government that it be taken in the form of a tablet?

Hon STEPHEN DAWSON: The protocols around this will be developed by the clinical panel during the implementation phase, so we are not presupposing one way or another.

Hon NICK GOIRAN: The minister is saying that he is not presupposing, but I am presupposing that a gun will not be one of the methods. I think we would all agree that is the case, so we can rule that out.

Hon Stephen Dawson: By way of interjection, I can indicate that a gun is not one of the proposed methods.

Hon NICK GOIRAN: Indeed. But there are other methods that obviously are under contemplation. There are options that are being actively considered by government. The reason this is important is that I would think that there is a very significant difference in the risks that the practitioner, under clause 26, has to inform the patient about. If they say to the patient, “You take this home and use it as a liquid”, the risks are far greater than if they take it in tablet form, because if they share the substance with another person in liquid form, there could be multiple victims as a result of this, whereas that is less likely to be the case if the substance is in tablet form. I imagine that the potential risks that will need to be explained to the patient will very much depend on the method outlined at clause 26(1)(f). I am interested to know what advice the government has sought or obtained from the ministerial expert panel on the methods that could be used under clause 26(1)(f).

Hon STEPHEN DAWSON: I am advised that we have not, because it would be a clinical decision.

Hon NICK GOIRAN: Have any methods been ruled out by the government at this stage?

Hon STEPHEN DAWSON: Earlier, the honourable member mentioned the issue of a gun; of course we are not contemplating guns. The bill refers to a “medication”. Therefore, it needs to be a substance. It rules out anything other than a substance.

Hon NICK GOIRAN: What are the clinical guidelines that the minister anticipates will be necessary and that the patient will need to be informed of under clause 26(2)?

Hon STEPHEN DAWSON: I am told that these are matters to be determined by the clinical panel. The clinical guidelines are yet to be established.
Hon NICK GOIRAN: What might “a plan in respect of the administration of a voluntary assisted dying substance” look like, as required under clause 26(2)(b)?

Hon STEPHEN DAWSON: Again, this is a matter that will be determined by the clinical panel. The guidelines are yet to be determined as to what the plan might be. An example of something that might be in a plan is how to manage someone’s nausea if they regurgitate particular drugs.

Hon NICK GOIRAN: That sounds horrible, minister. Section 19 of the Victorian legislation provides that a member of the patient’s family be provided with information about clinical guidelines and a plan for administration. Why does clause 26 of the WA legislation differ from section 19 of the Victorian legislation?

Hon STEPHEN DAWSON: I am advised that, in practice, this information would be provided to a family member if that is the patient’s wish.

Hon NICK GOIRAN: I move —

Page 19, line 13 — To delete “or,” and substitute —

and,

Hon STEPHEN DAWSON: I indicate that the government is amenable to this amendment, and will support this amendment, to make it clear.

Hon NICK GOIRAN: I thank the minister for that. I will very briefly explain to members what this amendment actually seeks to do. I need to give due credit to the Leader of the Opposition, Hon Liza Harvey, who moved exactly the same amendment in the other place but was told “No” by the government on that occasion. I am grateful that the government’s line of thinking on this issue has evolved. All the amendment does is indicate that the information that is provided must be also provided to the patient. By all means, the information should be provided to somebody else whom the patient asks for it to be given to, but what cannot possibly happen is that the information be provided to a third party and the patient not be informed. This amendment simply ensures that the statute before us is consistent with the explanatory memorandum, which actually deals with this point. I thank the government for its acceptance of the amendment.

Amendment put and passed.

Hon ADELE FARINA: I would like to understand why the coordinating practitioner “must” provide the information listed in clause 26(1), but at subclause (2), the coordinating practitioner “must take all reasonable steps” to fully explain to the patient and a person nominated by the patient, given the amendment we have just made. It just seems to me that if the patient is likely to elect to self-administer, the practitioner will want to be absolutely sure that the patient is aware of all the relevant clinical guidelines and understands the plan for the administration of the substance. I do not understand why the words “take all reasonable steps” are included in this subclause. I would have thought that it would be absolutely critical that the patient and the family member or other person nominated by the patient understands what needs to be done.

Hon STEPHEN DAWSON: We think it actually strengthens the obligation. They have to take all reasonable steps. They cannot just give the information to them; they have to take all reasonable steps to fully explain it to them. We think it strengthens the provision.

Hon NICK GOIRAN: Will the duty at clause 26(3) include informing another treating practitioner of a voluntary assisted dying request, if the practitioner is aware that another practitioner is also treating that patient?

Hon STEPHEN DAWSON: No, there is no provision in the bill. Is that seen as a deficiency? Is that going to be addressed in some other way; and, if not, why not?

Hon NICK GOIRAN: Subclause (3) does not provide this, but is there another provision in the bill that will require the practitioner to let another practitioner know that their patient is accessing voluntary assisted dying? Let us imagine, for a moment, that a general practitioner is aware that a patient is receiving treatment from a psychiatrist. The patient comes to see the general practitioner and says, “I would like to request voluntary assisted dying.” In those circumstances, I think it would be important, appropriate and maybe ethical—I do not know whether there are some guidelines along this line—for the general practitioner to let the psychiatrist know that their patient has requested voluntary assisted dying, just for the awareness of the psychiatrist and to assist in their general treatment of the patient. Is there a provision along those lines in the bill?

Hon STEPHEN DAWSON: The advice I have been given is no, honourable member.

Hon NICK GOIRAN: Subclause (3) does not provide this, but is there another provision in the bill that will require the practitioner to let another practitioner know that their patient is accessing voluntary assisted dying? Let us imagine, for a moment, that a general practitioner is aware that a patient is receiving treatment from a psychiatrist. The patient comes to see the general practitioner and says, “I would like to request voluntary assisted dying.” In those circumstances, I think it would be important, appropriate and maybe ethical—I do not know whether there are some guidelines along this line—for the general practitioner to let the psychiatrist know that their patient has requested voluntary assisted dying, just for the awareness of the psychiatrist and to assist in their general treatment of the patient. Is there a provision along those lines in the bill?

Hon STEPHEN DAWSON: No, there is no provision in the bill.

Hon NICK GOIRAN: Is that seen as a deficiency? Is that going to be addressed in some other way; and, if not, why not?

Hon STEPHEN DAWSON: No, it is not seen as a deficiency. Patient confidentiality exists. If the patient consents, the medical practitioner will be able to advise another practitioner. Otherwise, patient confidentiality is paramount.

Hon NICK GOIRAN: If a Western Australian patient consults a general practitioner and expresses suicidal ideation, and the general practitioner knows that the patient is being seen by a psychiatrist—in fact, the general

Extracted from finalised Hansard
practitioner may have even referred the person to a psychiatrist—does the general practitioner currently have any obligation or duty, ethical, legal or otherwise, to inform the psychiatrist of those circumstances, or would, as the minister said, patient confidentiality prevail over all, including the welfare of the patient, and there would be no communication between the GP and the psychiatrist?

**Hon STEPHEN DAWSON:** I am told that it depends on the scope of the duty of confidentiality between patient and doctor. Normal medical practice standards would apply.

**Hon NICK GOIRAN:** Where can we find the standards that the minister referred to?

**Hon STEPHEN DAWSON:** I refer the honourable member to the Medical Board of Australia document that has been mentioned previously in this debate.

**Hon NICK GOIRAN:** Where can we find the standards that the minister referred to?

**Hon STEPHEN DAWSON:** I refer the honourable member to the Medical Board of Australia document that has been mentioned previously in this debate.

**Hon NICK GOIRAN:** I indicate that this is not a reason to oppose clause 26, but it is an assessment that arises as a result of our consideration of clause 26; that is, I am troubled that a Western Australian can make a request for voluntary assisted dying to a medical practitioner in Western Australia, and, even though that practitioner knows that another medical practitioner is treating that patient, there would be no communication between those practitioners. This is a rhetorical question, but I would be very interested to know what medical practitioners in Western Australia think about that. I think they would be troubled and that they would want to have all possible information at their disposal, but that is not contemplated in the bill. The reason I make these remarks on the record now is that, as the minister indicated, there will be an extensive implementation period of at least 18 months. I do hope that those individuals who will participate in that implementation period will contemplate this issue and develop some form of protocol to ensure that this type of situation is addressed.

**Hon STEPHEN DAWSON:** The honourable member’s comments are noted.

**Clause, as amended, put and passed.**

**Clause 27: Outcome of first assessment —**

**Hon NICK GOIRAN:** Section 20 of the Victorian legislation is equivalent to clause 27 before us, and requires that the coordinating medical practitioner is satisfied that the person is acting voluntarily and without coercion and that the person’s request for access to voluntary assisted dying is enduring. Why have these requirements been excluded from clause 27?

**Hon STEPHEN DAWSON:** They have not been excluded. Clause 15 sets out the eligibility criteria. Further, clause 27 requires that the patient understands the information required to be provided under section 26(1) and meets all the eligibility criteria.

**Hon NICK GOIRAN:** I do not know whether the minister has a copy of the Victorian legislation handy, but I refer the minister to section 20(1)(c) and (d) and ask where we find that in our legislation.

**Hon STEPHEN DAWSON:** I am advised that it is similar to our clause 15(1)(e) and (f).

**Hon NICK GOIRAN:** If a patient is assessed by their coordinating practitioner as being ineligible for voluntary assisted dying under this scheme and, as I understand it, the request and assessment process ends, would the Voluntary Assisted Dying Board be informed of this?

**Hon STEPHEN DAWSON:** Yes, it would.

**Hon NICK GOIRAN:** Under what provision would that occur?

**Hon STEPHEN DAWSON:** It is under clause 28.

**Hon NICK GOIRAN:** Clause 28(3) sets out the information that would be provided in the form. Which section does the minister say ensures that the board is aware that the practitioner has determined that the person is ineligible for access?

**Hon STEPHEN DAWSON:** It is clause 28(3)(g).

**Clause put and passed.**

**Clause 28: Recording and notification of outcome of first assessment —**

**Hon ADELE FARINA:** I have an amendment standing in my name at clause 28 that I would like to move. The amendment is 469/28.

**Point of Order**

**Hon STEPHEN DAWSON:** We have already set a precedent that we would work through the amendments in the order in which they appear on the supplementary notice paper.

**Hon ADELE FARINA:** No-one stood up. I am more than happy to follow the order.

**The DEPUTY CHAIR (Hon Matthew Swinbourn):** That is noted.

Extracted from finalised Hansard
Committee Resumed

The DEPUTY CHAIR: The next amendment on the supplementary notice paper is by Hon Nick Goiran. Do you wish to move your amendment?

Hon NICK GOIRAN: I do. Perhaps just a few questions —

Hon Stephen Dawson: Perhaps the member does not need to ask questions.

Hon NICK GOIRAN: I move —

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.

Hon STEPHEN DAWSON: I indicate to the chamber that the government will support this amendment standing in Hon Nick Goiran’s name. The effect of the proposed amendment is to ensure that in addition to the patient being informed about the outcome of their assessment, they also get a suite of other information, including the assessing practitioner’s decision in respect of each of the eligibility criteria. During the implementation stage, the Department of Health will look at the most appropriate way to present this information to the patient. A printable extract may be provided to the patient that will also require provision of printed information to the patient about a State Administrative Tribunal review.

Hon NICK GOIRAN: I am pleased to see the support of the government for this amendment standing in my name. It was based on an amendment moved in the other place by the Leader of the Opposition, Hon Liza Harvey, the member for Scarborough, on 5 September 2019. I feel the duty to inform members that the drafting of this amendment differs slightly from the amendment moved on the floor of the chamber in the other place by the Leader of the Opposition, the member for Scarborough. However, the amendment meets the same objective. The reason that it is slightly different is that I consulted with parliamentary counsel and this was the preferred form of wording, so I seek the support of members.

Amendment put and passed.

Hon ADELE FARINA: I move —

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;

In my contribution to the second reading debate, I raised this issue about the need for medical practitioners to be very certain that when they are talking to people whose first language is not English, they are understanding what is being said to them. I also relayed to the chamber an experience with my father when a procedure was performed on him that he clearly did not want and did not consent to. However, his signature was on a consent form and I spoke about the difficulties that arose from that. It is absolutely critical that as part of this process we collect as much information as we possibly possibly can about who is applying for voluntary assisted dying and the circumstances. I also think that given the sort of information that is being relayed to the patient through this assessment process, it is fairly important that they understand what is being said to them and the decision that they are making is made with the full knowledge of the consequences of that decision. Inserting these two additional subparagraphs is really a matter of ensuring that an interpreter is used when one is needed and that information is recorded so that we have that statistical information if it is needed.

Hon STEPHEN DAWSON: I indicate that I am happy to support this amendment, too. It makes good sense from a policy perspective. The information was intended to be captured on a database anyway, but I have no issue with it being included as an amendment.

Hon ROBIN CHAPPLE: I thank the member for her amendment and I will be supporting that.

Hon AARON STONEHOUSE: I am glad to see this amendment receive support from across the chamber. It addresses in some part a concern that I had around assessing capacity and obtaining consent from people who come from different cultural backgrounds and have different attitudes towards the authority of a medical practitioner, or indeed have language difficulties. Providing a provision for interpreters is sensible and addresses the concern that I raised in my second reading contribution. I am happy to support the amendment.

Amendment put and passed.

The DEPUTY CHAIR: There is another amendment to clause 28 in the name of Hon Nick Goiran. Do you wish to move that amendment?

Several members interjected.

The DEPUTY CHAIR: Members, we will not proceed if we keep having these interjections. Allow Hon Nick Goiran to move his amendment.
Hon NICK GOIRAN: I move the amendment standing in my name at 179/28. I move —

Page 20, after line 19 — To insert —

(ea) a statement outlining the patient’s end of life concerns that formed the basis for the first request, for example —

(i) loss of autonomy;
(ii) loss of ability to engage in activities that make life enjoyable;
(iii) loss of dignity;
(iv) loss of control of bodily functions;
(v) being a burden on family members, friends or carers;
(vi) inadequate pain control or fear of inadequate pain control;
(vii) the financial implications of care and treatment (both curative and non-curative);

This amendment seeks to strengthen the data collection in the first assessment report forms to assist the Voluntary Assisted Dying Board in performing its functions under clause 117, particularly the function at paragraph (d), which states —

to conduct analysis of, and research in relation to, information given to the Board under this Act;

I seek to amend clause 28 to include not only the date when the first request was made, as currently required under clause 28(3)(e), but also a statement outlining the patient’s end-of-life concerns that form the basis of the first request. The list of end-of-life concerns in my amendment on the supplementary notice paper is taken from the end-of-life concerns listed in the Oregon Health Authority’s Death with Dignity Act annual reports. I draw to members’ attention page 12 of the current Oregon Health Authority Death with Dignity Act annual report, which is for the twenty-first year of operation of its scheme, in 2018, in which a similarly worded list appears. The table at page 12 of that Oregon Health Authority annual report reveals that of the deaths that occurred under the Death with Dignity Act in 2018, 91.7 per cent of patients cited concern about losing autonomy in their request for assisted dying; 90.5 per cent of patients cited concern about being less able to engage in activities making life enjoyable; 66.7 per cent of patients cited concern about loss of dignity; 36.9 per cent of patients cited concern about loss of bodily functions; 54.2 per cent of patients cited concern about being a burden on family, friends or caregivers; 25.6 per cent of patients cited inadequate pain control or fear of inadequate pain control; and, finally, 5.4 per cent of patients cited concern about the financial implications of treatment.

I suggest to members that analysis of such data will provide an opportunity to better understand the driving forces behind patient access to voluntary assisted dying. I would further suggest to members that analysis of the data would also provide an opportunity for ongoing improvements in the end-of-life care for patients in our state. I would trust that members agree with me that if 54.2 per cent of patients in Western Australia were to express a concern about being a burden on family members, friends or caregivers before accessing voluntary assisted dying, a government of either persuasion and the community in our state would be motivated to seek ways to better support people at their end of life and better support their family, friends and caregivers.

It is my view that data around financial concerns should also be collected. I trust that we would not support a patient accessing voluntary assisted dying based on their concern about the financial implications of care and treatment, whether that be care and treatment for curative or non-curative purposes.

I also note that the same data is collected in Washington state—another jurisdiction that has assisted suicide or voluntary assisted dying. Assisted dying has been legalised under its Death with Dignity Act. Washington state Department of Health’s Death with Dignity Act reports are produced annually and they cite the same statistics. The collection of this data would appear to be best practice in other jurisdictions where assisted dying has been legalised, including the two that I have just referred to. I therefore have moved the amendment in my name to mandate this best practice for our state to ensure that this information is included in the first assessment report forms referred to in clause 28(3). I seek members’ support for the amendment.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of this amendment. This amendment requires the patient to make a statement about their reasons for seeking access to voluntary assisted dying and proposes a list of examples. Although the government supports that robust data about voluntary assisted dying should be collected by the board, it does not believe it is appropriate to require the patient to, in effect, justify their request for voluntary assisted dying in addition to undergo assessments for eligibility. The proposed legislative requirement is intrusive for someone who is dying. This information can rightly be ascertained during the clinical process. It is anticipated that during the implementation phase, consultation with end-of-life and palliative care researchers and other jurisdictions would inform the collection of data that may facilitate and enhance the function of the board under clause 117(d) and also balance this with an appropriate client-centred approach to data collection. The inclusion of any agreed data elements can be managed during the implementation phase and is not required to be included in the legislation.

Extracted from finalised Hansard
Hon NICK GOIRAN: The minister mentioned that one of his objections to my amendment is that it is intrusive. Has there been any dialogue between the government and jurisdictions such as Oregon that have been collecting this data for 21 years, or indeed Washington state, to ascertain whether, under their very substantial regimes, there is any concern that this is intrusive?

Hon STEPHEN DAWSON: We have not specifically asked the question, but certainly our view is that it is not appropriate and it would be intrusive.

Hon NICK GOIRAN: When the minister said that the government has not specifically asked the question, has there been any dialogue with those in Oregon or Washington in respect of the bill?

Hon STEPHEN DAWSON: I am advised that there certainly has been in respect of the bill, but not in respect of this matter.

Hon ADELE FARINA: Would this not be part of the dialogue that the patient and the coordinating practitioner and the consulting practitioner would have in their whole discussion about accessing VAD? Would it not be easy enough to collect this information as part of that assessment process?

Hon STEPHEN DAWSON: In my answer to Hon Nick Goiran I want to clarify that there was dialogue between Western Australia and other jurisdictions in relation to voluntary assisted dying, not specifically in relation to the bill. I need to clarify that for the chamber.

I think Hon Adele Farina’s question was along the lines of: would it not be fairly easy to collect this data?

Hon Adele Farina: I expect the practitioner and the patient to have a discussion along these lines anyway as part of the whole process of asking for voluntary assisted dying and the assessment process.

Hon STEPHEN DAWSON: Discussions may well take place, and it is our intention, during the implementation phase, to work out a way in which data could be collected and provided to the board to help it do the work it is required to do. We think this is intrusive, and we do not think it is appropriate to include it in the bill.

Division

Amendment put and a division taken, the Deputy Chair (Hon Matthew Swinbourn) casting his vote with the noes, with the following result —

Ayes (6)
Hon Adele Farina
Hon Charles Smith
Hon Colin Tincknell
Hon Rick Mazza
Hon Aaron Stonehouse
Hon Nick Goiran (Teller)

Noes (28)
Hon Martin Aldridge
Hon Peter Collier
Hon Colin Holt
Hon Ken Baston
Hon Stephen Dawson
Hon Alannah MacTiernan
Hon Jacqui Boydell
Hon Colin de Grussa
Hon Kyle McGinn
Hon Robin Chapple
Hon Sue Ellery
Hon Michael Mischin
Hon Jim Chown
Hon Simon O’Brien
Hon Darren West
Hon Tim Clifford
Hon Diane Evers
Hon Martin Pritchard
Hon Alanna Clohesy
Hon Donna Faragher
Hon Samantha Rowe
Hon Nick Goiran
(Hon ADELE FARINA: I am not going to talk for very long on this. Everyone knows my position on palliative care in regional areas, and what is needed. I see the need for this amendment, and I would like the support of the chamber. Whether accessible palliative care is available to a patient is very important. I have indicated previously that the government has decided to pass this bill, so the government needs to prepare the community to facilitate this bill. Regional people have the right to the same care. There are things that the government can do to assist in making palliative care available. We have heard that voluntary assisted dying will be available to everyone everywhere, and I believe that the same should be happening with palliative care.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of the amendment moved by Hon Colin Tincknell. I draw honourable members’ attention to an amendment standing in my name on the supplementary notice paper issue 12 at 402/28. That amendment is to require the coordinating and consulting practitioners, in providing the first assessment report form and consulting assessment report form to the board, to include information about palliative care options available to the patient and the likely outcomes. This is to assist the board to gather data and identify any gaps in health service provision. This would include information such as whether the patient is currently receiving palliative care, and, if not, whether a palliative care service is available to which the patient could be referred, to assist them; whether the patient has been offered a referral to this service; and whether the patient has or has not been referred to this service.

Extracted from finalised Hansard
Hon AARON STONEHOUSE: I appreciate the sentiment with which this amendment has been put forward. It is worth noting that nothing in the amendment would improve access to palliative care for regional or other people in Western Australia. However, much like the amendment put forward by Hon Nick Goiran that we considered a moment ago, it would provide a reporting function for the availability of palliative care, which I think is desirable. However, it requires reporting on access to palliative care in regional Western Australia. I think it is too narrow, in that sense. It states —

(ga) whether accessible palliative care is or will be available to the patient in regional Western Australia;

I think that is not really ideal. We would be better off with something along the lines of what the minister has put forward, which would put in place a reporting requirement for palliative care and treatment options available to the patient, regardless of where they reside. As I said, I support the sentiment with which this has been put forward, but I would say that it would be more prudent to vote down this amendment in this case and support, instead, the amendment put forward by the Minister for Environment.

Amendment put and negatived.

The DEPUTY CHAIR: Hon Charles Smith, there is an amendment in your name; do you wish to move that amendment?

Hon Charles Smith: No, Deputy Chair.

The DEPUTY CHAIR: Members, we are now dealing with an additional amendment on the supplementary notice paper in the name of Hon Martin Pritchard.

Hon MARTIN PRITCHARD: We again have the situation in which the singular can refer to the plural. Clause 28(3)(i) states —

if the patient was referred under section 25(2) or (3), the outcome of the referral;

Is it intended that all referrals would be sent to the board. It says “outcome”, does that mean the referral information or just the outcome?

The DEPUTY CHAIR: Member, are you moving your amendment or are you just seeking clarification?

Hon MARTIN PRITCHARD: The answer I get back will determine whether I move the amendment.

The DEPUTY CHAIR: We will indulge the member’s position if the minister wants to give his response now.

Hon STEPHEN DAWSON: Yes, it refers to all referrals. It is just the outcome.

Hon MARTIN PRITCHARD: Thank you for your indulgence. I will not move my amendment.

The DEPUTY CHAIR: Members, we are still dealing with supplementary notice paper 139, issue 12, and there is another amendment in the name of Hon Nick Goiran. Member, do you wish to move your amendment?

Hon NICK GOIRAN: Certainly, Mr Deputy Chair. I move —

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);

Briefly, the amendment standing in my name to clause 28 mandates that the first assessment report form must include not only the outcome of a referral made under clause 25(2) or (3) to another practitioner or other qualified person, but also a copy of the report provided by that practitioner or other qualified person on their assessment of the patient’s eligibility to the coordinating practitioner. The government has reiterated the importance of the Voluntary Assisted Dying Board in monitoring the operation of the act. That can be found at clause 117(a). This amendment seeks to better support the Voluntary Assisted Dying Board in this function by ensuring that it has available to it all the relevant information on the assessment of the patient’s eligibility to access voluntary assisted dying. It is not apparent to me that there is any reason the amendment should not be supported and I seek the support of members.

Hon STEPHEN DAWSON: I indicate that the government does not support this amendment. There is a further one at 189/39 on which I will also make these comments. Hon Nick Goiran’s amendments seek to require the coordinating and consulting practitioners when respectively providing the first assessment report form and consulting assessment report form to the VAD board to include a copy of any referral report given as part of the patient’s assessment.

It is not the role of the board to undertake clinical review during the voluntary assisted dying process. The bill already requires that the board is advised of the outcome of any referrals via the first assessment report form or the consulting assessment report form. The board does not need to consider all the assessment documentation by the coordinating consulting practitioner or the person referred to. For those reasons we will not support it.

Hon NICK GOIRAN: If one of the objections is that it is not the role of the board to provide clinical review, what will the board actually do?

Hon STEPHEN DAWSON: The board will have a monitoring role and that is covered in part 9 of the bill.
Hon NICK GOIRAN: If the board is monitoring, should it not receive a copy of any report that is relevant?

Hon STEPHEN DAWSON: We do not believe it is necessary.

Hon NICK GOIRAN: Mr honourable minister, through the Deputy Chair.

Hon Sue Ellery: You’re losing it!

Hon NICK GOIRAN: Leader of the House, it is interesting that the role of the Voluntary Assisted Dying Board is to monitor this process, a very important report is available but we do not want the Voluntary Assisted Dying Board to see it. It does not make it much of a monitor.

Hon Sue Ellery: There is a lot of that going about!

The DEPUTY CHAIR: Leader of the House, it is not very helpful.

Hon NICK GOIRAN: It does not make it much of a monitor if it does not have all the information before it. It is not apparent to me how this would create any harm to the bill. On what basis is it a concern that the board would be getting more information? I would have thought that if it was a monitor, it would be a good thing if it got as much information as possible. It is just not at all clear to me what the objection could possibly be about the board receiving information. If a medical practitioner has determined that they are unable to make an assessment, we have previously said on that basis that they should refer to somebody else and we have said that they can adopt that particular report. They might not. As a monitor, they should be aware that a referral has been made and that a separate practitioner with expertise in the field has come to a certain determination and the coordinating practitioner has said, “Look, I’ve decided not to follow that particular assessment.” That is absolutely within the remit of the coordinating practitioner but the monitor should be aware of all that. That is the whole point of supervision and oversight. It is not apparent to me what the genuine objection is, but I conclude in that respect.

Hon STEPHEN DAWSON: Upon further reflection, it would not cause any issues for us, so the government is happy to accept the amendment.

Amendment put and passed.

Hon NICK GOIRAN: Before I consider moving the amendment standing in my name at 82/28, can the minister clarify, in light of the excellent amendment moved by Hon Adele Farina at 469/28, to what extent is amendment 82/28 still required? Is it different or do they simply duplicate each other?

Hon STEPHEN DAWSON: The honourable member’s amendment is different; it goes further than Hon Adele Farina’s amendment and it requires a greater level of detail to be collected and provided.

Hon NICK GOIRAN: In light of that, I move —

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;

Even though I gave notice of this amendment prior to the excellent amendment moved by Hon Adele Farina earlier today, I think this amendment complements that one. Members will recall that we agreed—as I understand it, without dissent—that it would be appropriate to record whether a coordinating practitioner had engaged an interpreter in accordance with clause 160(2) to communicate the information under clause 26 to the patient. This amendment will ensure that the name, contact details and accreditation details of the interpreter are collected. Clause 160(1)(a) provides for an interpreter to assist the patient in the request and assessment process. Clause 160(2) provides for the accreditation requirements of the interpreter and mandates certain independence standards for the interpreter, including that the interpreter cannot be a family member, a beneficiary under the will of the patient, an owner or manager of a health facility in which the patient is being treated or resides, or a person directly involved in providing health services or professional care services to the patient. As I say, this amendment will ensure that the name, contact details and accreditation details are included in the first assessment forms.

That these details were missing from the first assessment request forms was first identified in the other place by the member for Hillarys, my good and learned friend Mr Katsambanis. This is what he had to say during the debate in the other place —

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.

I note that there was a good exchange between Mr Katsambanis and the Premier, who indicated that he would give some consideration to the suggestion. I look forward to hearing the government’s response.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: It has been considered and I am in a position to indicate that we will support this amendment.

Amendment put and passed.

Hon STEPHEN DAWSON: In speaking against Hon Colin Tincknell’s amendment earlier on, I indicated that I had an amendment standing in my name on the supplementary notice paper, and I gave the reasons for it. I move —

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;

Hon COLIN TINCKNELL: I thank the minister. I did not say much on the last amendment, partly because of this amendment. I appreciate the government putting this through. It is a bit like having some of your cake but not all of it. I am happy about the fact that this must be included as part of the first assessment report. I would have preferred my amendment, but this is a step in the right direction.

Amendment put and passed.

Committee interrupted, pursuant to standing orders.

[page 9387]

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Martin Aldridge) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 28: Recording and notification of outcome of first assessment —

Committee was interrupted after the clause had been amended.

Hon NICK GOIRAN: Section 21 of the Victorian legislation, which is the Victorian equivalent to the clause that is before us, allows seven days for the coordinating medical practitioner to give a copy of the first assessment form to the board after the practitioner has completed the form. However, our clause allows only two days for this process. Why was this time frame chosen?

Hon STEPHEN DAWSON: It is our view that seven days is a long period of time. We think that two business days is a more appropriate time and we think that it is an achievable time, too.

Hon NICK GOIRAN: Whose advice was sought in respect of that contracted time period?

Hon STEPHEN DAWSON: Honourable member, apologies. We were just checking various documents to see whether it had been mentioned by others, but, no; it was a decision by the department. We wanted close to contemporaneous monitoring of the oversight. A database will be used to report to the board, so we believe that the two-day time period is completely achievable.

Hon NICK GOIRAN: Minister, there was no consultation with medical practitioners, notwithstanding the fact that the Victorian legislation allows practitioners seven days to provide information to the board and we will provide only two days because the department has said so. It sounds as though there has been no consultation with the AMA on this point. I am troubled by that, minister, particularly given that failure on the part of a coordinating practitioner to provide the completed first assessment form to the board within the two business days will attract a penalty, as I understand it, in the form of a fine of up to $10 000, under clause 107. Minister, it does strike me as a little unfair to be imposing such a heavy penalty on a medical practitioner simply because they do not submit a form to the board within two business days, let alone the circumstances whereby the Victorians get seven days to comply. Is there any explanation of why a penalty of this magnitude is appropriate for simply not providing a form within two business days?

Hon STEPHEN DAWSON: I am seeking that advice. I want to clarify, just to be clear: I did say it was a decision of the department, but it was actually a decision of the government. In relation to consultation, certainly the AMA WA branch has had an opportunity to comment on the bill. This issue was not raised as an issue of concern by it. Certainly no other group, I am advised, has expressed a contrary view. Doctors will know ahead of time that they will need to submit the form within two days, and, as I said, we think it is achievable.

Hon NICK GOIRAN: Is the $10 000 penalty that applies for not providing a form to the board with the outcome of the first assessment a consistent penalty that applies throughout the legislation for any forms that are not provided to the board?

Extracted from finalised Hansard
**Hon STEPHEN DAWSON:** As the bill stands, yes.

**Hon NICK GOIRAN:** I think in an earlier clause the minister indicated that a practitioner might not be available or might be unable or unwilling to perform the duties of a coordinating practitioner, including, as I understand it, because of unavailability—they might be simply unavailable. However, if they do not provide this form within two business days, they can receive a penalty of up to $10 000. It really seems so heavy-handed to be saying to medical practitioners in Western Australia that they can refuse to participate in this process if they are unavailable or for other reasons, but they will have to provide a form to the board and they have to do it within two business days. The Victorians get seven days, but we are giving them two days. That is fine; it is a decision of government, but if they do not do it, they will get a fine of up to $10 000. Has there been any discussion amongst the government at this stage as to the level of the fine? Obviously, the $10 000 fine would be a maximum penalty. It seems to be over the top to say to a medical practitioner that they will be fined $10 000 because they have submitted a form on the third day instead of the second day. What consideration has been given to the level of penalty that is likely to be imposed for this?

**Hon STEPHEN DAWSON:** I make the point that $10 000 is a maximum fine and the CEO has discretion in relation to it. Clause 28 is about the first assessment form and not the first request form. I am told further, it would follow ordinary prosecutorial practice. If they have a valid excuse, the CEO may elect not to prosecute.

**Hon NICK GOIRAN:** To clarify, minister, the penalty is the same if they do not submit the first request form or the first assessment report form—or is the penalty different?

**Hon STEPHEN DAWSON:** As the bill stands, it is the same.

**Hon NICK GOIRAN:** I think it is totally over the top, minister. The fact that the CEO, even if he or she has discretion, can give a fine of up to $10 000 to a medical practitioner because they do not submit a form to the board within two business days, including in circumstances in which the practitioner has said to the patient, “Sorry; I’m not available”, is excessive heavy-handedness. I guess if there are any complaints from medical practitioners, I can always refer them to the Minister for Health.

The first assessment report form in schedule 1 of the Victorian legislation requires information to be included about the coordinating medical practitioner’s specialty training and their relevant experience and training in the patient’s disease, illness or medical condition. Clause 28 requires only the name and contact details of the medical practitioner. Why is the information about the medical practitioner’s specialty training, if any, and experience and training in the patient’s disease, illness or medical condition, if any, missing from inclusion in the first request form in clause 28(2)?

**Hon STEPHEN DAWSON:** I am advised the difference is because the Victorian act has specialist requirements that we do not have in our bill.

**Hon NICK GOIRAN:** Also the Victorian regime, in its first assessment report form in schedule 1, requires the coordinating practitioner to certify that they have provided the patient with information required under section 19, which is the Victorian equivalent to our clause 26. Why does clause 28 in our bill not also require the coordinating practitioner to certify in the first assessment report form that they have provided the information required to be provided to the patient under clause 26?

**Hon STEPHEN DAWSON:** Obviously, we chose a different course of action. I am advised it is unnecessary to list every detail in the bill. The database may include a number of additional items.

**Hon MICHAEL MISCHIN:** I am intrigued by some of the answers given to Hon Nick Goiran regarding contravention of clause 28 of the bill. Clause 28(2) requires —

Within 2 business days after completing the first assessment, the coordinating practitioner must complete the approved form (the first assessment report form) and give a copy of it to the Board.

As I understand it, the minister told us that a failure to do so within two days can potentially lead to a fine. If I understand it correctly, that is through clause 107, “Failure to give form to Board”. Clause 107 states —

A person who contravenes a provision of this Act listed in the Table commits an offence.

Penalty: a fine of $10 000.

Clause 28(2) is one of the provisions in that table. A failure to comply with that provision within two days can make a doctor liable to prosecution before a Magistrates Court by the CEO and the imposition of a fine of up to that amount. The minister told us that the amount of the fine—that is a maximum—is up to the CEO. How does that work? What does the CEO have to do with the quantum of any fine that is imposed?

**Hon STEPHEN DAWSON:** Can I clarify that the discretion is not relating to the fine; the discretion is whether to prosecute. The Voluntary Assisted Dying Board is kept informed and up to date at each step of the process. Copies of completed forms must be sent to the board within two days. This will enable timely monitoring of voluntary assisted dying processes. This requirement for closely contemporaneous reporting reflects the board’s stringent monitoring role and provides an inbuilt safeguard in the legislation.

**Hon MICHAEL MISCHIN:** We will explore just how stringent this monitoring role is in due course. Plainly, the government regards the submission of the forms as of the essence and it needs to be done almost immediately, and
that to not do so is such a heinous offence that it can make a practitioner liable to prosecution, a conviction against his or her name, and a fine of up to $10,000. It is an offence of equal magnitude to any of the other noncompliance provisions identified in the table at clause 107. What comparable offences have been taken into consideration in setting $10,000 as an appropriate level for a fine? I mentioned that only because I understand that there is a bill before the other place because the government thinks a $200 fine for trespassing on railway works is wholly inadequate to deter activity such as riding on the roofs of trains and the like, and it is looking at a fine of only $5,000. Why is $10,000 thought to be appropriate for this sort of offence and only $5,000 for a person making a fool of themselves on public transport and endangering their life and potentially the lives of others?

**The DEPUTY CHAIR:** Before I give the call, I remind members that we are dealing with clause 28, “Recording and notification of outcome of first assessment”. At part 6 of the bill, on page 66, a number of clauses relate to offences. I will allow questions that relate to the operation of clause 28 and the likelihood of an offence being created, but specific questions about the operation of offence provisions in the bill are better suited to part 6 of the bill.

**Hon STEPHEN DAWSON:** We are seeking further information and looking at the Victorian act, so I will provide an answer shortly, but I make the point: this is not the bill that is before the Legislative Assembly. This is a very different bill. I am not going to canvass what is before that house. What I do say is that we are treating this issue seriously. The bill before us has a penalty of $10,000. We stand by it.

As to what may be in the Victorian legislation, I am trying to find out, but we believe the penalty as defined in this bill is appropriate, given the severity of the issues that are addressed in the bill.

**Hon MICHAEL MISCHIN:** I will not pursue it at this point, but that is part of my concern. I would like to know by what measure it is thought to be such a serious offence that it could expose a medical practitioner to that sort of penalty. No doubt, the minister will be able to tell us in due course what the comparable penalties are and whether there are any other offences of equal magnitude in Western Australia concerning the submission of forms. That was the point of my questioning, but we will leave the rest of clause 107 and the offence-creating provisions to then.

**Hon STEPHEN DAWSON:** Thank you, I am happy to do that, and happy to answer further questions on part 6. I now have further information. The Victorian act talks about a penalty of 60 penalty units. I am advised that a penalty unit is $165, and 60 of those is $9,900, so the penalty in Western Australia is $100 more.

**Clause, as amended, put and passed.**

**Clause 29: Referral for consulting assessment if patient assessed as eligible —**

**Hon NICK GOIRAN:** The minister assured the house in his second reading speech that assessments must be conducted by two independent registered medical practitioners. Can he just indicate where in clause 29 we can find a requirement that the two medical practitioners involved in these voluntary assisted dying assessments be independent from one another?

**Hon STEPHEN DAWSON:** There is no express reference in the bill to the assessments by the coordinating and consulting practitioners being independent. However, it is implicit. The independence to which we refer is individual assessments made by practitioners at distinct stages in the VAD process. This is the clinical medical independence of medical practitioners that patients rely on every day.

**Hon NICK GOIRAN:** Is there anything in clause 29 or elsewhere in the bill that prevents two doctors from setting up a voluntary assisted dying consulting service or clinic to provide patients with access to voluntary assisted dying in concert?

**Hon STEPHEN DAWSON:** There is nothing in this clause or any other clause to prevent them from setting up a facility.

**Hon NICK GOIRAN:** I am really troubled by this. I anticipate that there will not be a plethora of medical practitioners in Western Australia who will want to access or participate in this scheme. I think that a minority of medical practitioners will want to participate. Given that it will be a minority, and that the practitioners who are likely to want to participate will obviously have some form of personal bias towards voluntary assisted dying—in the absence of that personal bias, they would not want to be participating in the first place—it troubles me that we are doing nothing to protect the Western Australian community from two doctors seeing this as an opportunity to set up shop together. I do not think that we should allow a situation in which two doctors can run around Western Australia saying, “It doesn’t matter where you are; whether you are in regional Western Australia or the metropolitan area, fear not! Because the two of us will be out there in a flash. We’ll make sure that you’ve got access to voluntary assisted dying. We’ll take care of everything. We’ve got the training and the expertise. We’ve dealt with the CEO and the requirements, and we are the one-stop shop in Western Australia.” It really troubles me that we are leaving the door wide open to that scenario. I do not believe that most members are intending that scenario to happen. I think that most members, whether for or against this bill, are intending there to be a scenario whereby, most probably, a general practitioner will be used as the consulting practitioner at the first instance. That practitioner will get a request from their patient, certify the various requirements and send them off to the consulting practitioner, and I think most members think that the consulting practitioner will probably be a specialist, although not necessarily—obviously, it is not a requirement—but there will be independence and a referral process, as there would be in any other sense.

Extracted from finalised Hansard
I find it very, very distasteful that there could be a VAD clinic or one-stop shop set up under this legislation. I am concerned that we are providing no safeguard at all against this issue. I know that there is no amendment standing in my or the minister’s name at clause 29, but as we continue to contemplate this bill, I ask the government to consider this issue and whether it might contemplate prohibiting that type of scenario from being set up in our state.

**Hon ADELE FARINA:** I would like some clarification on how clause 29 will work. I am a bit concerned about the potential significant obligation that we are putting on medical practitioners, because a coordinating practitioner is required to refer the patient to another medical practitioner for a consulting assessment under this provision. How will the coordinating practitioner know which other medical practitioners have completed the voluntary assisted dying training and are therefore able to provide consulting services?

**Hon STEPHEN DAWSON:** I am advised that Victoria has a community of practice, and doctors make themselves known to each other and provide mentoring and support. In Western Australia, though, there will be a central database available to coordinating practitioners that will provide information about doctors who have completed training. It will not be a published list of doctors, though.

**Hon ADELE FARINA:** Thank you for that answer, minister. I just want to refer the minister to an article that I happened to come across. It is an ABC news story dated 18 July 2019 titled “Voluntary euthanasia patients in Victoria caught in red-tape bottleneck”. It is about a husband and wife. The wife has motor neurone disease and they are trying to access voluntary assisted dying, and the husband has been quoted in this article as saying that they have enormous problems in actually accessing voluntary assisted dying. It states —

… due to privacy reasons, there is no published list of doctors who have completed the necessary training to conduct VAD assessments.

The two government appointed navigators who were hired to assist patients and their families also did not have access to a list of doctors who had completed the training, which led to the navigators having to cold-call specialists and doctors to check whether they had the relevant training. This created a lot of stress for the individual who wanted to access voluntary assisted dying. Minister, based on your answer, I take it that we will not run into the same privacy issues when compiling and making that data available to coordinating practitioners and the navigators as well.

**Hon STEPHEN DAWSON:** Honourable member, we would hope to learn from Victoria’s implementation issues. It is something that we are aware of. The issue in Victoria has been brought to our attention, so it is something that we are contemplating at the moment and we anticipate learning from those issues in Victoria and coming up with a workable solution.

Clause put and passed.

**Clause 30: Medical practitioner to accept or refuse referral for consulting assessment**

**Hon NICK GOIRAN:** Clause 30(5) refers to “medical practitioner refuses the referral”. Remember that we are talking about a consulting practitioner, which is not to be confused with a coordinating practitioner. The patient already has access to a coordinating practitioner, and that part of the process has already been completed, but now there is this referral to a consulting practitioner. I notice that clause 30(5) states —

If the medical practitioner refuses the referral because the practitioner has a conscientious objection to voluntary assisted dying, the practitioner must, immediately after receiving the referral, inform the patient and the coordinating practitioner for the patient that the practitioner refuses the referral.

That, in part, brings about the query that was raised earlier by Hon Adele Farina about how the coordinating practitioner is supposed to know who to refer to. It is a pointless, exasperating exercise to everybody if they are referring to practitioners who have a conscientious objection. Putting that to one side, minister, why is it appropriate that a medical practitioner with a conscientious objection should then have to have any other requirements other than simply letting the patient and the referrer know the answer to the question? Why do they then have to notify the board?

**Hon STEPHEN DAWSON:** It is for the same reasons that we identified in relation to the coordinating practitioner having to notify the board. This issue has been canvassed generally—not in relation to this officer. But we believe that for the same reasons that the other practitioner has to advise the board, so too must the consulting practitioner here.

**Hon NICK GOIRAN:** There is a massive difference, because, remember, it is the first practitioner, the coordinating practitioner, and the justification provided by the government at the time was that everyone was very concerned that the patient would be left with no information. I remember members, including members of the government, standing up and saying, “Well, we can’t allow the patient not to have information, so it’s very important that the first practitioner provides this information to the patient, because we don’t want them to be left stranded. We feel so passionately about voluntary assisted dying in Western Australia that if a patient wants to know about it, even if you’ve got a conscientious objection as a practitioner you still need to provide the information.” We had that discussion; the minister is right about that. This is very different because this is a consulting practitioner. There can be no suggestion that the patient has been left high and dry and does not have information. They already have a coordinating practitioner, so they have someone looking after them and helping to navigate through the system.

Extracted from finalised Hansard
But this coordinating practitioner has now referred to a consulting practitioner, and the consulting practitioner says, “No, look; I’m not participating. I’ve got a conscientious objection.” Quite rightly, here in clause 30(5), it states that if the practitioner has a conscientious objection, they need to immediately tell the patient and the coordinating practitioner. I agree with that, but why does the person then have another obligation placed upon them that they have to run off to the board and provide a form? We are just making life miserable for the conscientious objector for no particular purpose. I hope the minister can appreciate the difference between the two, and I seek some clarification of why it is necessary for the conscientious objector, as a consulting practitioner—not to be confused with the coordinating practitioner—to have extra obligations put upon them.

**Hon STEPHEN DAWSON:** I will answer it this way. Subclauses (4) and (5) create a positive duty on the medical practitioner to inform the patient of their acceptance or refusal of the first request. This reflects the position that a medical practitioner is professionally obligated not to unduly delay a patient’s access to voluntary assisted dying. They should make a decision and inform the patient as quickly as possible. If the medical practitioner is a conscientious objector, they must inform the patient of their refusal immediately after receiving the referral request. For all other reasons, the medical practitioner must advise the patient within two business days of the request. This provision takes into consideration that any person who conscientiously objects to voluntary assisted dying will, as a matter of course, refuse a patient’s request. Thus, this medical practitioner does not require a length of time to come to that decision. However, other medical practitioners may require time to consider whether they are available or able to provide the service to the patient. The consulting practitioner has chosen to partake in voluntary assisted dying training. They will be aware of their obligations.

**Hon NICK GOIRAN:** The minister said that they have chosen to participate in the training, but what about clause 30(3)—would that not apply to someone who has not done the training?

**Hon STEPHEN DAWSON:** I am advised that they will still have to do the training before they do their assessment under clause 30(3).

**Hon NICK GOIRAN:** Clause 30(3) states —

> The medical practitioner must refuse the referral if the practitioner is not eligible to act as a consulting practitioner.

To qualify for clause 30(3), must they have done the training? I ask the minister to check that because I think that that cannot possibly be right.

**Hon STEPHEN DAWSON:** To do the assessment, they would have to undertake the training.

**Hon NICK GOIRAN:** But, minister, at this point, they have refused to do the assessment. Remember, we are not at the assessment process yet. They have said that they refuse the referral. They have said, “I’m not doing the assessment; I refuse it and the reason I refuse it is that I’m not even eligible to act as a consulting practitioner.” In those circumstances, why are we again creating an obligation for them to report to the board? Rather than us getting entrenched in trying to defend—can I say politely—the indefensible, I think that during the drafting process, the provisions for the coordinating practitioner have been uplifted and lobbed onto the consulting practitioner without necessarily some consideration of the differences and distinctions between the two. It strikes me as over the top. The consulting practitioner, who has not even met the patient—they just have a referral from another medico—should be able to say that they will not participate. Yes, they should have to inform the patient straightaway; I agree with the minister, and that is what this clause will do. But we are going one step further by creating an obligation for them to then provide information to the board.

To be clear, minister, when the consulting practitioner says that they do not want to perform this duty—for example, they may be concerned about the mental health of the patient—I think it is good that they report that to the board, because I am concerned about doctor shopping, amongst other things. There are circumstances in which a consulting practitioner should report to the board, but I do not think it should be when there is a conscientious objection or when a person is not eligible. If they are not eligible, we should just leave them in peace and allow the medical practitioners to go about their business.

**Hon STEPHEN DAWSON:** The honourable member’s comments are noted. The matter has been considered and we stand by the way that the bill has been drafted at clause 30.

**Clause put and passed.**

**Clause 31: Medical practitioner to record referral and acceptance or refusal —**

**Hon NICK GOIRAN:** The Victorian legislation contains no equivalent to clause 31. Why has it been deemed necessary for inclusion in the bill?

**Hon STEPHEN DAWSON:** I am advised that this is an issue of transparency. The purpose of this provision is to reflect the progression and enduring nature of the request and assessment process. It is an administrative record-keeping requirement and also allows resources to be provided to assist the patient through the voluntary assisted dying process if they require it.

**Clause put and passed.**

*Extracted from finalised Hansard*
Clause 32: Medical practitioner to notify Board of referral —

Hon NICK GOIRAN: When the board receives one of these notifications, what should the board do with the notification?

Hon STEPHEN DAWSON: The intent of this provision is to ensure that the Voluntary Assisted Dying Board is notified of a patient’s enduring and voluntary decision to participate in voluntary assisted dying, to track that the correct process is being followed in each case of voluntary assisted dying and to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

Hon NICK GOIRAN: What provision protects a medical practitioner from receiving nuisance referrals; in other words, a coordinating practitioner constantly refers voluntary assisted dying applications to a practitioner who they know full well either has a conscientious objection or has not done the training? What would protect a medical practitioner from those types of nuisance referrals and constantly having to report to the board?

Hon STEPHEN DAWSON: I am advised that this practice could be reported to the Australian Health Practitioner Regulation Agency.

Hon NICK GOIRAN: When we read clause 32 in conjunction with clause 30, we realise that a practitioner is able to refuse the referral because of unavailability. What is the medical practitioner to do if they are unavailable during the two business days that they are required to provide this information to the board?

Hon STEPHEN DAWSON: If there were extenuating circumstances, the CEO could exercise his or her discretion.

Hon NICK GOIRAN: Is this another one of those clauses under which the penalty for the practitioner is a fine of up to $10,000?

Hon STEPHEN DAWSON: Yes, it is.

Hon NICK GOIRAN: The minister is telling me that if I support the passage of clause 32, I will be supporting a decision of the state and the Parliament that a medical practitioner in Western Australia who exercises their rights as a medical practitioner under clause 30(2) and says that they are unavailable to participate in voluntary assisted dying will have two business days in which to provide information to the board even though they are unavailable. A medical practitioner in Western Australia, unlike those in another state, will be subject to the possibility of a $10,000 fine and they will just have to hope that, on the good grace of the CEO, he or she does not prosecute them. I am very troubled by that.

I think in an explanation to an earlier query, the minister indicated that the government had not received any real complaints about this. I suspect that the Australian Medical Association and others have not turned their minds to this particular issue, because if they were aware of this issue that we are discussing now, they would be shouting it from the rooftops. It is totally over the top for members in this chamber of Parliament to say that we authorise the CEO to issue, at his or her discretion, fines of up to $10,000 because a medical practitioner says that they do not want to participate in voluntary assisted dying. Remember, this is not the first medical practitioner; it is the second. I heard the concern of members earlier who said that they do not want patients who want to access VAD to be stranded because no-one is able to help them navigate the system. We have passed that point. This is the second practitioner. Surely there has to be a difference between the treatment of the second practitioner and the treatment of the first one. The second practitioner may say, “I don’t want to participate; I have a conscientious objection” or “I’m not available; I’m about to go on an overseas vacation for a month and am unavailable to do this. I’m about to jump on a plane tonight.” But we are saying, “Sorry; you’d better cancel that flight and make sure that you submit your form to the VAD board, because if you don’t, you’ll be subject to a $10,000 fine.” It is totally over the top, but that is what we are agreeing to in clause 32.

Clause put and passed.

Clause 33: Medical practitioner becomes consulting practitioner if referral accepted —

Hon NICK GOIRAN: Can a medical practitioner refuse to continue to participate in the assessment process once they have accepted the referral for a consulting assessment and formally become the consulting practitioner?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: What will be the implications for the patient and the coordinating practitioner in those circumstances?

Hon STEPHEN DAWSON: The coordinating practitioner will discuss the issue with the patient and, if the patient agrees, the coordinating practitioner will seek another consulting practitioner.
Hon STEPHEN DAWSON: I apologise to the honourable member; I thought I had given him an answer before the dinner break. The coordinating practitioner will discuss it with the patient and, if the patient agrees, the coordinating practitioner will seek another consulting practitioner. If the member has a further question, he can ask it again.

Hon NICK GOIRAN: Will the medical practitioner face disciplinary or legal action if they refuse to continue to participate in the assessment process after having become the consulting practitioner under clause 33; and, if not, what provision in the bill provides them with a shield from such action?

Hon STEPHEN DAWSON: Nothing in the bill suggests that a consulting practitioner will be penalised for bringing their role to an end. I am advised that clause 9 supports this view.

Clause put and passed.

Clause 34: Consulting assessment —

Hon NICK GOIRAN: Clause 34 is silent on the time frame within which the consulting assessment must be made. Does it need to be made in one consultation or can it be made over several consultations?

Hon STEPHEN DAWSON: I am advised that it can be made over several consultations.

Hon NICK GOIRAN: What evidence can the consulting practitioner take into account in assessing whether the patient meets all the eligibility requirements under clause 15? For example, will the consulting practitioner have access to all the patient’s medical records? I appreciate that the consulting practitioner might be able to have regard for them, but will they have access to them in the first place?

Hon STEPHEN DAWSON: They can request such information as medical history, and they can seek specialist reports and other reports from other health practitioners.

Hon NICK GOIRAN: They can do that, but will the consulting practitioner have access to the medical records?

Hon STEPHEN DAWSON: If the patient consents, they can access that information. Obviously, that would be in the patient’s best interests.

Hon NICK GOIRAN: The amendment standing in my name at 66/34 provides that the consulting practitioner must make a decision on each of the eligibility criteria. That is already in the bill at clause 34(2), but if my amendment were to be moved and supported, it would also require the medical practitioner—that is, the consultant practitioner—to take into account the medical history of the patient. I appreciate that the minister indicated that that would only be able to be complied with with the consent of the patient. If that is the case, would that be a necessary implication of the amendment currently standing in my name?

Hon STEPHEN DAWSON: I am sorry, but would the honourable member mind asking the question again?

Hon NICK GOIRAN: The issue here is that there is an amendment standing in my name at 66/34. It seeks to expand current clause 34(2) by requiring the consultant practitioner, in addition to making a decision on each of the eligibility criteria, to take into account the medical history of the patient. The minister indicated earlier this evening that the consulting practitioner would have access to the medical history of the patient if the patient provided consent. My question is: if we were to pass the amendment standing in my name as it is, would it be a necessary implication that consent had to have been granted by the patient in order for the consulting practitioner to access the medical history?

Hon STEPHEN DAWSON: I am sorry, but would the honourable member mind asking the question again?

Hon NICK GOIRAN: The issue here is that there is an amendment standing in my name at 66/34. It seeks to expand current clause 34(2) by requiring the consultant practitioner, in addition to making a decision on each of the eligibility criteria, to take into account the medical history of the patient. The minister indicated earlier this evening that the consulting practitioner would have access to the medical history of the patient if the patient provided consent. My question is: if we were to pass the amendment standing in my name as it is, would it be a necessary implication that consent had to have been granted by the patient in order for the consulting practitioner to access the medical history?

Hon STEPHEN DAWSON: I am sorry, but would the honourable member mind asking the question again?

Hon NICK GOIRAN: The issue here is that there is an amendment standing in my name at 66/34. It seeks to expand current clause 34(2) by requiring the consultant practitioner, in addition to making a decision on each of the eligibility criteria, to take into account the medical history of the patient. The minister indicated earlier this evening that the consulting practitioner would have access to the medical history of the patient if the patient provided consent. My question is: if we were to pass the amendment standing in my name as it is, would it be a necessary implication that consent had to have been granted by the patient in order for the consulting practitioner to access the medical history?

Hon STEPHEN DAWSON: The patient would have to consent.

Hon NICK GOIRAN: In light of that, given that the patient has to consent anyway, I move —

Page 23, line 10 — to delete “criteria.” and substitute —

criteria and take into account the medical history of the patient.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of this amendment. In fact there is an alternate amendment standing in my name at 461/34. This proposed amendment makes clear that the consulting practitioner, when making the consulting assessment, can consider and rely on relevant information about the patient from a registered health practitioner. This is to reflect that, although the assessing practitioner must have regard to their own skills and training when determining the eligibility criteria, they should also rely as part of their assessment on contemporary and relevant information—for example, a medical report containing a clinical diagnosis. Of course, this is already something medical practitioners can and will do as part of good clinical practice. This clause has been included following consultation with the AMA. The government considers this to be a good amendment.

In relation to Hon Nick Goiran’s amendment, “medical history” is an expansive term. It could mean medical services received from the patient’s time of birth and could include information not relevant to this assessment.

Amendment put and negatived.

The CHAIR: Minister, would it be convenient for you to move an amendment in your name at this point?

Hon Stephen Dawson: Yes, it would.

Extracted from finalised Hansard
The CHAIR: Then I give you the call.

Hon STEPHEN DAWSON: I move —

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.

This amendment will make clear that the consulting practitioner, when assessing a patient’s eligibility to access voluntary assisted dying, must not just adopt the coordinating practitioner’s decisions without question but independently form their own opinions on the matters to be decided. This highlights that the coordinating and consulting practitioners must make decisions in a clear and distinct manner, separate from each other’s assessment. Although both practitioners may look at the same materials such as the patient’s medical history and reports from specialists, they each must make their own determination on each of the eligibility criteria.

Hon ADELE FARINA: Does that mean that the coordinating practitioner does not provide information to the consulting practitioner about the decisions that he made in relation to each of the eligibility criteria?

Hon STEPHEN DAWSON: I am advised that the standard referral includes providing relevant information. By virtue of the referral, the consulting practitioner will know that the coordinating practitioner has assessed the patient as eligible, but it would likely be basic information that is provided. However, there is nothing to preclude the practitioner asking the other practitioner for further advice or asking to see the reasons for making such a decision. Certainly, my amendment indicates that the consulting practitioner must not just adopt the coordinating practitioner’s decision, but also independently form their own opinions on the matters to be decided.

Hon MARTIN ALDRIDGE: I seek clarification to avoid any doubt on this amendment. When the minister refers to “independently of the coordinating practitioner form their own opinions”, how far will that independence extend? The minister is not suggesting that the independence is as far as saying they need to be independent of one another in commercial or employment arrangements. Is it just their professional view that they must have an independent assessment?

Hon STEPHEN DAWSON: That is correct.

Hon NICK GOIRAN: This is an excellent topic that has just come up from Hon Martin Aldridge. I find it instructive that page 65 of the “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report” reads —

Although not a direct point for consultation, points were raised in relation to the independence of the assessing practitioners. Whilst not explicitly precluded, if the assessing practitioners are from the same practice (for example) it may be difficult to determine that each practitioner is truly independent of the other. There is a risk that a consulting practitioner may feel implicit pressure to concur with the first assessment findings. The Panel particularly notes that in assuring independence it is important that neither practitioner is in a supervisory or employing role in relation to the other. Each practitioner is responsible for arriving at their own conclusion and must provide an independent assessment.

My question is: does the amendment before us give effect to the analysis provided by the ministerial expert panel at page 65?

Hon STEPHEN DAWSON: It will give effect to the second part; that is, each practitioner is responsible for arriving at their own conclusion and must provide an independent assessment. The government considered the expert panel’s comments, but determined that the independent assessment is the key issue and the implementation will include guidelines for practitioners to ensure that that occurs.

Hon NICK GOIRAN: On whose advice was it decided to dismiss the concerns raised by the ministerial expert panel?

Hon STEPHEN DAWSON: The issue was considered by government and this was the course of action government decided to take.

Hon NICK GOIRAN: What information was at the government’s disposal? Did it consult other people and weigh the competing views and determine one over the other? That consideration process must have had some particularly weighty information provided to government that said, “With all due respect to the ministerial expert panel, we will dismiss what it said on this point.” What significant piece of information came to government that caused it to take a different course of action?

Hon STEPHEN DAWSON: I am advised that this clause was a direct consequence of discussions with the Australian Medical Association. I understand this approach has been fully endorsed by the AMA WA branch.

Hon NICK GOIRAN: That is indeed interesting, minister, because the AMA surveyed its membership and 83 per cent of its members believe that a commercial contract, business relationship or personal relationship other than collegiate should not exist between the coordinating and consulting practitioners. Does the amendment that is before us give effect to that result?
Hon STEPHEN DAWSON: Following the survey, the government met with the Australian Medical Association and had further consultations. I should clarify, honourable member. I said this “clause” was as a result of conversations with the AMA; I should have said this “amendment”.

Amendment put and passed.

Hon STEPHEN DAWSON: I move the amendment standing in my name at 461/34 —

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.

I do not propose to speak for too long on this amendment. I have indicated previously in speaking against Hon Nick Goiran’s amendments that I had an amendment on the supplementary notice paper in my name and the reasons for putting that amendment.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 35: Consulting practitioner to have completed approved training —

Hon NICK GOIRAN: The consulting practitioner and the coordinating practitioner have two very different roles under this scheme. Will the mandatory practitioner training be different for coordinating practitioner and consulting practitioner roles?

Hon STEPHEN DAWSON: The training will be tailored for the specific roles.

Hon NICK GOIRAN: It would be the case in Western Australia that some practitioners will not do the training so they will not be eligible, but some will do the training for consulting practitioners and will not do the training for the coordinating practitioner so they will be eligible to be only a coordinating practitioner but not a consulting practitioner. Is that right?

Hon STEPHEN DAWSON: I will give some general information before I get to the specifics. The bill requires that the assessing medical practitioners, coordinating and consulting practitioners, and the administering practitioners—medical or nurse practitioner—must have successfully completed approved training in relation to voluntary assisted dying before they can perform the functions required of them under the bill. The CEO will approve training in relation to the roles of practitioners and their obligations under the bill, and that is clause 158. Other health practitioners will also be able to register interest in receiving training. Appropriate training packages will be created to support any role they may have under the bill or in supporting patients who are accessing voluntary assisted dying—for example, pharmacists, allied health professionals, interpreters or healthcare support workers. The training will be similar for coordinating and consulting practitioners, but it will be tailored to reflect the respective roles. The likelihood is that one may well be able to do the other’s role by virtue of the broad training that they will receive.

Hon NICK GOIRAN: Could it be the case that a Western Australian practitioner only qualifies as and is only eligible for being either a coordinating practitioner or a consulting practitioner? I appreciate that they may well be able to do both and qualify for both, but I am interested to know whether there could be a scenario in which they qualify as being eligible to do only one.

Hon STEPHEN DAWSON: They would have to do the full training that encompasses both roles, so it is not likely that they could be a consulting practitioner but not a coordinating practitioner, if they have done the full training.

Hon NICK GOIRAN: Correct me if I am wrong: is it not the case that a coordinating practitioner is in the first instance considered to be the administering practitioner, but has the capacity to transfer that role to another practitioner if they want to? Could there be a Western Australian medical practitioner who says, “Look, I’m happy to participate in this VAD process, but I’m not prepared to give that final injection. I’ll give an assessment as to whether a person has a terminal illness that’s going to cause death over the next six months, I’m prepared to tell them about their palliative care options, I’m prepared to tell them all the different criteria, and I’m even prepared to assist them against the eligibility criteria, but the one thing I’m not prepared to do is give that final injection”?

Should a medical practitioner not have the right to just be a consulting practitioner and just do that training and not have to also do the training for administration and coordinating?

Hon STEPHEN DAWSON: To be a coordinating practitioner, there is training for the whole lot, if I can put it that way. A coordinating practitioner may later ask the consulting practitioner to take over the role. Training must therefore be whole and complete. If a coordinating practitioner is unable to administer, there is a process for that at clause 62. Just on training, further details regarding training will be determined at the implementation phase, after further consultation with stakeholders.

Clause put and passed.
Clause 36: Referral for determination

The CHAIR: I turn to issue 13 of supplementary notice paper 139. There are a number of amendments on the supplementary notice paper relating to clause 36, each of them dealing with matters that have previously been debated, with some decided in the negative and some in the affirmative. Hon Nick Goiran, are you wishing to give some indication of what you would like to see done with those?

Hon NICK GOIRAN: Indeed, Mr Chair. Under clause 36, there are numerous amendments standing in my name—five in total. The first four—83/36, 67/36, 68/36 and 84/36—are all matters that I consider to have great merit, but in light of the decision made on the like clauses to do with coordinating practitioners, I do not fancy my chances at convincing the chamber that these provisions should be applied to consulting practitioners, so I do not propose to move those first four amendments.

The CHAIR: Thank you for that advice. I will indicate from the chair, too, that there is a further amendment in a similar vein standing in the name of Hon Martin Pritchard, who is away on urgent parliamentary business.

Hon ADELE FARINA: Mr Chair, Hon Martin Pritchard has asked me to indicate to the chamber that he does not intend to move the two amendments that stand in his name—that is, 23/36 and 24/39. He apologises; he has been called away on urgent parliamentary business.

The CHAIR: I thank both of you for that advice. Members, there is one substantive amendment to this clause, which we will come to when the member wishes to move it. For now, the question is that clause 36, “Referral for determination”, do stand as printed. Hon Nick Goiran.

Hon NICK GOIRAN: I move —

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.

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment. We have had similar amendments moved and passed at earlier stages of the bill. The reasons were given at that stage. I indicate that we are supportive of this amendment standing in Hon Nick Goiran’s name.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 37: Information to be provided if patient assessed as meeting eligibility criteria

Hon NICK GOIRAN: To what extent can the consulting doctor rely on the information provided to the patient by the coordinating doctor about the matters referred to in clause 26(1)?

Hon STEPHEN DAWSON: To the extent that the consulting doctor thinks appropriate, but they have to make their own determination about the evidence.

Hon NICK GOIRAN: Clause 37(1) makes reference to clause 26(1). One of the things listed under clause 26(1) is —

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

Is the minister indicating to us that the consulting practitioner cannot simply rely on the information provided by the coordinating practitioner with regard to the palliative care options and the likelihood of those outcomes?

Hon STEPHEN DAWSON: A thorough assessment by the consulting practitioner will include checking that the patient has information about the matters at clause 26, and checking that the patient understands this information and whether they need any further information or clarification.

Hon NICK GOIRAN: Is that one way of saying that the consulting practitioner can rely on the information already provided by the coordinating practitioner with regard to palliative care and treatment options and the likely outcome of those things?

Hon STEPHEN DAWSON: They can consider it, honourable member, but they have to make up their own mind.

Clause put and passed.
Clause 38: Outcome of consulting assessment —

Hon NICK GOIRAN: Section 29(1) of the Victorian legislation is the equivalent to the clause that is before us. The Victorian legislation requires that the consultant practitioner be satisfied that the patient is acting voluntarily and without coercion and be satisfied that the request for access to voluntary assisted dying is enduring. Why have these assessments been excluded from clause 38?

Hon STEPHEN DAWSON: We have addressed that issue under clause 15 of the bill, “Eligibility criteria”.

Hon NICK GOIRAN: We are talking about consulting practitioners. The minister is now referring me back to clause 15 regarding eligibility requirements. Is that because the minister is saying that at clause 15(1)(e) states that one of the eligibility requirements is that “the person is acting voluntarily and without coercion”?

Hon STEPHEN DAWSON: Yes, it is in subclauses (1)(e) and (1)(f).

Hon NICK GOIRAN: If the patient is assessed by their coordinating practitioner as ineligible for access to voluntary assisted dying, as I understand it, the request and assessment process ends under clause 26(2). If a patient is assessed by their consulting practitioner as ineligible for access to voluntary assisted dying, clause 38 does not provide that the request and assessment process ends. Why is that?

Hon STEPHEN DAWSON: If the consulting practitioner determines that a patient is ineligible for access to voluntary assisted dying, the coordinating practitioner may refer the patient to another medical practitioner for a consulting assessment, and that is under clause 40.

Hon NICK GOIRAN: On how many occasions could that happen?

Hon STEPHEN DAWSON: The short answer is as many times as they need. If a patient is assessed as ineligible by a coordinating practitioner, they may commence a new request and assessment process with another registered medical practitioner to act as their coordinating practitioner. This is consistent with any person seeking a second or even a third medical opinion from different doctors. It is a basic component of the Australian healthcare system that patients are able to seek a further medical opinion of their own volition.

Clause put and passed.

Clause 39: Recording and notification of outcome of consulting assessment —

Hon NICK GOIRAN: I move —

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.

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment.

Amendment put and passed.

Hon NICK GOIRAN: There is a further amendment standing in my name at 188/39. This is the issue we discussed about coordinating practitioners and the information that in my view should be provided to the board. The explanation I provided to the chamber on the last occasion was that it would be consistent with the data collected in Oregon and the state of Washington. Therefore, it would be best practice to collect this information, given that it seems to me that the board has no purpose other than to collect information. However, given that I was unable to persuade the chamber on the last occasion with respect to coordinating practitioners, I do not wish to hold my breath with regard to consulting practitioners, so I will not move my amendment at 188/39.

The CHAIR: Thank you for that. Member, was there a further amendment that you wish to move on this clause?

Hon NICK GOIRAN: I move —

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);

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment. This replicates an amendment made earlier in the bill. I indicated at that stage that we were supportive of it, and we are also supportive of it now.

Amendment put and passed.

Hon NICK GOIRAN: I move —

Page 25, after line 25 — To insert —

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

Extracted from finalised Hansard
I have noticed a potential typographical error in this amendment. Can the minister clarify whether the phrase used in the bill is “consultation assessment” or “consulting assessment”?

**Hon Stephen Dawson:** It is “consulting”, honourable member.

**Hon Nick Goiran:** In light of that, can I seek leave of the chamber to amend the amendment standing in my name at 86/39 so that it will read —

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

By way of brief explanation, this simply seeks to use the phrase “consulting assessment” rather than “consultation assessment”.

**Amendment, by leave, altered.**

**Hon Stephen Dawson:** I indicate that the government supports this amendment. It replicates an amendment made earlier in consideration. I gave reasons at that stage, and we are happy to support this one here.

**Amendment, as altered, put and passed.**

**Hon Stephen Dawson:** I move —

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;

**Hon Alison Xamon:** We have just passed an amendment with paragraph (ka).

**Hon Stephen Dawson:** That was an issue I was going to raise. We have just passed an amendment at 86/39 that inserted a paragraph (ka). This will be a clerk’s amendment. I will leave the wording in my amendment at 403/39 as is. I previously moved a similar amendment to clause 28 and I gave an explanation about why I moved it at that stage, so I do not propose to give the explanation again at this stage, unless a member has a concern. Essentially, this is to assist the board to gather data and identify any gaps in health service provision.

**Amendment put and passed.**

**Hon Nick Goiran:** It strikes me that at clauses 39(2) and (4), the consulting assessment report form has to be provided to the board and also to the coordinating practitioner. The clause appears to be silent about the patient. How does the patient get a copy of a consulting assessment report form?

**Hon Stephen Dawson:** I am advised that the patient could ask for it.

**Hon Nick Goiran:** I move —

Page 25, line 30 — To insert after “patient” —

and to the patient

**Hon Stephen Dawson:** We just passed amendment 85/39, which inserted —

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

My advice is that this further amendment is not needed.

**Hon Nick Goiran:** The minister is quite right, so I seek leave to withdraw my amendment.

**Amendment, by leave, withdrawn.**

**Hon Adele Farina:** I have a question, and I am not sure whether I should ask it here or under the clause about the board, but I looked at all the clauses and I could not find where I should ask the question, so I will ask it now and beg the minister’s indulgence. If the board receives the notification from the consulting practitioner that is different from that from the coordinating practitioner, will that then raise a red flag for the board to pay closer attention to whether there is another report from another consulting practitioner that may be different, or will the board simply be checking that all the boxes have been ticked?

**Hon Stephen Dawson:** I am advised that it may raise red flags, but there are occasions when practitioners have a difference of opinion, so it will depend on the circumstances.

**Clause, as amended, put and passed.**

**Clause 40: Referral for further consulting assessment if patient assessed as ineligible —**

**Hon Nick Goiran:** Clause 40 allows the coordinating practitioner to refer the patient to another medical practitioner for a further consulting assessment if the consulting practitioner assesses the patient as ineligible —

**Hon Stephen Dawson:** Deputy Chair, there was a bit of noise with movement around the chamber, so I did not hear Hon Nick Goiran. I ask him whether he would not remind repeating it.
Hon NICK GOIRAN: Obviously, there is a lot of enthusiasm about clause 40. Clause 40 allows the coordinating practitioner to refer the patient to another medical practitioner for a further consulting assessment if the consulting practitioner assesses the patient as ineligible for access to voluntary assisted dying. Do I understand it correctly that there will be an unlimited number of opportunities for a coordinating practitioner to refer a patient to consulting practitioners? This goes to the concern about doctor shopping.

Hon STEPHEN DAWSON: The coordinating practitioner can refer as many times as deemed medically appropriate. But this is something that the board could pick up. If the board recognised that the patient was being assessed as ineligible multiple times, it could advise the CEO, who could then investigate. The short answer is yes. Technically, they could refer as many times as deemed medically appropriate, but I think a safeguard is that the board would see that, and could raise that with the CEO and action could be taken.

Hon NICK GOIRAN: How regularly is the board going to be meeting to make these determinations?

Hon STEPHEN DAWSON: That would be down to the implementation phase. We are not talking about large numbers of people accessing voluntary assisted dying in Western Australia, so that is something to keep in mind.

Hon NICK GOIRAN: My concern is not how many people access the scheme. There may be one person who accesses the scheme and is constantly doctor shopping while the coordinating practitioner continues to send them to different consulting practitioners. My concern is that this board, if it is anything like most boards, is probably going to meet once a month. The problem is that, as I understand it, this bill will allow a Western Australian to access so-called voluntary assisted dying within nine days. If I am not mistaken, I believe there is even a capacity to AHPRA. Clause 120 of the bill identifies that the board will have staff, services and facilities. The likelihood is that the board did see a pattern of doctor shopping emerging in its real-time oversight of the request and assessment process. But this is something that the board could pick up. If the board recognised that the patient was being assessed as ineligible multiple times, it could advise the CEO, who could then investigate. The short answer is yes. Technically, they could refer as many times as deemed medically appropriate, but I think a safeguard is that the board would see that, and could raise that with the CEO and action could be taken.

Hon NICK GOIRAN: How regularly is the board going to be meeting to make these determinations?

I note that Dr Richard Lugg, who is the deputy WA convener of Doctors for Assisted Dying Choice, is quoted in the Australian Medical Association’s Medicus publication earlier this year as stating —

If there is a theme running through our Bill, it is one of a cautious approach, with a strong emphasis on safeguards. Some of these safeguards are unprecedented in the history of VAD legislation, to a greater extent than is generally realised.

I pause there for a moment. I would like someone to point out to me one of these unprecedented safeguards in the Western Australian legislation, given that the context is that our legislation is verifiably less safe than the Victorian legislation or any other one. Nevertheless, this is Dr Richard Lugg, the deputy WA convener of Doctors for Assisted Dying Choice, quoted in the AMA’s Medicus earlier this year. He continues —

There have certainly been no claims from government spokespersons about “a world first for WA”.

But in fact, there are two significant world firsts in this Bill. While it rejects the Victorian permit system (which requires the health bureaucracy to sign off on every voluntary assisted death before lethal medication can be prescribed), it has substituted a plethora of forms that must be sent to the VAD Board at every step along the VAD process.

These forms will be resent by doctors, and may well put some off participating in the process. Nevertheless, a set of digital templates could be developed to aid the completion of the forms and facilitate their dispatch to the Board by email.

They will, however, have one effect of crucial importance—they will enable the Board to maintain surveillance in real time at every step along the VAD process. Any attempt at supposed “doctor shopping” will be readily visible to the Board. Such surveillance is unparalleled anywhere where VAD is legal.

I also note that in the debate in the other place on 4 September this year, the Minister for Health had this to say —

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?”

That quote can be found at page 6476 of Hansard.

If what Dr Richard Lugg said is correct and if what the Minister for Health said earlier this year is correct and the board did see a pattern of doctor shopping emerging in its real-time oversight of the request and assessment process, how might the board respond to that situation and can it intervene in an individual case to ensure that the process is adequately safeguarded, including making an application to the State Administrative Tribunal?

Hon STEPHEN DAWSON: The board would refer it to the CEO, but it could also refer it to the Australian Health Practitioner Regulation Agency. The CEO can refer things to AHPRA, as can the board. In fact anyone can refer to AHPRA. Clause 120 of the bill identifies that the board will have staff, services and facilities. The likelihood is

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the board will have a secretariat, so this stuff can be monitored—it will advise the board if necessary. Clause 131 of the bill refers to the board being able to hold meetings at times and places determined by the board. The short answer is: the likely action that will take place is a referral to the CEO and also a referral to AHPRA.

**Hon NICK GOIRAN:** My concern here, minister, is that all we are talking about is more forms being sent from the board to other people. If a complaint is sent off to the CEO and to AHPRA, all these things take time. In the meantime, a vulnerable Western Australian is being taken advantage of by a coordinating practitioner who is consistently shopping this patient around, searching for a consulting practitioner to agree with them. The minister mentioned that the board will have some form of secretariat. Has any determination been made about what budget will be provided to the board to be able to facilitate these functions?

**Hon STEPHEN DAWSON:** No, there has not, as yet.

**Hon NICK GOIRAN:** I am really concerned about this doctor shopping issue. I am not satisfied with the responses that have been provided, which seem to indicate that there will be this board. We do not know how often the board will meet. I have no confidence that this board will meet within a nine-day time frame, let us say every week; we do not know how much money will be provided to the board and the secretariat; and we are told that if the board has any concerns, it can send some information off to the CEO of the Department of Health. I am sure that the CEO of the Department of Health will drop everything and make sure that this is their top priority. They can write to AHPRA; meanwhile, while everybody is sending forms to each other, a vulnerable Western Australian will be taken advantage of.

I note that this issue was raised in the other place. The member for Darling Range proposed a solution. The member for Darling Range suggested that there should be a limit on how many assessments could be done. Her suggestion was that there be no more than three assessments. Has any consideration been given to providing some finite limit to how many of these assessments can be done?

**Hon STEPHEN DAWSON:** The matter was considered, but where we have landed with the board is what the government believes is most appropriate. I should also make the point that the patient needs to have agency in the process, and they are not simply shopped around.

**Hon NICK GOIRAN:** The minister might say that, but that was not the experience under the Northern Territory legislation, when Dr Nitschke was some form of expert in doctor shopping. I might add that those of us who take a few moments to look at the lived experiences in other jurisdictions see that doctor shopping is prevalent in other jurisdictions. I am concerned that a person may be taken advantage of by the coordinating practitioner. Yes, the coordinating practitioner may have fulfilled all the requirements and done all the training and so on and so forth, but if they are a person with heavy bias towards voluntary assisted dying—maybe like some other high-profile infamous practitioners around the globe, with some great desire for publicity and notoriety—they may then take advantage of a patient. I accept at the outset and I underscore that that type of practitioner is likely to be rare—thank goodness they are rare—but it will take only one notorious medical practitioner to decide to go on a doctor shopping excursion, and be consistently told by other practitioners, “No, we are not agreeing to this. We don’t accept that the person has a terminal illness. We don’t accept that the person is likely to die in the next six months. We have concerns about depression and other comorbidities.” The person could consistently do this. We know that this happened in the Northern Territory when Dr Nitschke was told by the oncologist and the dermatologist that the person did not have a terminal illness, and he kept shopping until he found an orthopaedic surgeon to sign off on it. That is what I would like to stop. We are poor students of history if we completely ignore the Northern Territory experience.

In the absence of the government providing a superior option, I am inclined to move the amendment that the member for Darling Range moved in the other place, which would at least provide a cap of assessments to say that there can be no more than three of them. In other words, the coordinating practitioner can refer to a consulting practitioner, and an assessment can be carried out, but the referral cannot occur more than three times. There has to be a limit. If practitioners are saying, “No, sorry, you’re not eligible; it is not right”, then surely as a chamber we have to have some sort of cap.

In the absence of the government providing a superior option, I am inclined to move the amendment that the member for Darling Range moved in the other place, which would at least provide a cap of assessments to say that there can be no more than three of them. In other words, the coordinating practitioner can refer to a consulting practitioner, and an assessment can be carried out, but the referral cannot occur more than three times. There has to be a limit. If practitioners are saying, “No, sorry, you’re not eligible; it is not right”, then surely as a chamber we should be able to say that that is the cap. Some member will inevitably ask me, “Why three?” That is an excellent question, but it is in absence of the government providing any cap or limit whatsoever. It seems to me that it is right that a patient should be able to seek a second opinion; I have no problem with that. But there has to be a limit to constant doctor shopping, so the proposal I have is for three referrals, which is consistent with the amendment moved in the other place. For those reasons, I move —

Page 26, line 6 — to delete “assessment.” and substitute —

assessment no more than three times.

**Hon STEPHEN DAWSON:** The government does not support this amendment. In the context of voluntary assisted dying, there are circumstances in which it is entirely appropriate for the person to approach another medical practitioner with a first request—for example, if they are having 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

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practical risk of frivolous doctor shopping is 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 health system for care and support.

The patient cannot seek another consulting practitioner, as the coordinating practitioner makes a referral to the consulting practitioner. The use of the term “doctor shopping” in relation to voluntary assisted dying also creates negative connotations of the integrity and skill of medical practitioners involved in the voluntary assisted dying process. These practitioners are experienced doctors who must have undergone and successfully passed mandatory education. That process also requires two independent assessments of eligibility, and that is a further safeguard against the mostly perceived risk of doctor shopping.

The honourable member spoke about the Northern Territory. I want to place on record that the honourable member’s version of events in the Northern Territory is strongly contested by Marshall Perron and others. Marshall was the Chief Minister at the time of the passage of the Rights of the Terminally Ill Act.

I also want to make clear that it is common for a person to seek a second or even a third medical opinion from different doctors. It is a basic component of the Australian healthcare system that patients are able to seek a further medical opinion of their own volition.

Hon AARON STONEHOUSE: I want to clarify a couple of things before forming my opinion on the amendment. Hon Nick Goiran has moved this amendment, so perhaps he might be able to answer my question. What would happen if a patient, or perhaps the coordinating practitioner, exhausts those three referral opportunities? Does the process have to begin again, with the patient approaching a new coordinating practitioner? No time period is specified here, so I am wondering what happens when those opportunities are exhausted.

Hon NICK GOIRAN: It is a good question from the honourable member. The process ends. There is no capacity to continue to refer at that point in time. I take it—maybe the minister will have advice to confirm this—that probably nothing then prevents a patient from starting all over again. That is a good thing, because at that point in time, all this information would have gone to the board. We do not know how much funding this board will have, and we are not sure how regularly it will meet, but at least a pause button will be hit. The minister said that the board will be able to get the CEO to investigate, and get the Australian Health Practitioner Regulation Agency to do this, that and the other. All of those things will take time, so we are at least able to hit the pause button and get the board to actually do something. I do not have confidence that this will be viewed in real time. I know that that phrase kept getting used in the debate in the other place. How can anyone have confidence that the board is going to be viewing and overseeing all of this in real time, when we do not know the budget of the board, the extent of the secretariat and how regularly the board will meet? This would at least be an opportunity to press the pause button on that, and if the patient then goes through the whole process again, this great overseer will be able to intervene.

Hon AARON STONEHOUSE: Indeed, the Voluntary Assisted Dying Board will not have a gatekeeping function so I would not expect that it would review this process in real time anyway.

My next question is: what can the CEO of Health or the board do if they identify what appears to be doctor shopping, for lack of a better word? They can investigate it, but what powers will they have to put a stay or a hold on someone’s request if they think that something inappropriate is going on between a coordinating practitioner and their patient or that a coordinating practitioner is shopping around for a consulting practitioner who will merely confirm their findings? That is a question for the minister. Can he give me more information about what the CEO of Health or the board can actually do? What powers will they have to intervene if they are concerned that doctor shopping is occurring?

Hon STEPHEN DAWSON: The likely course of action the CEO would take is to contact the Australian Health Practitioner Regulation Agency and for it to investigate the matter.

Hon KYLE McGINN: I want to delve deeper into this matter. Hon Nick Goiran has moved an amendment in respect of three assessments. It is mentioned there that they would have to hit pause if they had to restart the process. I also suggest that it would take time to see three different practitioners, and I assume that would provide enough time for the board to also identify that that is happening. My question to the minister is: if there is a record of, say, three failed attempts to the board and the fourth attempt is successful, how will the board assess that and will there, maybe, be an investigation into that scenario?

Hon STEPHEN DAWSON: The VAD board will be notified of each referral to an assessment by consulting practitioners. This gives the board oversight of the progress of an individual patient. In the event of multiple referrals or assessments, the board may seek further information from the coordinating practitioner about the situation and then may refer a matter of concern to the appropriate authority.

Hon KYLE McGINN: Would that be by seeking further information from the ones who said no or from the one who has approved it?

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Hon STEPHEN DAWSON: Hon Kyle McGinn referred to three assessments but the amendment is about three referrals. In relation to whom the board could talk to, the board could seek further information from any of those involved in that situation. As a result of a practitioner seeking and considering that further information, if they deem it appropriate, they may refer the matter of concern to the appropriate authority.

Hon KYLE McGINN: Would a certain number of failed referrals not trigger that process? Would it be up to the board’s discretion?

Hon STEPHEN DAWSON: No; there is no defined number. It could be two or more referrals. It would be up to the board to consider the matter. The board’s role will be the oversight of the progress of an individual patient. As I said, it could seek further information.

Hon NICK GOIRAN: In response to Hon Aaron Stonehouse, the minister might be interested to know that the Attorney General said in the other place on 5 September, on page 6690 —

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.

On page 6694 he states —

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.

If what the Attorney General said in the other place on 5 September could somehow be supported by the words in the bill before us, I would be far more relaxed about this issue. I agree with Hon Aaron Stonehouse that it is not clear at all that the board has some great powers to enable it to look into things in real time and intervene. It sounds as though all it can do is shuffle a few papers over to some other agencies that may or may not investigate. I do not say that as a criticism of the board, I say that to indicate that it is all too late in an expedited process in which a Western Australian can be dead within nine days. The bill has provisions that allow us to accelerate that. I wish the board would have real-time oversight and the instant a form goes to the board, it will not be just a matter of somebody catching it, recording it and putting it on a database and on the agenda for the next meeting, along with matters arising and other correspondence. I wish that with real-time reporting somebody with teeth, if you like, could investigate these things and injunct those circumstances in which a vulnerable person is being taken advantage of. Unfortunately, I cannot see those safeguards in this bill and, therefore, the amendment moved by the member for Darling Range in the other place is the next best alternative.

Hon AARON STONEHOUSE: It is my assessment of the bill that the board will not act as a gatekeeper in this case. In the absence of that gatekeeping role, I think it is certainly desirable for some controls to be in place to ensure that doctor shopping, for want of a better term, does not occur. I can appreciate that the board will monitor the situations and refer to the Australian Health Practitioner Regulation Agency. My concern is, as was just pointed out, that in a process that can be completed within nine days, without the board being able to order that the consultation and the process and prescription of a substance be halted, the patient could be dead before the case even arrives on the desk of someone at AHPRA to investigate something like this. Looking at what controls might be possible, limiting the number of referrals to a consulting practitioner to three is not perfect. It is a very clumsy way of putting a limit on the number of consultations that may take place. However, compared with the alternative and in the absence of any controls, it is certainly preferable. I agree that the number is arbitrary, but I take the point that we have to pick a number, although it is interesting to note that “three” was chosen by the member for Darling Range and was put forward by Hon Nick Goiran. The language used by the minister is that it is not uncommon for a patient to seek a second or third opinion, so I think “three” might not be too far off an ideal number.

In any case, putting such an arbitrary limit on the number of times somebody may make some kind of administrative request is not uncommon. In fact, I believe the Births, Deaths and Marriages Registration Amendment (Change of Name) Bill 2018 on the notice paper does exactly that. It seeks to limit the number of times someone can change their name. The consequences of that are certainly minor. It might be a nuisance person applying to the Registry of Births, Deaths and Marriages to change their name on a regular basis. That would be a pain to administrators in that agency having to fill those requests on a regular basis, but here we are talking about the consequences of somebody perhaps dying when doctor shopping may have taken place. I think the consequences of mistakes being made in this instance are far, far greater to impose upon someone the inconvenience of having a limit of three consultation referrals and then to perhaps start the process again if absolutely necessary. It is not ideal. It is not perfect. It is quite a clumsy way to do it, but it does, from my understanding, insert a new control—a new safety mechanism—to limit cases of doctor shopping. I certainly would feel safer with this amendment to the bill than I would without it. In that case, I am happy to support the amendment put forward by Hon Nick Goiran.

Hon COLIN HOLT: If we accept this amendment, is there the potential to promote doctor collusion? Thinking it through, if we limit a person to having three cracks at it, does the consulting doctor then say, “Maybe I’ll just go deal with one who has that reputation or is a VAD heavy?” I do not know whether there are maybe some consequences to this. Does the government have a view on that?

Hon STEPHEN DAWSON: My advisers tell me it is a risk, honourable member. It certainly could allow doctors to collude to stop access, so that would remove the patient’s voluntary decision. That certainly is a risk.
Hon NICK GOIRAN: How would it remove the voluntary decision of the patient?

Hon STEPHEN DAWSON: We are creating an artificial line in the sand. I am going to put some further words on the record. If the patient is assessed as eligible by a coordinating practitioner but ineligible by a consulting practitioner, there are circumstances in which it is entirely appropriate for the coordinating practitioner to approach more than one medical practitioner with the referral request for consulting assessment. Although unlikely, it is possible that it may be reasonable for this to occur multiple times. Not allowing multiple referrals may create an inadvertent barrier for a person who would otherwise be eligible. For example, if the coordinating practitioner is having difficulty finding a practitioner able to be involved in the VAD process or if the coordinating practitioner is of the view that the consulting practitioner’s assessment may not be correct or because the patient strongly wishes for another consulting assessment. Not limiting this is consistent with current practice for a doctor seeking further medical opinion from different doctors. It is a basic component of the Australian healthcare system that further medical opinions are able to be obtained.

Division

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

Ayes (10)
Hon Peter Collier Hon Rick Mazza Hon Robin Scott Hon Ken Baston (Teller)
Hon Donna Faragher Hon Michael Mischin Hon Charles Smith Hon Aaron Stonehouse
Hon Nick Goiran Hon Simon O’Brien

Noes (23)
Hon Martin Aldridge Hon Stephen Dawson Hon Colin Holt Hon Dr Sally Talbot
Hon Jacqui Boydell Hon Colin de Grussa Hon Alannah MacTiernan Hon Colin Tincknell
Hon Robin Chapple Hon Sue Ellery Hon Kyle McGinn Hon Darren West
Hon Jim Chown Hon Martin Pritchard Hon Samantha Rowe Hon Alison Xamon
Hon Tim Clifford Hon Adele Farina Hon Matthew Swinbourn Hon Pierre Yang (Teller)
Hon Alanna Clohesy Hon Laurie Graham

Amendment thus negatived.

Clause put and passed.

Clause 41: Patient assessed as eligible may make written declaration —

Hon NICK GOIRAN: If the patient’s written declaration requesting access to voluntary assisted dying is made voluntarily and without coercion, is that considered by the minister to constitute sufficient evidence for the coordinating practitioner to be satisfied that the patient’s request is voluntary and without coercion?

Hon STEPHEN DAWSON: That is just one example, honourable member; it is not the only one.

Hon NICK GOIRAN: What other evidence might the coordinating practitioner take into account to determine the voluntariness of the patient’s request?

Hon STEPHEN DAWSON: Under this legislation, concerns about coercion and voluntariness will be addressed twofold in order to allay concerns about family, carers or health practitioners coercing or inadvertently encouraging a patient to seek access to voluntary assisted dying. When assessing medical practitioner is unable to determine whether the patient’s decision is voluntary and without coercion, they must refer for further assessment; that is covered under clauses 25 and 36. This may include experienced registered health practitioners or healthcare workers, including social workers, and police officers with the skills and training to determine whether a person is acting voluntarily and without coercion. They may talk to the patient’s family members, carers and other supports in order to get a sense of a patient’s voluntariness or whether they are being coerced or unduly influenced. The coordinating practitioner makes an assessment, the consulting practitioner makes an assessment, then the patient may make a written declaration, including what the patient says when writing the declaration—for example, oral history given by the patient and evidence of the patient’s interactions with family members—and then there is a final assessment.

Hon ADELE FARINA: I move —

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;

Members, this is identical to an amendment that we adopted for an earlier, similar provision, so I am not going to go into any further explanation. It is pretty self-explanatory.

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment. I identified at earlier stages why we accepted the amendments then, so I will not do it again, but we do support it.

Amendment put and passed.
Hon ADELE FARINA: I move —

Page 27, line 7 — To delete “declaration.” and substitute —

declaration; and

(iii) is not a beneficiary under a will of the patient and will not benefit financially or in any material way from the death of the patient; and

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

Again, I will be very brief. This picks up on an amendment we made earlier, and I think it is appropriate that it be repeated at this point. I will provide further explanation if members need it, but I think it is pretty self-explanatory.

Hon COLIN HOLT: I probably will want some further explanation from the mover. Reading this division, clause 41 is titled —

Patient assessed as eligible may make written declaration

Potentially, a person who is quite ill goes through the process and decides that they want to make a written declaration. For some reason, the person cannot actually sign the declaration, so they ask someone else to do it on their behalf, or they indicate for someone else to do it on their behalf. We then have another process in clause 42 for independent witnesses. I suspect that at that point in time, the person who has to sign on their behalf could be a relative or a loved one. They have gone through the whole process together. They might have been looking after the patient in palliative care for a long time to get to this point. The patient may have motor neurone disease or something like that, so the person knows their mannerisms or the indications of how they communicate. The potential is that that is the person the patient will call on to sign on their behalf. I think Hon Adele Farina is suggesting that someone else will potentially have to come into the process who is not a beneficiary in any way. I am wondering whether this will have the potential to add an extra burden to the patient and potentially exclude a person who has been with the patient on their complete journey. I guess a further explanation would be beneficial at this point.

Hon ADELE FARINA: I am happy to oblige. This is really going back to the issue about trying to avoid a conflict of interest. Obviously, a person who is a beneficiary under the will has an interest in that person’s death. This is to ensure that it is not a person who has a conflict of interest or is likely to obtain a benefit as a result of acting in that capacity and the resultant person’s death. If the person is in palliative care, I am sure there would be nurses or doctors who could assist in that process and take on the role of signing the form on behalf of the patient. It does not necessarily need to be a family member. I think it is in the patient’s best interests for it not to be a family member who may be a beneficiary under the will.

Hon COLIN HOLT: I understand the intent. I am just trying to figure out the practicalities of it. I assume that the witnesses to the signing of the declaration under clause 42 will have to be independent. I assume that in their role as a witness they will just witness the signature, or will they make a judgement about the patient’s best interests at that time, given they have gone through the whole process to get to this point through clause 41 and all the rest of them? I understand the intent. I am struggling a bit with the practicality. I know the patient may be in a palliative care or hospice situation, but they may not be. They may have gone through all that. They have gone home and are living with their loved one. Their loved one is looking after them. Their loved one has the morphine that they dispense to them. This whole scenario sounds like an extra step that might be a big burden on the family. I understand the member’s explanation, and I will leave it to the minister.

Hon ROBIN CHAPPLE: Again, I would like to ask Hon Adele Farina a question about this. A person may be operating as an interpreter in this situation. It may not be in a hospice or palliative care facility. It may be someone who is a close relative, because of the nature of the language involved.

Hon Adele Farina: The interpreter?

Hon ROBIN CHAPPLE: Yes.

Hon Adele Farina: It is under clause 160(2).

Hon ROBIN CHAPPLE: Okay; all right.

The DEPUTY CHAIR (Hon Dr Steve Thomas): The question is that the words to be deleted be deleted.

Hon STEPHEN DAWSON: Mr Deputy Chair, I am still seeking advice on this, so I would ask that we do not call it yet.

Hon JACQUI BOYDELL: I just go back to the scenario that Hon Colin Holt was talking about in which the patient might be in their final days or hours and the person assisting them to write the declaration is a family member. How would the family member know that they are a beneficiary of the will? There would be some scenarios in which people are not aware, even if they are a family member, that they could be a beneficiary of the will. With good intent, a person, as the assistant, would be helping their family member, trying to relieve their suffering and fulfil their wishes, without knowing that they are potentially a beneficiary of their will.

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Hon NICK GOIRAN: Can I assist in some way, hopefully, at this point. I should indicate at the outset that, in principle, I agree with the amendment that has been moved. But I take the point that has just been made by Hon Jacqui Boydell and note that the language that we have used in some of the prior amendments refers to a person who knows or believes they are a beneficiary under a will of the patient rather than this language that the person “is not a beneficiary under a will”, so it is a slightly different test. Does the person know that they are a beneficiary under the will? If they know, they should not be doing it. If they believe they are, they should not be doing it. But in the circumstance in which they do not know and they do not believe they are, they would be open to do it. I just put that on the record for consideration and to see whether there is an inclination to move a slight amendment to reflect that.

Hon STEPHEN DAWSON: The point that Hon Colin Holt made is a valid one. This would be a risk in implementation. However, I am advised that the risk could be mitigated, and this would be another safeguard to include in the bill. I propose to move an amendment in my name that, I think, deals with what Hon Adele Farina was trying to do but which clarifies the point that has recently been raised by a few people. Therefore, I propose that on page 27, after line 7, to delete “declaration” and substitute “declaration and”—sorry, I will just clarify something.

Hon COLIN HOLT: I understand the intent of this amendment, but I want to try to draw a potential parallel. Family members make decisions on behalf of loved ones on life and death matters quite a bit. The decision to not resuscitate is one such decision. I am not completely familiar with advance healthcare directives and the signatories to those, but I would have thought that health decisions would be made under enduring powers of guardianship and that loved ones sign up to those, even though they might be beneficiaries of the patient’s will. I understand that we are dealing with life and death decisions under the bill, but these people will go through a process involving a coordinating practitioner and a consulting practitioner and must then have two independent witnesses to their written declaration. I understand that it is an extra safeguard, but I wonder whether it is just another hurdle that a sick patient will have to go through to get to this point, given that they are probably quite ill. They will get to this point because they are ill. The person who knows them the best and who might be called upon by the patient to sign the declaration for them at that time will say, “Sorry, I don’t think I can sign.” If we adopt this amendment, the bill will say that they cannot. What will the patient do then? They will have to go and find someone to sign it on their behalf. I have run through the scenario in my head and it is a pretty big ask to find an independent person to sign the written declaration on their behalf. That is a big call. I would have thought that a loved one who has been through the journey with them would be best placed to do that. I understand the hurdle, but I am just not sure that I support it. I understand where the minister is going, but life and death decisions are put on families right now without these extra safeguards. The decision to not resuscitate comes to mind. Decisions are made about whether to turn off life support systems. These decisions may well be made by beneficiaries. In these circumstances, I am struggling to support the amendment.

Hon STEPHEN DAWSON: We were trying to make Hon Adele Farina’s amendment better, if I can use that language—to make it work. Upon reflection, and upon taking further advice from my advisers, we feel that this amendment could really hamper those in regional and remote areas. The coordinating practitioner will still be able to confirm with the patient that it has been done validly and under the person’s direction. I indicate that the government is not in a position to support the member’s amendment.

Hon ADELE FARINA: I point out that clause 42(2) is exactly the same and actually says that a person will be ineligible to be a witness if that 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;

What we are saying here is that a person cannot be a witness, but they can sign the declaration on behalf of the patient, even though they are likely to be a beneficiary and obtain a benefit from that person’s death. That does not make sense to me. If we are saying that a person who may be a beneficiary under a will or might benefit from the person’s death in some other way should not be a witness, then surely a person in exactly the same position should not sign the form on behalf of the patient who, as a result, will end up dead at the end of this process. It just does not make sense to me. From reading clause 42, if we are going to stop a person in that position from being a witness, to my mind such a person should not be signing the form on the patient’s behalf.

Hon NICK GOIRAN: Not only do I agree with Hon Adele Farina, but I also draw to the attention of members that there is an amendment to clause 42 standing in the name of the minister at 404/42 that seeks to delete one of the safeguards, which is to prohibit one of the witnesses being a family member of the patient making the declaration. I know there is supplementary amendment 405/42 indicating that no more than one witness can be a family member of the patient. This is all starting to get pretty murky from my perspective. For starters, I am not enthusiastic about the amendments that the government proposes to move at clause 42, but if we are going to go down that path, which I suspect we probably will, that is all the more reason that we need to have this amendment to make sure that the person signing off does not get the benefit from the death of a patient.

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I think this has been a very good and important debate, and Hon Colin Holt has raised some excellent points. The only point I would make to the honourable member is that with the circumstances we were discussing of healthcare decisions, “do not resuscitate” and so on one important difference is that in those circumstances the patient does not have capacity. They have lost decision-making capacity and therefore a substitute decision-maker comes in their place who is, quite rightly, a family member. But in this instance a person still has capacity; the only thing they cannot do is sign. They still have decision-making capacity, and that is a significant difference. Members might recall that in examinations of earlier clauses of this bill—it might have been clause 1—we confirmed that there was no intention under this bill for either supported decision-making or substitute decision-making.

Hon AARON STONEHOUSE: When considering the amendments to this bill, we are riding a very fine line between ensuring that we have adequate protections for vulnerable people and making sure that we do not make the bill too administratively burdensome and completely unworkable. When looking at the amendment proposed by Hon Adele Farina, I am reminded of scenarios that I have gone through, and that I am sure everyone here has gone through, of having to get a statutory declaration signed. When someone has to get identification verified by a justice of the peace, they go to somebody who is a witness to that document—one at a courthouse, some trusted person perhaps who is a justice of the peace—to sign off on the document, give them the stamp and verify that the document is authentic, that the person has signed the statutory declaration and that they are who they say they are. When someone is making a declaration about their end-of-life choices, I do not think it is too onerous to require them to have two witnesses who are not beneficiaries of their will in this instance. I think it is appropriate in this case, and not all that much more burdensome than what people are already subject to when having identification, a signature and things like that verified. I am keen to hear what other members have to say on this, but I am not convinced at this point that this would be too burdensome, given other requirements out there already in much less dire circumstances.

Hon STEPHEN DAWSON: I think Hon Colin Holt outlined compelling circumstances of a person close to the patient maybe needing to sign on their behalf. This is intimate involvement that may require someone close to the patient. It is different from finding a witness to the declaration. The act of signing on behalf of someone is very different from the act of witnessing. I just make the point that it is important to keep a patient-centred focus and not make the process so bureaucratic that people cannot practically access voluntary assisted dying.

Hon PETER COLLIER: I have sympathy for this amendment, particularly given that if we vote this amendment down, we will then be asked to support clause 42, which is pretty much the same wording with a different format. The contradiction there is profound. The only issue I have is one that was raised by Hon Jacqui Boydell, which is that in so many instances there will be a situation of someone not knowing whether or not they are a beneficiary. I note that a lot of people have no idea that they will be a beneficiary to someone’s will. What happens if they are a witness and after the event it turns out that they are a beneficiary? I am having difficulty grappling with that conflict. I do not know whether there can be an amendment to the amendment by Hon Adele Farina. I would like to support the amendment because I think it is valid and falls into line with, and is consistent with, clause 42, but given that issue about the lack of identification of a beneficiary, I probably will not support it at this stage unless there can be an amendment to the amendment.

Hon ADELE FARINA: I would like to indicate that on reflection I agree with inserting the words “knows or believes that they are a beneficiary”. We would need to delete the word “not” and make the wording consistent with the wording at clause 42(2)(a). I seek guidance from the Deputy Chair on whether he wants me to withdraw the current amendment and substitute another, or perhaps another member in the chamber can move an amendment to my amendment to fix that issue. Either way, I am quite comfortable with the arrangement.

The DEPUTY CHAIR: If the member has the wording in front of her, she can seek leave to amend her amendment.

Hon NICK GOIRAN: I do not have an amendment to the amendment, but I suggest that it would be achieved by deleting in the member’s amendment the word “is” at proposed subparagraph (iii) and substituting “knows or believes that they are”. Therefore, it would read —

(iii) knows or believes that they are not a beneficiary under a will of the patient and will not benefit financially or in any material way from the death of the patient; and

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

Hon ROBIN CHAPPLE: I go back to the point that Hon Jacqui Boydell made. What happens if the person does not have a will? It then goes off to the relevant authority and it determines at some stage how the property of the individual will be distributed. In that case, one of the people who might have been a witness may be a beneficiary.

Hon JACQUI BOYDELL: My answer to that is that the suggested alteration to the amendment would address that.

Hon ADELE FARINA: I seek leave to alter my amendment by deleting “is” at proposed subparagraph (iii) and substituting “knows or believes that they are”.

The DEPUTY CHAIR: We will just get a signed copy of that.

Amendment, by leave, altered.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: The minister initially indicated that the government was going to prepare its own amendment, but decided to oppose this amendment altogether. The minister cited some regional hardship that would arise as a result of this provision. I think some members have become a little confused in the course of this debate because clause 42, which we are not yet debating, relates to witnesses. At clause 41, we are dealing with somebody signing the written declaration that is part of the process on behalf of the patient. Can the minister explain to me why this amendment would place a regional person in a position of hardship as opposed to another person?

Hon COLIN HOLT: I do not know whether this will be useful, but I have to have a say anyway. We have had some discussion about the involvement of family during the debate on this bill. I think Hon Charles Smith introduced an amendment to provide that family must be involved. I want to flip this around a little bit, if possible. If a patient wants to make a written declaration, they could potentially make it without the involvement of family. They could potentially get an independent witness not involved with the family to sign it. I come back to the journey to where we are at. Potentially, if a critically ill person wants someone to sign on their behalf, their request will have to go to that person. If this amendment goes through, they potentially will not be able to ask the ones closest to them to take that step on their behalf; they will have to go to someone else to do that. It seems wrong to me.

Hon MARTIN PRITCHARD: I am not going to support the amendment, but I have a lot of sympathy for it. The reason I will not support it is that I think it is, as Hon Colin Holt suggests, quite comforting to have a relative sign on your behalf. What gives me comfort that there will not be any collusion is that it will have to be done in front of two witnesses, both of whom are not beneficiaries and one of whom is not a family member. I think the fact that a family member will sign on that person’s behalf with two witnesses present gives me comfort.

Hon NICK GOIRAN: It gives me no comfort whatsoever, because it is so easy to organise a mate, who is not a beneficiary and is not a family member, to be one of the witnesses and to get another family member to be the other witness and presto—that is the end of it. These are pretty significant circumstances. This is effectively the final signing off by the patient to say, “Everything else has taken place and I’m ready to go.” The stakes could not be any higher as to who makes this final signature. It is a little like, dare I say it, the needle is basically there and the patient is pressing the green button to say go. But in this particular instance, it is a person signing off to say, “Yes, I’m ready. This is voluntary and I am going ahead with all that.” The stakes cannot get any higher than this. The greater the amount of independence at this point, the better.

Hon STEPHEN DAWSON: Honourable member, I think what I was saying was that it may be more difficult to find someone in regional WA who is intimately involved with the patient and is prepared to sign on their behalf. People in regional Western Australia may live miles apart in different towns and different communities. They have to travel, so it would not be as easy as perhaps in the metropolitan area. Who would be prepared to sign? Only someone who is close to the person. Witnessing the signing of a document is totally different from signing on behalf of a person. I am still not supportive of the altered amendment on the supplementary notice paper.

Hon MARTIN ALDRIDGE: I do not accept the minister’s argument that it is a uniquely regional issue. If that argument were to hold true, that argument would apply to all Western Australians, not just those people in regional Western Australia. I had not given this clause a great deal of thought, until now. When I look at clauses 41 and 42 together, at the moment clause 42 requires two witnesses who are not family members. Obviously, there is an amendment standing in the name of the minister to change that. If we were to say, at clause 41, that the witnesses cannot be a family member but, at clause 42, that only one of the witnesses can be a family member, we would not be changing the number of people involved—it would still be three. It would still be limited to two people if the chamber accepts Hon Adele Farina’s amendment and the honourable minister’s amendment. The number of people required will not change and the number of family members who are able to participate will not change.

What concerns me about clause 41, and the reason why I am inclined to support the amendment, is that some members made some comments during the debate that the reason a family member should not be excluded from signing on behalf of the patient is that a family member would be more aware of the mannerisms and the communication method of the patient. That almost indicates to me that there is some intimacy in this relationship, to the exclusion of all others, that only this family member will be able to communicate and say, “Yes, this person actually has just signalled to me in a particular way that they want to die and therefore I’m going to sign on their behalf, and you two witnesses are going to witness my signature.” To me, that runs contrary to clause 41, which is about this independent written declaration. If the argument is that only a family member is likely to understand the communication of the person who is otherwise eligible, what safeguard is there that that person is communicating yes? That is why I think members really need to give some serious consideration to this amendment. I do not accept the argument that it will create some hardship. Keep in mind that at this point the person is still only mid-process; they have not yet qualified for voluntary assisted dying. This is not somebody who has qualified, is holding on to the substance and in their final hours will have to whip these three people together. I draw members’ attention to clause 5 of the bill that outlines the request and assessment process. We are at step 4. There is a first request, a first assessment, a consulting assessment and a written declaration. We still have a final request and a final review to go. The person is not yet qualified. People have almost intimated that this is somebody who is in their dying hours and the struggle to get three people and these independent witnesses...
together will be burdensome, along with regional hardship. I do not accept these arguments. Notwithstanding what might happen at clause 42, the amendment before the chamber that now stands in the name of Hon Adele Farina is a good one and should be supported by the chamber.

**Hon RICK MAZZA:** When someone signs on behalf of another person, that needs to be at arm’s length. Regardless of what we are talking about, if someone is nearing the very end of their life and therefore makes this decision, to me, that does not wash. It has to be a person at arm’s length who signs on behalf of the patient. We have heard about the involvement of family, and, from memory, the amendment that Hon Colin Holt referred to that was put up by Hon Charles Smith was rejected by the chamber. In this case, the amendment that has been put forward by Hon Adele Farina is sound. It makes perfect sense and is consistent with clause 42 when it comes to a witness not knowingly being a beneficiary in a will or standing to gain a benefit from it. I support this amendment. It is very important that this be at arm’s length.

**Hon Dr SALLY TALBOT:** I just want to make one quick point on these two clauses that have to be read together, clauses 41 and 42. I absolutely agree with the safeguards that need to be in place, the issues raised by Hon Martin Aldridge and, to a certain extent, the points just made by Hon Rick Mazza. But that is precisely why we need the distance placed in clause 42 about the witnesses. The witnesses are the ones who will ensure the integrity of the process, which has been very eloquently outlined by Hon Colin Holt. It is the witnesses who must be independent, who must not be either aware of or suspect that they might be beneficiaries.

**Hon Martin Aldridge:** Have you seen the supplementary notice paper? In the name of the minister, he is proposing to change that.

**Hon Dr SALLY TALBOT:** I am talking specifically about the words in this clause, the ones that the member just addressed.

There is one other point I want to draw to members’ attention. There is one other point at which we can clearly see that the separation that is being proposed in Hon Adele Farina’s amendment does not apply to clause 41 to the person who is signing for the patient, and that is that the person who will be signing for the patient will be directed by the patient. That is what has to be attested to by the witnesses. It is very clear on those two specific and narrow points that the situation described by Hon Colin Holt is exactly the one that we must consider in clause 41.

**Hon DIANE EVERS:** I see this a bit differently from Hon Rick Mazza, in that signing on behalf of a person is not really an arms-length transaction. It usually occurs in a situation in which a person has the right to sign for somebody else. It is usually quite an intimate situation that would be family, when a person is taking the role of another person and signing on their behalf, as we do for children and elderly people. In this clause, the patient directs the person to sign—no-one else. The patient is saying, “This is the person I want to do that for me.” We are not talking about buying a house or something. This is a very significant act. In the majority of cases, I would imagine the patient would want those closest to them, being their family. I disagree with the comments made recently, in that the act of that person, being family, to me seems most important; if that is the person who is closest and who is willing to sign such a significant statement, that is the person we would want.

**Hon AARON STONEHOUSE:** I take the point that the person signing on behalf of the patient under clause 41(4) is directed to do so by the patient, so it might be more appropriate for that person in that instance to be a family member, or it may not be inappropriate that that person be a family member, as they are acting as directed by the patient. However, in the absence of clause 42(2)(b), I think it is appropriate to agree to the amendment moved by Hon Adele Farina. We need one or the other. We need to have some degree of separation in either the person signing the declaration on behalf of the patient, or in the two people who are the witnesses. If we cannot have that for the witnesses, as we have on the supplementary notice paper at 404/42 an amendment in the minister’s name to delete lines 28 and 29, then we should ensure that is that there, at least for the person referred to in clause 41(4), signing on behalf of the patient. I could go either way on this, but there needs to be a degree of separation for one of these groups of people—either the person signing on behalf of the patient or the witnesses. We cannot have all three involved being family members. I think that would be highly inappropriate.

**Hon NICK GOIRAN:** I indicate to members that nothing in the amendment moved by Hon Adele Farina would prevent a family member from being a signatory. The only thing they cannot do is know or believe that they are a beneficiary under a will. If a cousin, or second cousin three times removed—whoever it is—wants to be the person who signs, that is absolutely fine. This one provision here at subclause (3) will make sure that they cannot benefit, and I think that that is an important distinction.

**Hon JACQUI BOYDELL:** I concur with the comments of Hon Nick Goiran. There is nothing in the amendment that states that we are talking only about family members; I agree with that. I also think that clause 41 refers to someone who is directed by the patient, and I think in that instance we need to be considering the support mechanisms of the patient. For that reason, I will not support the amendment. The patient has to have capacity to make the decision. We are trusting that they are making that decision and have capacity to have made that final decision, so we must trust that they will have capacity in the same instance to ask a person they trust most, whether a family member or somebody else—it might be a carer—to sign the document on their behalf. I agree that the safety mechanism is in clause 42. I cannot support the amendment because I think we need to support the safety mechanism for the patient.  

*Extracted from finalised Hansard*
The DEPUTY CHAIR: The question is that the words to be deleted be deleted. Bear in mind we are dealing with the altered amendment.

Division

Amendment, as altered, put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the ayes, with the following result —

Ayes (17)
Hon Martin Aldridge  Hon Nick Goiran  Hon Tjorn Sibma  Hon Alison Xamon
Hon Jim Chown  Hon Rick Mazza  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Peter Collier  Hon Michael Mischin  Hon Aaron Stonehouse  Hon Dr Steve Thomas
Hon Donna Faragher  Hon Simon O’Brien  Hon Colin Tincknell  Hon Adele Farina
Hon Robin Scott  Hon Peter Collier  Hon Michael Mischin  Hon Aaron Stonehouse
Hon Tjorn Sibma  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Rick Mazza  Hon Aaron Stonehouse  Hon Dr Steve Thomas
Hon Tjorn Sibma  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Rick Mazza  Hon Aaron Stonehouse  Hon Dr Steve Thomas
Hon Tjorn Sibma  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Rick Mazza  Hon Aaron Stonehouse  Hon Dr Steve Thomas
Hon Tjorn Sibma  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Rick Mazza  Hon Aaron Stonehouse  Hon Dr Steve Thomas
Hon Tjorn Sibma  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Rick Mazza  Hon Aaron Stonehouse  Hon Dr Steve Thomas
Hon Tjorn Sibma  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Rick Mazza  Hon Aaron Stonehouse  Hon Dr Steve Thomas
Hon Tjorn Sibma  Hon Charles Smith  Hon Ken Baston (Teller)

Noes (18)
Hon Jacqui Boydell  Hon Colin de Grussa  Hon Alannah MacTiernan  Hon Dr Sally Talbot
Hon Robin Chapple  Hon Sue Ellery  Hon Kyle McGinn  Hon Daren West
Hon Tim Clifford  Hon Diane Evers  Hon Martin Pritchard  Hon Pierre Yang (Teller)
Hon Alanna Clohesy  Hon Laurie Graham  Hon Samantha Rowe  Hon Matthew Swinbourn
Hon Stephen Dawson  Hon Colin Holt  Hon Graydon Hunter  Hon Mark Yeo (Teller)
Hon Stephen Dawson  Hon Colin Holt  Hon Graydon Hunter  Hon Mark Yeo (Teller)
Hon Stephen Dawson  Hon Colin Holt  Hon Graydon Hunter  Hon Mark Yeo (Teller)
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Hon Stephen Dawson  Hon Colin Holt  Hon Graydon Hunter  Hon Mark Yeo (Teller)
Hon Stephen Dawson  Hon Colin Holt  Hon Graydon Hunter  Hon Mark Yeo (Teller)

Amendment, as altered, thus negatived.

The DEPUTY CHAIR: Honourable members, we are still dealing with clause 41, so the question is that clause 41, as amended, be agreed to.

Hon Stephen Dawson: Clause as amended?

The DEPUTY CHAIR: I understand that Hon Adele Farina’s original amendment was agreed to.

Hon NICK GOIRAN: Under clause 41(6), what remedy will be available for the patient or, if deceased, the patient’s family, if the interpreter fails to provide a true and correct translation of any material translated?

Hon STEPHEN DAWSON: One remedy is to make a complaint to the accreditation body. Interpreters are accredited through the National Accreditation Authority for Translators and Interpreters Ltd. It could be captured also by clause 101, “False or misleading information”.

Hon NICK GOIRAN: If it is captured, what remedy would be available to the patient or the family?

Hon STEPHEN DAWSON: In relation to clause 101, that makes it a criminal offence, so there is no remedy for the patient, necessarily. The court could order that the penalty that is paid be directed to the patient or the family member, and the patient or family member could take civil action in court.

Hon NICK GOIRAN: Before we move off clause 41, we had quite a lengthy discussion on the amendment proposed by Hon Adele Farina. Basically, the entirety of the debate was in respect of the third limb—discussion around whether the person who signs should be able to know or believe whether they are a beneficiary under the will. Fully respecting the decision of the chamber with regard to the third limb, my only concern is that I think the fourth limb was lost in all of that. The fourth limb moved by Hon Adele Farina indicated that the person who signs off on this cannot be the coordinating practitioner or the consulting practitioner. I have a lot of sympathy for that. I would like to know what the government’s position is in respect of that provision, putting aside the issue of whether the family member can be a beneficiary; we have dealt with that. It is specifically in relation to whether the person who signs off should be the coordinating practitioner or consulting practitioner. It appears to me that, as clause 41 is currently worded, it is still possible for that person to be the signatory.

Hon STEPHEN DAWSON: I am told that the bill does not contemplate that the person being directed to sign the declaration could be the coordinating practitioner or the consulting practitioner. I am further told that this issue would be addressed during the training, and the CEO could declare that to be the case, so the practitioners would be captured by that.

Hon NICK GOIRAN: There are two things here, Mr Deputy Chair The first is a point of clarification, through you, on a procedural matter, and maybe after that to the minister to see whether there is an appetite to do this. I want to know whether it would be possible and in order for me to propose to delete “declaration.”, as was proposed by Hon Adele Farina, and substitute a different set of words than was proposed by the honourable member but is remarkably similar; that is, to insert a new subparagraph (iii) —

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

The words to be substituted in their entirety are different from what was proposed earlier. Is that in order?

The DEPUTY CHAIR (Hon Robin Chapple): My view is that it is not the identical question; therefore, you can move.
Hon NICK GOIRAN: Thank you, Mr Deputy Chairman, for that clarification. I would be happy to move that, but I do not want to do it if there is not an appetite to do it. We have had a lengthy discussion about the beneficiary of the will issue. I think this is a separate and distinct issue. It sound as though there is capacity for the government to deal with this by way of declarations later, but it seems to me that it would be neater and more appropriate to insert those words now, which would give intent to at least half of the good amendment that was moved by the honourable member. If the minister would indicate whether there is an appetite to support the amendment, I will be happy to move it.

Hon MARTIN PRITCHARD: I indicate that I would have an appetite for those words to be put in.

Hon STEPHEN DAWSON: I indicate that that would be putting the intent into practice. I do not have an issue with supporting the amendment.

Hon NICK GOIRAN: I move, in the speediest fashion that I can — Page 27, line 7 — To delete “declaration.” and substitute —

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

While that amendment is being distributed, I indicate briefly that this is really with all due credit to Hon Adele Farina, who had those words as the fourth limb of her original amendment at 472/41.

The DEPUTY CHAIR: Hon Nick Goiran, are you seeking the call again?

Hon NICK GOIRAN: This is what happens when one tries to do things fast. I should clarify for members that because “declaration.” is being deleted, we would then, of course, insert —

declaration; and

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

Hon STEPHEN DAWSON: In light of that update, I indicate that we will support the amendment.

Amendment altered

The DEPUTY CHAIR: Members, just for clarity I will read what Hon Nick Goiran has moved; that is, on 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.

Hon STEPHEN DAWSON: I indicate that we can support the amendment.

Amendment, as altered, put and passed.

Clause, as amended, put and passed.

Clause 42: Witness to signing of written declaration —

Hon NICK GOIRAN: Section 35 of the Victorian act is the equivalent provision to clause 42 in the Western Australian bill, but it goes further than this clause in that, under subsection (2), it prohibits a person who —

(b) is an owner of, or is responsible for the day-to-day operation of, any health facility at which —

(i) the person making the declaration is being treated; or

(ii) … resides; or

(c) is directly involved in providing health services or professional care services to the person making the declaration.

Why is this important safeguard not included in clause 42?

Hon STEPHEN DAWSON: It should be noted that section 35(2) of the Victorian VAD act specifies that a person is an ineligible witness if they are the owner of or person responsible for the day-to-day operation of the health facility in which the person making the declaration is being treated or resides, or is a person directly involved in providing health or professional care services to the person making the declaration. However, the existing subclause (2)(a)(ii) in the WA bill already contemplates these circumstances; that is, these persons are ineligible when they may financially or materially benefit from the patient’s death. If the owner of the health facility or person involved in providing health professional care services stands to benefit in any material way from the patient’s death, they cannot be a witness. If they do not or may not benefit in some way, there is no issue or conflict of interest.

Extracted from finalised Hansard
Hon NICK GOIRAN: I am not sure I agree with that, but I accept that is the response. If the patient’s written declaration is witnessed by an ineligible witness, would this invalidate the request and assessment process?

Hon STEPHEN DAWSON: It could invalidate the declaration, and in those circumstances we would seek a further declaration.

Hon NICK GOIRAN: It would invalidate the request and assessment process. When the minister says, “We would seek another declaration”, who is “we”? Who is going to identify that an ineligible witness has signed it and then take remedial action?

Hon STEPHEN DAWSON: I want to clarify that we are talking about invalidating a written declaration. A family member, a social worker or a care worker could raise concerns, or a doctor doing the final review could see the issue. In that case, the coordinating practitioner would take the concern to the patient and would seek a further declaration.

I have two amendments standing in my name at clause 42. I move —

Page 27, lines 28 and 29 — To delete the lines.

Hon RICK MAZZA: I rise to say that I will not be supporting the amendment. We have just defeated a proposed amendment to clause 41, which now allows a family member who is a beneficiary of a will to sign on behalf of the patient. Surely if we are going to provide for that, both witnesses should not be family members; they should be independent witnesses. I have a concern that the person signing on behalf of the patient could be a family member who will benefit from the proceeds of the will, and a witness, notwithstanding that they cannot benefit from the proceeds of the will, could also be a family member. On that basis, I think that both witnesses should be excluded if they are family members.

Hon STEPHEN DAWSON: I did not get a chance to speak to my amendment so I will do that now. We have parked clause 41. We have dealt with that issue of directing the person to sign the declaration and so we have parked that. It is gone. In relation to the amendment before us now, the bill currently does not allow any family members to witness the patient’s written declaration. The proposed amendment will allow one family member to be a witness. This clause has been included following consultation with the Australian Medical Association’s WA branch, and, upon consideration, the government thinks that this is a good amendment.

Hon MARTIN ALDRIDGE: This amendment is most intriguing. I would be interested to know what specifically the Australian Medical Association’s interest was in the involvement or inclusion of a family member as one of the two witnesses. I have had several interactions with, and received numerous pieces of correspondence from, the Australian Medical Association. This is not a matter that I recall ever conversing with the association about, so I would like the minister to elaborate on the need for this. Notwithstanding that, the chamber has just resolved debate on clause 41. As Hon Rick Mazza has said, a family member who is knowingly the entire beneficiary of a will would be allowed to sign on behalf of the person. That is what the chamber has just agreed at clause 41. I am pretty sure I heard Hon Dr Sally Talbot say in response to Hon Rick Mazza and me that members should not worry, because when we get to clause 42, we will have two independent witnesses. I interjected and said that the member clearly had not read the supplementary notice paper and the amendment standing in the name of the minister. Given the debate we had at clause 41, I am surprised that the minister has moved the amendment standing in his name at clause 42. The third paragraph in the clause 42 section of the explanatory memorandum states —

This clause is a safeguard —

I assume that is one of the numerous safeguards that the government quotes —

for people who may be vulnerable to abuse and coercion. The requirements are aimed at ensuring witnesses do not have a conflict of interest in witnessing the declaration.

My question is: why is the government watering down the safeguard on the advice of the Australian Medical Association?

Hon AARON STONEHOUSE: Following on from the comments made by Hon Martin Aldridge about the Australian Medical Association’s advice, I was just reading the document distributed by the AMA titled “Some suggested Amendments to the Voluntary Assisted Dying Bill 2019 WA”. Contrary to what has been suggested by the minister, the Australian Medical Association on page 20 of that document under part 12, “Exclude conflicted parties as witness to a written request for VAD”, mentions a policy intent of —

Added safeguard to protect patients who may be vulnerable to abuse or coercion and removes category of witnesses who have a conflict of interest.

Nothing there suggests that anything should be removed from clause 42. In fact, it proposes including new provisions in clause 42 to prohibit witnesses who are the owner of or responsible for the day-to-day operation of the health facility at which the person who is making the declaration is being treated. Based on the information that the AMA has made public so far, it seems that its view is the opposite of what the minister has suggested. In any case, regardless of what advice the AMA has put forward, in light of the current state of clause 41 and no prohibition being in place against a conflict of interest for somebody who acts on behalf of a patient in clause 41, there needs to be some protection in clause 42 to ensure that there is not a conflict of interest for people who act as witnesses.

Extracted from finalised Hansard
If one of the two witnesses can be a family member, we might as well just change this entire division so that only one witness be needed. If one of the witnesses can have such a conflict of interest as to be a family member and not be an independent witness, what on earth is the point of having two witnesses? It might as well just be a single witness. In my mind, a family member is not an adequately independent witness.

I am concerned about elder abuse. I gave a scenario in which two family members colluded to abuse an elderly patient—all they need to do is seek one independent witness to sign off on this. It creates too great a risk, from what I can tell. There needs to be two independent witnesses or else there is no point in having two at all.

Hon STEPHEN DAWSON: I hope the honourable member, by his earlier comments, was not suggesting that I was lying or misleading the chamber. I hope he was not suggesting that.

As I have indicated to the chamber, I can confirm that this amendment was specifically suggested by the AMA in subsequent discussions with the Minister for Health. I draw the honourable member’s attention to a document from the Western Australian branch of the AMA titled “Some suggested Amendments to the Voluntary Assisted Dying Bill 2019 WA” dated 21 October 2019. Page 22 of that document is headed “Facilitating family involvement in VAD process”. Comments attributed to the AMA at the bottom of page 22 state —

Family and next of kin involvement must at least be facilitated by the WA VAD Bill, as outlined in the Victorian legislation.

The wider impact of grief, some forms of which are diagnosable mental illness and have significant physiological implications, have not been considered by the WA VAD Bill, as the process focussed entirely on patient autonomy which downplays both the trauma to family members and the value they can add in the assessments.

It is important that the Bill does not limit family involvement where it is appropriate.

That is mentioned in that, but I can certainly indicate to honourable members that this was specifically raised by the AMA.

AMA members are professionally involved with people at their end of life. They know that at end of life, most people are surrounded by family and loved ones. The AMA was of the view that it would be appropriate to have a safeguard that only one witness is a family member, bearing in mind that the person is likely to be surrounded by family at this point.

Hon AARON STONEHOUSE: It is certainly frustrating, from my perspective, when discussions have taken place between the AMA and the minister’s office behind closed doors, which other members of this place, who are expected to make a conscience vote, are not privy to and are not advised of. That is not a reflection on the minister, but it perhaps would be helpful for stakeholders such as the AMA, when it is trying to seek support for amendments, to make sure that its views are widely known. I am not aware of the AMA’s view that this amendment should be supported. It has not been communicated to me and I do not think it has been communicated to anybody else, aside from perhaps the Minister for Health.

In any case, in support of this amendment, the minister has pointed us to page 22 of that same document I was quoting from before. I will re-read some of this to make sure we are very clear about what it says and what it does not say. It states —

Family and next of kin involvement must at least be facilitated by the WA VAD Bill, as outlined in the Victorian legislation.

The wider impact of grief, some forms of which are diagnosable mental illness and have significant physiological implications, have not been considered by the WA VAD Bill, as the process focussed entirely on patient autonomy which downplays both the trauma to family members and the value they can add in the assessments.

That does not really say anything about the need for family members to be involved as a witness. It refers to the importance of having family members involved in the decision-making process that a patient may go through and the support that a family may provide to a patient, but it says nothing about family members being witnesses. If we are seeking to ensure that families are involved in the voluntary assisted dying process, including them as witnesses will not accomplish that. A witness merely sights that a declaration has been signed and that is it—that is their involvement. They are not involved in the process beyond that at all by being a witness. It is farcical to imply that being a witness somehow involves them intimately in the process and will help to support a patient with their emotional and psychological needs through the voluntary assisted dying process.

The final part of the comments by the AMA on page 22 states —

It is important that the Bill does not limit family involvement where it is appropriate.

The most important part is “where it is appropriate”. In clause 41, we just made sure that family members are not prohibited from being involved; that is, a family member acts on behalf of a patient to sign their declaration. Family members are involved in that process and that seems a little more appropriate, at least in some regards. I am sympathetic.
to the argument put by Hon Dr Sally Talbot and others that in this case it will be someone acting on behalf of a patient. Under clause 41, they will be directed by the patient. It seems at least more appropriate that a family member or a beneficiary might be involved in that process. But is it appropriate that a family member be a witness? Does that help in any way to alleviate the grief or the psychological distress that a patient may suffer due to going through the voluntary assisted dying process? I cannot imagine how that does at all. Perhaps it would be easier if some correspondence between the Australian Medical Association and the minister’s office could be tabled that might help us understand what the AMA was seeking to achieve through this amendment, because I do not see the connection between this amendment and the comments made by the AMA on page 22 of that document I mentioned earlier.

Hon STEPHEN DAWSON: I am sure that we are reading the same document. Could the member just raise the document that he is reading from?

Hon Aaron Stonehouse: I am sure it is. It is titled “Some suggested Amendments to the Voluntary Assisted Dying Bill 2019 WA”.

Hon STEPHEN DAWSON: Very good. We are at page 22, and the suggested wording states —

Page 27, line 28, delete subsection (b).
Page 28, line 1, before “is” delete “(c)” and insert “(b)”.
Page 28, line 3, insert a new subsection:

“(c) For the purposes of section 41(3)(b), only one witness to the signing of a written declaration may be a family member of the patient making the declaration.”

The AMA has made its intention clear in this document, which the honourable member has in his hand. Earlier this evening, I indicated that the amendment that stands in my name has come about because of the consideration of the document prepared by the AMA and consultations and conversations that have happened between the minister’s office and the AMA. This refers to the suggested wording. We have put the suggested wording into practice and although we have worded it slightly differently, it has the same intent. I bring that to the member’s attention. This is not me making stuff up and telling lies to the chamber. This came from the AMA and here is part of the proof of that. The conversations have happened, as, I have to say, conversations have happened between the AMA and other members of this chamber during the debate. Since that 22 October document was published, many meetings have happened with members in this place, and I know that is a fact because some members in this place have told me or I have seen some members in this place meet with the AMA about the concerns that they have raised. Going back to the amendment before us, as I said, this is a result of the AMA’s conversations with the government. I also take the opportunity to make the point that being a witness can be an important symbolic role for family members and for the patient. I leave members with that.

Hon AARON STONEHOUSE: The minister is right; I missed the suggested wording. It specifically suggests that at page 27, line 28, paragraph (b) be deleted and at page 28, line 1, some new words be inserted. I apologise to the minister; he is absolutely right. I do not think that diminishes the point I was making, which is how on earth including a family member as a witness includes them in the process to provide support. The need to have independent witnesses should still be of great concern to members—of the two witnesses, one will not be independent. It raises the question: what is the point of having two witnesses if only one is truly independent? It is also interesting to note that the government has agreed to some of the AMA’s amendments and rejected others. Why this one? Of all the amendments that the AMA has put forward, why this one? It seems the most inconsequential, but it also seems to create the most risk of all the amendments put forward by the AMA. It does not reduce risk in any way; it increases the risk of an almost intangible increase in family involvement. I was certainly mistaken about the AMA’s explicit recommendation, but my views on this amendment have not changed at all, and I cannot support it.

Hon STEPHEN DAWSON: I am grateful for the honourable member’s acknowledgement. I have no issue with the member having a different view; that is obviously his right in this debate before us at the moment. I am glad that he has acknowledged that I have not plucked this out of thin air.

Hon NICK GOIRAN: I indicate that I intend to oppose the amendment, for exactly the reasons Hon Aaron Stonehouse has articulated very well. I remind members that earlier we debated an amendment by Hon Adele Farina that would have ensured that the person signing was not a beneficiary under the will. I am very concerned that this particular amendment will reduce the safeguards. If anything, we should be lifting the safeguards, in my view, or leaving them as they are, but I certainly cannot support an amendment that reduces the safeguards.

Hon ADELE FARINA: I also would like to put on the record that I will be opposing this amendment, for the same reasons that everybody else has raised. We need safeguards in this bill, and it makes no sense at all to be removing these safeguards, particularly when we are allowing a family member to sign the document on behalf of the patient. We should at least make sure that the two witnesses are independent. I am not too sure why the AMA has recommended this amendment, but it makes no sense. From a legal point of view, which is not the expertise of the AMA, it makes a lot of sense to keep these safeguards in place.

Hon MARTIN ALDRIDGE: I spoke earlier in the consideration of this amendment, and indicated my inclination not to support the words to be deleted, as proposed by the minister. I want to put on record that nothing has

Extracted from finalised Hansard
transpired during the course of the debate that has convinced me otherwise. I need much more than a reference to
the AMA to justify this safeguard being watered down in the way that is being proposed. I must say I agree with
the government and Hon Darren West about clause 42. It is perfect, and it should be left as it is.

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

Ayes (16)
Hon Robin Chapple
Hon Colin de Grussa
Hon Colin Holt
Hon Matthew Swinbourn
Hon Tim Clifford
Hon Sue Ellery
Hon Alannah MacTiernan
Hon Dr Sally Talbot
Hon Alanna Clohesy
Hon Diane Evers
Hon Kyle McGinn
Hon Pierre Yang (Teller)
Hon Samantha Rowe
Hon Stephen Dawson
Hon Laurie Graham
Hon Samantha Rowe
Hon Pierre Yang (Teller)

Noes (18)
Hon Martin Aldridge
Hon Jacqui Boydell
Hon Nick Goiran
Hon Alannah MacTiernan
Hon Jacqui Boydell
Hon Rick Mazza
Hon Kyle McGinn
Hon Darren West
Hon Donna Faragher
Hon Michael Mischin
Hon Charles Smith
Hon Aaron Stonehouse
Hon Donna Faragher
Hon Simon O’Brien
Hon Aaron Stonehouse
Hon Donna Faragher
Hon Martin Pritchard
Hon Colin Ticeknell
Hon Jacqui Boydell
Hon Nick Goiran
Hon Rick Mazza
Hon Tjorn Sibma
Hon Martin Pritchard
Hon Colin Ticeknell
Hon Martin Aldridge
Hon Michael Mischin
Hon Charles Smith
Hon Colin Ticeknell

Amendment thus negatived.

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

Legislative Council
Thursday, 28 November 2019
[page 9524]

VOLUNTARY ASSISTED DYING BILL 2019
Committee

Resumed from 27 November. The Deputy Chair of Committees (Hon Matthew Swinbourn) in the chair;
Hon Stephen Dawson, (Minister for Environment) in charge of the bill.

Clause 42: Witness to signing of written declaration —
Progress was reported after the clause had been partly considered.

Clause put and passed.

Clause 43: Certification of witness to signing of written declaration —

Hon NICK GOIRAN: Under clause 43(2) a witness must make a declaration that the patient appeared to freely
and voluntarily sign the declaration. Section 36 of the Victorian legislation, the equivalent to our clause 43, goes
further by requiring that the witness declared that the patient also appeared to have decision-making capacity in
relation to voluntary assisted dying and that the patient appeared to understand the nature and effect of making the
declaration. Why does the bill not include the declarations relating to capacity and understanding at this clause?

Hon STEPHEN DAWSON: I am advised that is not appropriate to expect laypersons to make those assessments.
It is for trained coordinating or consulting practitioners to do so.

Hon NICK GOIRAN: How might a witness determine that a patient appears to be freely and voluntarily signing
a declaration? What factors would a witness take into account in making this assessment?

Hon STEPHEN DAWSON: On clause 43, the explanatory memorandum states —

The purpose of the declaration is to reflect the voluntary and enduring nature of the patient’s request for
access to voluntary assisted dying. The purpose of the two witnesses is to provide independent verification
that the written declaration was signed freely and voluntarily by the patient.

They should be able to see whether the patient looks stressed or pressured, and they should be able to tell that no-one
is coercing or standing over the patient.

Hon NICK GOIRAN: Should they also be able to appreciate whether the patient appears to understand that they
are making the declaration?

Hon STEPHEN DAWSON: It is not for them to judge comprehension. That is why we have the separate
assessment process.

Hon NICK GOIRAN: Given that these requirements are in section 36 of the Victorian legislation, upon whose
advice was it decided to eliminate these particular safeguards?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: It was a government decision. I will make the point that Western Australia has not slavishly followed the Victorian example or the Victorian bill. A discussion did happen at the Ministerial Expert Panel on Voluntary Assisted Dying. Page 67 of the final report notes —
In relation to witnessing provisions, the Panel noted advice from Victoria that their provisions were potentially complex in implementation and that Western Australia should aim to strike a balance between safeguards and practicality in this regard and wherever possible to base these provisions on an existing practice.
The Panel determined that the written declaration should be witnessed by two witnesses to attest that the person requesting voluntary assisted dying signed the declaration voluntarily. The witnesses would be people who are aged 18 or over and have no reasonable grounds for belief that they will benefit financially from the person’s death.

Hon NICK GOIRAN: I agree with the minister. It is clear that the government has not slavishly followed the Victorian legislation. The government has removed several significant safeguards that are in the Victorian legislation. Two of those safeguards are the ones that we have just outlined, and of course members will be familiar with the safeguards that have been eliminated—the mandatory requirement that a specialist be involved, and prohibiting a doctor from initiating the conversation with the patient. Therefore, I agree with the minister entirely that the government has not slavishly followed the Victorian legislation. Perhaps where we differ is that, in my view, it is now verifiably the case that this legislation is less safe than the Victorian legislation.

Clause put passed.
Clause 44: Coordinating practitioner to record written declaration —
Hon NICK GOIRAN: Will the board have access to the clause 44 record in the patient’s medical record for the purpose of monitoring the operation of the bill, or if the board holds concerns that the correct process has not been followed by the medical practitioner?
Hon STEPHEN DAWSON: I am told the board can request the information to assist in performing its functions. That is clause 149.
Hon NICK GOIRAN: Sorry, minister; there was some noise then. Did you say clause 140?
Hon Stephen Dawson: Clause 149.
Hon NICK GOIRAN: Very good. How long are these medical records required to be kept?
Hon STEPHEN DAWSON: It is generally seven years. There might be a slight difference between private hospitals and public hospitals, or private medical services and public medical services. It is seven years for the state and it could be between seven and 10 years for private services.

Clause put and passed.
Clause 45: Coordinating practitioner to notify Board of written declaration —
Hon NICK GOIRAN: What is the board required to do with this notification under clause 45?
Hon STEPHEN DAWSON: The intent of the provision is to ensure that the board is able to ensure that the correct process is followed in each case of voluntary assisted dying. Further, the clause enables the board to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.
Hon NICK GOIRAN: However, the board will not know about it. The board will catch the form supposedly within two business days, but of course it might not receive it within two business days, so how can it then know whether the process has been complied with? It will not know when the written declaration was made. The provision says that within two days of the written declaration having been made, the coordinating practitioner has to give a copy of the form to the board. The board will have no idea of the date of the written declaration until it receives the form. What is its role in this particular instance, when it catches the form?
Hon STEPHEN DAWSON: The onus is on the doctor to do this. The board has a simple monitoring role in this regard.
Hon NICK GOIRAN: To monitor what, minister? Is it to monitor whether the practitioner has provided the form within the two business day? Is that the only thing the board will do? Will it look at when the written declaration was made and when the board received the form and check whether it was within two business days; and, if it was not, will it potentially get the CEO to prosecute the practitioner? Will it otherwise perform no other role with regard to this form? It seems to be merely a function to facilitate prosecution of a medical practitioner.
Hon STEPHEN DAWSON: The form will evidence that the written declaration has been given before the final review. It is a declaration that confirms that the patient wants to continue in the voluntary assisted dying process. I previously mentioned that the clause enables the board to maintain complete and accurate statistics of participation in voluntary assisted dying, so there is that element of capturing statistics, too.
Hon NICK GOIRAN: Will the board also ascertain whether any of the witnesses were ineligible?
Hon STEPHEN DAWSON: No, it will not, but if somebody makes a complaint, it could.

Clause put and passed.
Clause 46: Patient may make final request to coordinating practitioner —

Hon NICK GOIRAN: Will a clause 46 final request made via clause 156(2)(a) be affected in any way by sections 474.29A and 474.29B of the commonwealth Criminal Code Act?

Hon STEPHEN DAWSON: The final request is initiated by the patient, so no.

Hon NICK GOIRAN: The coordinating practitioner knows that the next step that needs to be taken by their patient—let us say it is a regional patient—is to make a final request. What happens if the doctor initiates the audiovisual technology with a carriage service, maybe by phone or Skype or some other facility? I cannot see that a patient, who will probably not be that familiar with this process, is likely to say, “We’re up to section 46 in the process and it’s my job as the patient who has a terminal illness to realise that I now need to ring my coordinating practitioner and let them know I would like to make a final request.” I think that is quite unlikely. I think it is far more likely that the coordinating practitioner would initiate the phone call and use the carriage service. Would that make any difference in respect of this provision and its intersection with commonwealth law?

Hon STEPHEN DAWSON: The medical practitioner will not be prompting the patient to make a final request, but who does the dialling will not make a difference. In this case, a patient making a final request is not breaching the commonwealth provisions.

Hon NICK GOIRAN: I realise the patient might not be, but would the medical practitioner be?

Hon STEPHEN DAWSON: He is just receiving a request, so no.

Clause put and passed.

Clause 47: When final request can be made —

Hon NICK GOIRAN: This is a very interesting clause. It refers to when the final request can be made. Could the final request be made more than six months after the written declaration?

Hon STEPHEN DAWSON: There is no specified time limit between the written declaration and the final request, but clause 46 states that the final request must be clear and unambiguous.

Hon NICK GOIRAN: In my view, this is a real problem. Let us look at the Oregon experience, which has had this regime for more than 20 years. The patient has to have a prognosis of six months to live. Our bill also says six months but in certain situations it is 12 months. Interestingly, during the first 17 years of data in Oregon, the longest recorded time between the initial request and the ingestion of the lethal drug was 1 009 days. In case members think that is an isolated incident, in 2015, the longest recorded period was 517 days. In four of the 17 years between 1998 and 2015, there was at least one case in which the duration between the initial request and the ingestion was more than two years. I think this is a point of real concern that we are saying that the doctor has said this patient is going to die within six months, yet we will leave open the possibility of the patient making the final request more than six months after they have signed the written declaration. The very fact that they are making that request more than six months after the written declaration would be evidence that the prognosis by the doctor was wrong. Surely the board should intervene and investigate, rather than allowing that to continue to take place. Would the board investigate that situation?

Hon STEPHEN DAWSON: I am advised that it is possible that it could refer it for investigation.

Hon NICK GOIRAN: There should be a cap. A safeguard should be implemented here, minister, but that is to do with the outer end of the request process, but clause 47 also allows the process to be accelerated. It says that it cannot happen any sooner than nine days, other than in certain specified circumstances. For many insurance policies, for example, 14 days is not an unusual cooling-off period and in Oregon the period is 15 days. Another legislature that has assisted dying is Hawaii and it has 22 days. Why was nine days selected by the government in this instance?

Hon STEPHEN DAWSON: It was recommended by the ministerial expert panel after considering the various time frames used in different jurisdictions around the world.

Hon NICK GOIRAN: The minister says that it was recommended by the ministerial expert panel. Can the minister draw to our attention the panel’s analysis of the different jurisdictions and why it concluded nine days?

Sitting suspended from 1.00 to 2.00 pm

Hon STEPHEN DAWSON: Before the break, Hon Nick Goiran had asked a question about the nine-day period outlined in the bill. That nine-day period is the same as in Victoria. It is dealt with in the ministerial expert panel’s report from page 69 to 71. The section titled “Reflecting on the decision” at page 69 of the MEP final report deals with these considerations.

Hon NICK GOIRAN: I notice that at page 71 of the ministerial expert panel’s report it states that the period should be at least nine days. Why was nine days chosen by the government? Is it because that was the time the ministerial expert panel chose? What consideration was given to having a longer period?

Hon STEPHEN DAWSON: The fact that nine days is used in Victoria was considered, and that was where we landed.

Extracted from finalised Hansard
Hon NICK GOIRAN: Was that just slavishly following the Victorian model then, minister? Take that as rhetorical.

Hon Stephen Dawson: I have taken it that way.

Hon NICK GOIRAN: Section 241.2(3)(g) of the Canadian Criminal Code requires —

… at least 10 clear days between the day on which the request was signed by … the person and the day on which the medical assistance in dying is provided or—if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent—any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

The latest government report from Quebec indicates that 40 per cent of medical assistance in dying cases were performed less than 10 days after the patient first made a request. Given that from the latest data the rate in Quebec is 40 per cent, does the government anticipate that in Western Australia we will see similar levels of expedited final requests and an administration of voluntary assisted dying substances inside the designated nine-day period as outlined in clause 47?

Hon STEPHEN DAWSON: Obviously, the laws in Quebec do not necessarily mirror the bill before us. I will just say that it is impossible to foresee.

Hon NICK GOIRAN: Clause 47(3) provides that if, in the opinion of the coordinating practitioner for the patient, the patient is likely to lose decision-making capacity before the end of the nine days, the patient’s final request can be made before the nine-day period has elapsed. In what circumstances might a coordinating practitioner be able to determine that a patient is likely to lose decision-making capacity before the end of nine days?

Hon STEPHEN DAWSON: An example of a situation that may satisfy the clause 47(3) provisions is when a person’s loss of decision-making capacity may occur from high doses of pain medication.

Hon NICK GOIRAN: If a person is assessed as being on the verge of losing capacity, what degree of certainty can there be that the person currently has full capacity?

Hon STEPHEN DAWSON: A doctor assesses decision-making capacity to, I guess, the same level. If they know the likelihood of the pain medication that the patient would be required to take would result in them losing capacity, they could act.

Hon NICK GOIRAN: If a patient’s request is expedited under clause 47(3), what is the minimum period in which the entire request and assessment process can take place?

Hon STEPHEN DAWSON: Technically, it is two days, and I think the honourable member knows that. I am advised that that is highly unlikely, given the steps that need to be followed—making a formal request, the assessment being undertaken by the coordinating practitioner, the assessment being undertaken by the consulting practitioner, the written declaration, the final request and the final review. Technically, it is two days, but we anticipate longer.

Hon NICK GOIRAN: If the patient’s request is expedited under clause 47(3), we now know it can all happen within two days. I have to say that I am really troubled that we are going to put some Western Australians on this express pathway and that the whole process can happen within two days. Are we as legislators going to pretend that this board will somehow provide oversight for a process that can happen in two days? I just want members to reflect on that for a moment. I find that reckless. Two days—the express pathway for a Western Australian patient. I know that the government has boasted over the course of the journey of this bill that there are supposedly 100-odd safeguards. What could possibly go wrong in two days on this express pathway? Be that as it may, in the absence of anyone else sharing the concern that that will happen under clause 47, we will set Western Australians on this express two-day pathway.

If people do access this expedited route at clause 47(3), can the minister indicate to us how the patient’s request can then be assessed as enduring, as required by eligibility clause 15(1)(f) and clause 58(5)(c)?

Hon STEPHEN DAWSON: I want to clarify that. It is technically possible, but that does not mean that it is operationally likely. I am advised that it is highly unlikely that the practical process will be two days. The endurance assessment is made at the first request. The coordinating practitioner will take all relevant health information on board to determine the matter of endurance.

Hon NICK GOIRAN: I had understood during an earlier part of the debate that the minister indicated that the patient would need to have decision-making capacity at the time of administration. If that is true, how can the final request be accelerated on the view of the practitioner that the person is likely to lose decision-making capacity within the nine-day period?

Hon STEPHEN DAWSON: I want to say two things. The patient may lose decision-making capacity, and this qualifies for the waiver; however, if they have lost decision-making capacity, they are not eligible. At the time of making the administration decision, the medical practitioner may advise that the self-administration method is not suitable.
Hon NICK GOIRAN: They may advise that, but they may also proceed under the practitioner administration method. We need to know: at what point does decision-making capacity become irrelevant? Once somebody has accessed the express pathway under clause 47, does decision-making capacity remain relevant any longer?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: The patient has accessed the express pathway under clause 47. The coordinating practitioner has allowed that to take place because the coordinating practitioner, in his or her opinion, says that the patient is likely to lose decision-making capacity. After that, the patient loses decision-making capacity. Is there not a process whereby the patient needs to make an administration decision? In any event, assume for a moment that the person has elected for the practitioner administration process and then loses capacity, and this is all being done within the nine-day period because they have accessed the express pathway, to what extent is decision-making capacity still relevant in any of those processes?

Hon STEPHEN DAWSON: Clause 58(5)(a) deals with this issue. Its states —

The administering practitioner for the patient is authorised, in the presence of a witness, to administer the prescribed substance to the patient if the administering practitioner is satisfied at the time of administration that —

(a) the patient has decision-making capacity in relation to voluntary assisted dying …

Hon NICK GOIRAN: The patient has accessed the express pathway. It will now take place in less than nine days—possibly two days, as we have discussed. The patient has lost capacity. The practitioner knew that that was going to happen because they certified the express pathway because the person was going to lose capacity—as the minister said, potentially because of the painkilling medications that the person is taking. They lose capacity and that eliminates from them the possibility of practitioner administration. Is self-administration still an option at that stage?

Hon STEPHEN DAWSON: If they have lost capacity, they cannot self-administer. I also wanted to raise that the so-called express pathway does not change the requirements and eligibility for access to voluntary assisted dying and this includes decision-making capacity. These are elements for discussion at clause 57, “Self-administration”.

Hon NICK GOIRAN: That may be convenient, minister, but at this point in time we have to decide whether we are going to agree to clause 47. I am trying to understand, in effect, that if a practitioner allows the express pathway because they are concerned that the person is likely to lose decision-making capacity, and then the person loses capacity thereafter, have they eliminated as an option practitioner administration because of the clause that the minister referred to and are they left only with self-administration? The minister indicated that it is not possible for someone to self-administer if they lose decision-making capacity. I am not sure how that can be the case given that the person takes the substance home with them. We have already ascertained that there is no supervision over that whole process, so I do not think that the advice that the minister received on that point can be correct. We surely have to get to the bottom of this. If we are going to allow patients to complete the whole process in two days, what I hear from the minister is that if they lose capacity, the only option at that point will be self-administration. I am hearing from the minister that there is at least a safeguard; that is, if somebody accesses the express pathway and then loses capacity and has chosen practitioner administration, they are safe because the practitioner will not perform the final injection if the person has lost capacity. That is a good thing and I support that. But I remain concerned that the other pathway might effectively be steering them down self-administration, and I want an assurance from the minister that there is definitely no possibility of a patient accessing the express pathway and choosing self-administration and losing capacity.

Hon STEPHEN DAWSON: I just want to clarify—I think Hon Nick Goiran has indicated this—that if a patient has chosen practitioner administration and then loses capacity, they must go back to the coordinating practitioner for a new administration decision. But they would not be eligible if they have lost capacity. If a person has chosen the self-administration method, it is no different whether they are on the express pathway or the regular pathway, to use that terminology; they are prescribed a substance and they have self-autonomy to take it.

Hon NICK GOIRAN: Yes, I agree with that, minister. This is further and further convincing me that in due course—I think Hon Rick Mazza is seeking to remove self-administration from the scheme; correct me if I am wrong, honourable member.

Hon Rick Mazza: Not remove self-administration, but —

Hon NICK GOIRAN: That amendment will definitely have my support, because clause 47 has convinced me that if ever there were a case for it, this is it. How can we have a situation in which a doctor says, “We’re going to accelerate this process for this patient because I’m concerned that in the next nine days, this patient is going to lose capacity”? Within that nine-day period, that practitioner also extracts an administration decision out of that patient, who still has capacity. The administration decision is that the person self-administers. Off they go with their substances, and after the nine days, in the full knowledge of the doctor who has determined that the person is going to lose capacity in nine days, the doctor says, “Off you go with your poison. Go and take it 10, 12, 15 or however many days later.” That should be prohibited under this legislation. One way of doing it will be to ensure

*Extracted from finalised Hansard*
that there is somebody present. We will look at those amendments in due course, so long as they ensure that somebody says at the time of self-administration that the person has decision-making capacity, because if they do not, then absolutely there needs to be not just a pause button, but a stop button, hit.

Clause put and passed.

Clause 48: Coordinating practitioner to record final request —

Hon NICK GOIRAN: Why is this clause deemed necessary for inclusion and is there an equivalent in the Victorian legislation?

Hon STEPHEN DAWSON: My advisers tell me that it is not in the Victorian legislation. The purpose of this provision is to reflect the progression and enduring nature of the request and assessment process. It is an administrative record-keeping requirement and allows resources to be provided to assist the patient through the voluntary assisted dying process if they so require.

Clause put and passed.

Clause 49: Coordinating practitioner to notify Board of final request —

Hon NICK GOIRAN: I move —

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;

Hon STEPHEN DAWSON: The government is supportive of this amendment. Similar amendments were moved earlier in the bill. Reasons were given at that stage, so I do not propose to give them again, other than to say we support it.

Amendment put and passed.

Hon NICK GOIRAN: What is the board required to do with the financial request form once it has been received from the coordinating practitioner?

Hon STEPHEN DAWSON: The intent of this provision is to ensure that the board is notified progressively of the patient’s participation in the voluntary assisted dying process, including the outcome of each assessment to track that the correct process is being followed in each case of voluntary assisted dying and to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

Hon NICK GOIRAN: What special measures will the board take in the event that it receives a final request form that indicates that a patient has taken advantage of the express pathway?

Hon STEPHEN DAWSON: None will be taken.

Hon NICK GOIRAN: No special action will be taken by the board when somebody has accessed the express pathway. It can all happen in two days. Normally, the legislation says nine days, but in certain circumstances it can happen within two days and the board will proceed at a normal pace. Maybe the board will have meetings once a week, but, of course, that will be too late in this instance. The board will receive the final review and say, “Thank you very much, coordinating practitioner. We will file away your final review form and look at it in seven days.” Seven days later, the board will look at it and realise that there is a manifest error. It will be too late; the funeral will already have taken place. That situation is untenable. I realise that at the moment we are not in a position to deal with the resources for the board; however, this highlights once again that this board will have to be on red alert. Every time it receives a form, it will need to drop everything and make sure that the patient is not being taken advantage of and that ineligible people have not accessed it. If somebody is said to be losing their capacity within the next nine days, if that is the reason that is provided by the practitioner, absolutely everyone needs to be on red alert. I trust that those things will be taken into account by the government during the 18-month implementation phase.

Clause, as amended, put and passed.

Clause 50: Final review by coordinating practitioner on receiving final request —

Hon ADELE FARINA: What is the purpose of clause 50(1)(a)? The coordinating practitioner has to review the first assessment report form, all consulting assessment report forms and the written declaration. What is the purpose of that review?

Hon STEPHEN DAWSON: This clause sets out the requirements of the final review that the coordinating practitioner must undertake on receipt of a patient’s final request for access to voluntary assisted dying. The purpose of the final review is for the coordinating practitioner to review all the forms completed throughout the request and assessment process, complete the final review form for the patient and certify whether the request and assessment process has been completed in accordance with the legislation. The final review will provide the coordinating practitioner with the opportunity to ensure that all the necessary steps in the request and assessment process have been completed. The coordinating practitioner is not required to repeat those steps. They are required to ensure that every step has been properly adhered to.

Extracted from finalised Hansard
Hon ADELE FARINA: As I understand it, the coordinating practitioner is required to provide the first assessment report, the consulting assessment report forms and the written declaration to the board. If there were a deficiency with those forms and those reports, would the board not contact the coordinating practitioner to advise that there were deficiencies in the forms that had been provided to the board and to immediately correct them?

Hon STEPHEN DAWSON: Yes; in practice I agree with Hon Adele Farina, but this is an assurance step, if I can call it that.

Hon ADELE FARINA: Will the person who is supposed to properly complete these forms be the person who will also be tasked with the job of ensuring they have been correctly completed?

Hon STEPHEN DAWSON: They are not the person who will complete all the forms. Clause 50(1)(a) refers to the first assessment report form, all consulting report forms and the written declaration. That would not necessarily be the person completing all the forms; it would be other people, too.

Hon CHARLES SMITH: Can the minister confirm that under clause 50(1)(a) the board will review all the paperwork for the final request?

Hon STEPHEN DAWSON: The board has a monitoring function rather than a clinical function. Clause 117, “Functions of Board”, states —

The Board has the following functions —

(a) to monitor the operation of this Act;

…

(c) to refer to any of the following persons or bodies any matter identified by the Board in relation to voluntary assisted dying that is relevant to the functions of the person or body —

I will let Hon Charles Smith read the rest. Clause 50(4) states —

Within 2 business days after completing the final review form, the coordinating practitioner must give a copy of it to the Board.

Hon NICK GOIRAN: Is it not the case that we moved an amendment earlier at clause 39 that will ensure that when receiving the consulting assessment form, the board will also receive a copy of any report given by the registered health practitioner or other person to whom the patient was referred?

Hon STEPHEN DAWSON: Yes, that is the case.

Hon ADELE FARINA: I move —

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;

I do not want to take credit for this. This is an amendment moved earlier by Hon Nick Goiran. I am simply seeking to ensure that it fits in where it is needed in subsequent clauses.

Hon STEPHEN DAWSON: The government supports this amendment.

Amendment put and passed.

Hon NICK GOIRAN: Clause 50(2) refers to decisions made by the tribunal. What type of decisions might be made by the tribunal under part 5 of the bill in respect of a decision made in the request and assessment process that the coordinating practitioner may be required to have regard to under clause 50(2)?

Hon STEPHEN DAWSON: Clause 87 identifies the types of decisions that can be taken into account or whatever the language the honourable member used.

Hon NICK GOIRAN: Schedule 1 of the Victorian legislation provides the forms that are required to be completed under the request and assessment process of its act. The information required to be included in the final review form is included in clause 50(3), but the form itself is not found in the schedule to the bill. Why has the final review form not been included in the schedule to the bill?

Hon STEPHEN DAWSON: I am advised that the forms will be developed during the implementation phase.

Hon NICK GOIRAN: Clause 50(3) requires only that the coordinating practitioner’s name and contact details be included in the final review form. Why is information about the coordinating practitioner’s experience and training in the patient’s disease, illness or medical condition missing from inclusion in the final review form? The context, of course, is that we know that in certain circumstances, the practitioner may not necessarily have the right experience and training. There is a discretionary provision in the bill indicating that they should refer elsewhere. That is the kind of information I would like the board to have so that it can perform its oversight function.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: There is no requirement for them to be a specialist in the disease, as the honourable member said.

Hon Nick Goiran: I didn’t say “specialist”.

Hon STEPHEN DAWSON: I thought you did. What word did you use?

Hon Nick Goiran: I said they do not have any experience or training in the patient’s disease.

Hon STEPHEN DAWSON: Sorry; to use the member’s language, there is no requirement for them to have that.

Clause 16 outlines the eligibility criteria of the coordinating practitioner.

Clause, as amended, put and passed.

The DEPUTY CHAIR: I draw members’ attention to supplementary notice paper 139, issue 15, page 3 and the proposed amendment by Hon Charles Smith in relation to a new part.

Hon STEPHEN DAWSON: It is my understanding that the amendment standing at 37/ND7 would be moved as a consequence of the amendment of proposed new clause 52A. If that is the case, the honourable member may wish to park the first one and we may go back to it subsequently, depending on the success or not of proposed new clause 52A.

The DEPUTY CHAIR: Sorry, minister, I was distracted through that. Is Hon Charles Smith going to move his amendment?

Hon CHARLES SMITH: Yes, thank you, Madam Deputy Chair. I think we need to seek to defer the new clause.

Point of Order

Hon COLIN HOLT: I might have missed it, but have we passed clauses 51 and 52?

The DEPUTY CHAIR (Hon Adele Farina): This comes in before then. If you read the proposal, it is at page 32, after line 13.

Committee Resumed

The DEPUTY CHAIR: Hon Charles Smith, you are seeking just to defer that amendment until later?

Hon CHARLES SMITH: That is correct, Madam Deputy Chair.

The DEPUTY CHAIR: Okay, we will not deal with that at this time. The question now is that clause 51 stand as printed.

Clause 51: Technical error not to invalidate request and assessment process —

Hon NICK GOIRAN: What might constitute a “minor or technical error in a final review form” that would not affect the validity of a voluntary assisted dying request and assessment process for the purposes of clause 51?

Hon STEPHEN DAWSON: Examples of a minor or technical error include a spelling error in a name or address, or an accidentally incorrect date on a witness’s signature. Such things should not have the effect of invalidating a patient’s entire request and assessment process.

Hon NICK GOIRAN: What type of error contained in a final review form might affect the validity of a voluntary assisted dying request and assessment process?

Hon STEPHEN DAWSON: Anything other than a minor or technical error will mean that the form is invalid. For example, anything in substance affects the operation, integrity or meaning of the form will render the form invalid. Examples of matters that would have a substantive invalidating effect include situations in which the form is unclear about whether the core requirements of an assessment have taken place—that is, that the patient meets each of the eligibility criteria and reasons—or in which the names of the assessing practitioners cannot be ascertained. I am advised that other Western Australian legislation has this type of clause.

Hon NICK GOIRAN: That might be true, but there is no other piece of legislation —

Hon Stephen Dawson: Just being helpful, honourable member.

Hon NICK GOIRAN: I know the minister is, but I am also just making my assessment in respect of that remark. I think this is the only piece of legislation that authorises one Western Australian to take the life of another, albeit with the supposed consent of that individual, so I think this is a unique piece of legislation. Be that as it may, are there any errors other than those contained in the final review form that might affect the validity of a voluntary assisted dying request and assessment process?

Hon STEPHEN DAWSON: I am sorry; would the honourable member ask his question again, please?

Hon NICK GOIRAN: Are there any errors other than those contained in the final review form that may affect the validity of a voluntary assisted dying request and assessment process?

Hon STEPHEN DAWSON: I refer the member to clause 50(1)(a). Those are the forms that clause 51 refers to.

Hon NICK GOIRAN: Clause 50(1)(a) lists things that a practitioner needs to review prior to completing the final review form, but my question was: are there any other errors that can take place, other than those contained in
the final review form, that may affect the validity of a voluntary assisted dying request and assessment process? Clause 51 provides that if there are any minor or technical errors in the final review form, they will not affect the validity of the request and assessment process. Subsequent to that, the minister indicated some types of errors in a final review form that might affect the validity of the process. My question is: is there something outside that? Are there some other errors that could be made that would affect the validity of the process, or is it all only contingent on the accuracy of the final review form? I would assume that there must be some other errors that can be made, other than merely in the final review form. I am trying to ascertain what those other errors are.

Hon STEPHEN DAWSON: If the member is talking about errors in general, a failure to make an assessment of a patient’s capacity would be an example of an error in the assessment process.

Hon NICK GOIRAN: What remedy would there be for a patient if an error is made by one of the practitioners in the assessment process that affects the validity of the patient’s request and, thereby, their access to voluntary assisted dying is prevented or delayed by the error?

Hon STEPHEN DAWSON: There would be the option of civil action.

Hon NICK GOIRAN: When the minister says civil action, would it be some form of negligence claim against the practitioner to claim that the patient has suffered some form of pain, suffering, loss of enjoyment of life and the like as a result of their delayed access to voluntary assisted dying; is that the type of thing the minister is referring to?

Hon STEPHEN DAWSON: Yes. That is theoretically possible.

Hon NICK GOIRAN: Would that remedy be available to the patient’s family in the event that the patient deceases before the civil action has taken place?

Hon STEPHEN DAWSON: The answer is no. The remedy would not be available to the family if the person has deceased.

Hon NICK GOIRAN: There will be no remedy available to the patient’s family. The only remedy would be available to the patient and it is available only to the patient for as long as they are alive.

Hon STEPHEN DAWSON: That is correct.

Clause put and passed.

Clause 52: No obligation for patient to continue after completion of request and assessment process —

Hon NICK GOIRAN: Is there any point after the coordinating practitioner has completed the final review forms and the request and assessment process is deemed complete at which the voluntary and enduring nature of the patient’s request is further assessed?

Hon STEPHEN DAWSON: The test of the endurance will be demonstrated by attending the appointment with the medical practitioner to make the administration decision—that is clause 55—and then when the substance is prescribed for them. In the case of practitioner administration, enduring capacity will be assessed before administration. During the course of the appointment for the administration decision, if the medical practitioner is not satisfied of any of these, they will not be compelled to proceed.

Hon NICK GOIRAN: Clause 52 states that there will be no obligation on the part of the patient to continue the process after the request and assessment process is completed. That is quite appropriate. I do not think it is even necessary for us to state that in the statute; it would already be right for a patient in any event, whether we had clause 52 or not. I am not so sure that clause 52 adds anything, but I certainly do not object to its inclusion. Would it not be better to ensure as a safeguard that a practitioner cannot follow up a patient in the circumstances? If the patient does not want to continue to exercise their right under clause 52, they should be left in peace. Is there any prohibition against a practitioner continuing to initiate conversations with a patient at this point?

Hon STEPHEN DAWSON: I am told it is contrary to good medical practice. I remind the honourable member that during the implementation phrase of this legislation, training will be undertaken with the various practitioners who will be involved in implementing the bill.

Hon NICK GOIRAN: For what it is worth, there should be a penalty against a medical practitioner who pursues a patient after they have exercised their right under clause 52. If they say they do not want to continue anymore, they should be left in peace, they should be left alone and they should not be pursued by an aggressive medical practitioner. If they were, albeit we would hope those circumstances would be rare, there should be a significant penalty and the penalty should be more than some form of professional misconduct against the practitioner. Some criminal penalty should be applicable, given, as we identified earlier, that under this bill, if practitioners fail to submit forms to the board, they can be up for a penalty of up to $10 000. I would like to think a penalty far greater than that would apply to a medical practitioner who pursues a patient after they have exercised their clause 52 rights.

Hon STEPHEN DAWSON: Australian Health Practitioner Regulation Agency sanctions may apply, but the member’s comments are noted.

Clause put and passed.

Extracted from finalised Hansard
New clause 52A —
Hon CHARLES SMITH: I move the new clause standing in my name.

The DEPUTY CHAIR: Hon Charles Smith has moved the new clause standing in his name. It is new clause 52A at 38/NC52A on the supplementary notice paper and it seeks to insert at page 32, after line 23, a fair bit of script. I assume that everyone has the supplementary notice paper and I will not take the time of the chamber to read it, so I give the call to Hon Charles Smith.

Point of Order

Hon NICK GOIRAN: I have a point of order, Madam Deputy Chair.

The DEPUTY CHAIR (Hon Adele Farina): Are you going to make me read it?

Hon NICK GOIRAN: Not necessarily. I am happy for it not to be read, but I want to know, will it appear in Hansard for those people who are following the debate?

Committee Resumed

The DEPUTY CHAIR: That is absolutely a fair point, because people are following the debate online. I will read it. Hon Charles Smith has moved —

Page 32, after line 23 — To insert —

52A. Board to be notified if patient decides not to continue or if request for access to voluntary assisted dying ceases to be enduring

(1) This section applies if —

(a) at any time before the request and assessment process in respect of a patient is completed, the patient informs the coordinating practitioner for the patient of a decision not to continue the request and assessment process; or

(b) at any time after the request and assessment process in respect of a patient has been completed, the patient informs the coordinating practitioner for the patient of a decision not to take any further step in relation to access to voluntary assisted dying; or

(c) at any time after making a first request, a patient’s request for access to voluntary assisted dying ceases to be enduring because the patient indicates to the coordinating practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

(2) The coordinating practitioner or administering practitioner referred to in subsection (1)(a), (b) or (c) must —

(a) record the decision, or that the request has ceased to be enduring, in the patient’s medical record; and

(b) within 2 business days after being informed of the decision, or after the request has ceased to be enduring, complete the approved form (the request cessation form) and give a copy of it to the Board.

(3) The request cessation form must include the following —

(a) the name, date of birth and contact details of the patient;

(b) the name and contact details of the person completing the form;

(c) if the person completing the form is not the coordinating practitioner for the patient, the name and contact details of the coordinating practitioner;

(d) the date when the first request was made;

(e) if the request and assessment process in respect of the patient has been completed, the date when the final review form was signed;

(f) the date when the coordinating practitioner was informed of the decision referred to in subsection (1)(a) or (b), or the date when the request for access to voluntary assisted dying ceased to be enduring as referred to in subsection (1)(c), as the case requires;

(g) the signature of the person completing the form and the date when the form was signed.

Hon CHARLES SMITH: I appreciate that and I am sure the chamber does as well.
I first draw members’ attention to clause 52 itself, which states —

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.

Members will also note that as the bill currently stands, there is no requirement for any note to be made on a patient’s record, or any notification to the VAD board, to document the cessation or the patient’s request to stop. This new clause, which is lacking in our WA model, is taken from the Northern Territory model. It is inspired by section 10(2), which requires —

Where a patient rescinds a request, the patient’s medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient’s medical record.

Quite simply, new clause 52A will require the coordinating practitioner to notify the board of a patient’s decision not to continue with the application to access voluntary assisted dying, whether this occurs during the request and assessment process or after the request and assessment process is completed; therefore, a new form, the “request cessation form”, will be required to be completed and submitted to the Voluntary Assisted Dying Board. This only further strengthens the oversight functions of the board and in this particular case, in this important part of the journey, that is wise to be documented.

Hon STEPHEN DAWSON: Hon Charles Smith’s new clause seeks to formalise when a patient decides not to continue with the request and assessment process. We are not supportive of the amendment. My advisers tell me that the inclusion of the amendment adds to the complexity and bureaucratic burden of the bill. The coordinating practitioner would be able to make a note on the person’s medical file and to record, via the recording system, if the patient makes a formal decision to withdraw from the voluntary assisted dying process. We do not believe that what Hon Charles Smith is asking us to do is needed.

Hon NICK GOIRAN: I am not convinced by that, because when we discussed clause 52, I indicated that I think there should be a prohibition against a doctor pursuing a patient who does not want to proceed down this path. We do not have that in the bill and this new clause does not do that either, but at the very least this new clause seems to make sure that the board is aware of what is going on. I would have thought that that was a good thing. The minister indicated that this would be too bureaucratic. Correct me if I am wrong, but it appears that, under this new clause, the only person who will have to do anything is the practitioner, and they will have two business days to let the board know that they have been told the patient does not want to continue. I think that is a good thing. That way, if the board hears anything further about this particular patient, that is going to be a red flag for them, because they will have known from this other practitioner that the patient has already said they do not want to pursue it. If a new practitioner suddenly appears on the scene and forms are flying into the board, at least there is a red flag. I think this is a good safety mechanism; I just do not think it goes far enough. I would like to see this, plus a prohibition and a penalty against a practitioner who decides to pursue a patient, but we do not have that type of amendment before us. In the absence of that, it is not clear to me what is so bureaucratic about a coordinating practitioner having to send in a request cessation form, as I see it, within two business days.

Hon STEPHEN DAWSON: I said that it adds to the complexity and bureaucratic burden rather than that it was “too bureaucratic” or whatever words Hon Nick Goiran used. During the debate we have clarified and made changes to the bill that will give extra responsibilities or, indeed, jobs to the board. This proposed new clause seeks to create another form and more work for the board—or more information that needs to be provided to the board. As I have said previously, the coordinating practitioner would be able to make a note on the person’s medical file and they could record it via the reporting system if the patient makes a formal decision to withdraw from the voluntary assisted dying process. I know that Hon Nick Goiran said that this does not go far enough for him and there are other changes he wants to make. For us, we do not believe it is needed; we believe the system as outlined in the bill before us on this issue does not need to be changed.

While I am on my feet, I might take the opportunity to ask Hon Charles Smith whether this new clause came wholly from the Northern Territory legislation. I am not being disparaging. Was this a cut and paste? Did the member copy clauses from the Northern Territory legislation and bring them across?

Hon Charles Smith: That’s correct.

Hon AARON STONEHOUSE: I have a question for the mover of the proposed new clause. Are there any consequential amendments that come along with this? Are there any other references to the request cessation form in any consequential amendments?

Hon Charles Smith: I don’t believe there are.

Hon AARON STONEHOUSE: I am looking at how this proposed new clause would work. If we jump ahead a bit in the bill, we see clause 56, “Revocation of administration decision”, which states —

(1) 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 …

Extracted from finalised Hansard
In which case a medical practitioner or the coordinating practitioner must, under subclause (3) —

(c) within 2 business days after the revocation, complete the approved form (the revocation form) …

This provision is rather similar, but I think the proposed new clause fits in a little earlier in the process. Proposed new clause 52A states —

(1) This section applies if —

(a) at any time before the request and assessment process in respect of a patient is completed, the patient informs the coordinating practitioner for the patient of a decision not to continue the request and assessment process;

Although there is already a reporting mechanism for a patient cancelling just prior to self-administration, this would create a reporting obligation for the medical practitioner earlier in the process, presumably before the patient has been provided with the voluntary assisted dying substance. It can be at any time before the request and assessment process for the patient is completed. I suppose it does add to the administrative burden of coordinating practitioners, but I do not think it is inappropriate necessarily, in that there is already the revocation form that would have to be completed at that stage. This is merely replicating a reporting mechanism that exists at the end of the process and is putting it a little earlier in case a patient wants to opt out at that stage. I think the policy intent is solid and desirable. There will be more reporting to the board and more opportunities for the board to provide oversight of this process. Given that the board does not have a gatekeeping or approval role, but merely an oversight role, it will provide the board with more information. It might be helpful as well in later years for looking back and reviewing the voluntary assisted dying regime to find out how many people go through the process and then opt out. I am interested to know whether it would be possible to record why somebody decided not to continue. Did they decide not to continue because they found that their palliative care treatment options would be sufficient in their case or was there some other consideration? Obviously, we all want to respect patients’ privacy, but that kind of information might be helpful. I am not suggesting that it be amended to include that, but it is something worth bearing in mind.

Although I appreciate that the proposed new clause would create an additional administrative burden, I am inclined to support it because it does add to transparency and potentially creates a safeguard if the board does its job properly. It seeks to strengthen the protections in this bill.

Hon MARTIN ALDRIDGE: I am seriously considering the proposed new clause before us. I understand the operation of the proposal but I do not necessarily understand the mischief or perceived mischief that the member is trying to address. I take Hon Aaron Stonehouse’s point about gathering more information that may be useful down the track, but we have to balance that with the added layers and requirements we would place, in this case, on practitioners. We have to balance those competing concerns. Looking at the bill, and not having a chance to collate all the reporting provisions, I see that there are many reporting provisions to the board in the bill, but they usually relate to—in fact, they may entirely relate to—the progress of a patient through the process, whereas this is a situation in which a patient who has made the decision is put in the position of having to move forward, and then ultimately do not follow through and take the substance so they die without accessing voluntary assisted dying. We will never record that because the patient has made the decision themselves, which brings us back to the point that this legislation is voluntary and it is about the patient and the patient making decisions. We should not force that patient to have to then formally report that they did not take the substance because that is their decision. We will not get any stats that truly reflect whether someone has changed their mind because we will only capture the people who make a formal request. A whole lot of other people will not access voluntary assisted dying and will not take the substance, although they might have it in their possession, and pass away peacefully with their family around them. They do not need to take the substance, so we will never capture them. Therefore, I will not be supporting the proposed new clause.

Hon STEPHEN DAWSON: It is my belief that Hon Charles Smith’s proposed new clause could put unnecessary pressure on the patient. The process is patient centred and the framework is based on a principle that the patient moves it forward, that they are in control and that they decide when to go to the next stage. Requiring formal cessation could have the unintended consequence of placing the patient in the position of having to move forward at a time when they wish to pause, so I also agree with what Hon Jacqui Boydell has just outlined.

Extracted from finalised Hansard
Hon AARON STONEHOUSE: Just to provide some further clarity, if a patient is given the voluntary assisted dying substance and they then decide to cancel or put an end to the process, there is a reporting requirement in that instance—that already exists. That is the revocation form, which the coordinating practitioner must complete. This would create an additional reporting obligation earlier in the process. I take the point. In a lot of cases, we would not know, but I imagine that a lot of people would begin the process, begin the discussion, and then simply not follow through the cycle. Sadly, people may pass away before they have an opportunity to go through the entire process. However, this proposed new clause would not put any obligation on the patient. This is an obligation on only the medical practitioner if the patient makes a cessation request to the practitioner. I understand the concern that pressure might be brought to bear on a patient, but nothing in this amendment would do that. I think that would happen only if the medical practitioner was overstepping their bounds and unnecessarily or inappropriately putting pressure on their patient. That is something that there is already a risk of anyway, so I do not think that this amendment would add any new risk of pressure being brought to bear on patients.

An aspect of this amendment that has been overlooked so far is new subclause (1)(c), which states—

at any time after making a first request, a patient’s request for access to voluntary assisted dying ceases to be enduring because the patient indicates to the coordinating practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

That is slightly different from a patient merely changing their mind at an earlier stage. It provides for before the request and assessment process, after the request and assessment process and after making a first request. It provides a reporting mechanism all the way through until the end. Currently, we have a reporting mechanism for opting out only at the very end. Although it may again be an additional administrative burden, in situations in which a patient makes an overt request to their medical practitioner to cease the process, I think it would be helpful to have that recorded.

We are not asking for a lot of information in this instance; it is the same information that would be included in a lot of the other forms that a medical practitioner will be required to fill out. It is very similar to the information in the final request form, in the final review form and in the first request form. It is the name, date of birth and contact details; if the person filling in the form is not the coordinating practitioner for the patient, the name of the coordinating practitioner; and the date that the first request is made. This information would already be at hand.

Again, although it does add to the administrative burden, I do not think it does so unnecessarily. The medical practitioner already has to fill out quite a number of forms as part of this process, and it would apply to only a very small section of patients who begin the voluntary assisted dying process and make that overt request to their medical practitioner to cease the process before they get to the administration phase. Again, I do not see a problem with this proposed new clause, and I am inclined to support it at this time.

Hon COLIN HOLT: I have a quick question for the mover of the motion. I wonder whether he could explain the interaction of this new proposed clause with clause 21, which states that, on the first request, the medical practitioner must complete the approved form—the first request form. How will that clause interact with proposed new clause 52A?

Hon CHARLES SMITH: It will work in harmony with that clause as a total record-keeping process. The idea is that records will be kept the whole way through the voluntary assisted dying journey so that in years to come we can study how well VAD is working. That is the idea.

Hon JACQUI BOYDELL: I will put a scenario to the chamber. There may be five patients who go through the process of accessing voluntary assisted dying. They follow the procedure all the way through. One of those five patients might overtly—to use the words of Hon Aaron Stonehouse—go to their coordinating practitioner and say that they do not want to participate anymore. Two of the remaining four patients may pass away without accessing the substance, which is returned, and the remaining two patients may actually follow through and take the substance. The reporting requirements as suggested in the proposed new clause will not capture any statistical information for the board to reflect on, moving forward—either the decisions made by the patient or the reasons for taking or not taking the substance.

In fact, information and historical data from overseas suggests that a lot of people who access voluntary assisted dying and receive the substance actually do not take it. Again, I say that we will only be recording the statistics of the people who put their hand up to fill out the form. I am still not clear what use that is for voluntary assisted dying, moving forward. I think it could also potentially cause some pressure for practitioners, when the board may come back to them and say, “Why didn’t you keep asking the patient whether they were still enduring on their decision? Are you sure that they didn’t want to withdraw?” I think there is a potential problem for practitioners, and I do not see any use of the collection of this data into the future, so I will not be supporting the motion.

Hon COLIN HOLT: I just want to pick that up. This proposed new clause adds to clause 21, under which the practitioner has to put in the first request form when the person makes the first request. If we take the numbers used by Hon Jacqui Boydell, if five people go in and make a first request, they may never go back and make
another one, and they may never say to anybody that they are stopping the process, which seems to be the requirement in the proposed amendment. As soon as a patient ceases the process, someone is responsible for notifying the board of that cessation. However, a patient may go to step one and say, “I’ve gone to see my doctor”, and they make a request that is unambiguous—I think they are the words used. They get some information about it, but they never proceed and never go back and say that they have changed their mind and they have stopped. A patient may well ask for information because they are curious about it, or whatever it might be, and they may never go back to even say that they are not proceeding after their first request. I am not sure how we deal with this. If we have this enacted in legislation, how will it interact with completion? Is there a time limit? If someone pushes pause for a little while, is that cessation? Is it only when they say, “I’m not going to go on with it”? Can the honourable member explain how it would work?

Hon CHARLES SMITH: What I have been trying to do throughout this debate is assist the state authorities and the government to keep more records of who is accessing voluntary assisted dying, why they are accessing it and when it stops. All that data can be collected for future analysis. This is just part of the process of who is accessing it, who is stopping it and at what stage they are stopping it, so for future reviews, whenever they may occur, we can see what is actually happening as best as we can. I understand that this is a greater bureaucratic burden, as members have said, but for us to have an accurate picture of how the legislation is working, it will be essential to collect as much data as possible.

Hon STEPHEN DAWSON: Hon Charles Smith just used the word “accurate”, and I will go back to Hon Jacqui Boydell’s point. There is no obligation on the patient to inform the practitioner, so the data of who elected not to proceed will not be complete. Therefore, the member’s proposed new clause does not guarantee accuracy. That is another reason why we are not going to support it.

Hon AARON STONEHOUSE: I will make one very quick point about data. Hon Jacqui Boydell raised the point that the quality of the data recorded may not really warrant the recording of it in the first place, and that is true if we are looking for some kind of statistical narrative in aggregate data. However, it would be valuable in the sense of tracking individuals through the process, and that is something that we often overlook. When we look at aggregate data statistically to try to get a snapshot of a situation, we often neglect what is happening to the individuals on the ground as they journey through this process. It may be valuable in that sense. I take Hon Jacqui Boydell’s point that it is going to be valuable only to an extent, but I do not think it is —

Hon Jacqui Boydell: Only for the people who do it.

Hon AARON STONEHOUSE: That is right; it is only for those people who do it, so we should be realistic about the value of this data, but it is not completely relevant. I think it may be helpful in some regard.

Hon Jacqui Boydell interjected.

Hon AARON STONEHOUSE: We do not, obviously, but at the very least we would get an idea of those people who began the process and decided to opt out. That may provide information on the reasons why they opt out and how many people out of the total number of people who made an initial request did opt out. That would tell us something about —

Hon Jacqui Boydell: But you won’t know that, because you don’t know that someone made a personal choice.

Hon AARON STONEHOUSE: We would at least know the number of people who make a first request and of them we would know how many made a cessation request and how many followed through to make the final request and the administration request. Under the bill, we have a form for people who cancel at the administration phase. Obviously, that does not record those people who do not cancel at the administration phase and decide never to go to collect their prescription. There is obviously a gap in data there, too, so I take the member’s point. We are getting only part of the picture, so it does call into question the quality of the data in an aggregate sense, but it can be useful. There is some value to that, but maybe much less than what was discussed earlier in this debate. I just wanted to point that out.

Hon NICK GOIRAN: There has been an interesting debate taking place in regard to data and I respect members who want to either support or oppose this amendment for data collection purposes. Can I just indicate that I am totally disinterested in data collection. My only interest is in patient safety. I am supporting this new clause because I believe this will be a yellow alert or a red flag—whatever language members want to use—to the board to say that a Western Australian patient has gone through all of this part of the VAD process and they have just spoken to their practitioner and said, “I don’t want to do this anymore.” I think it is good that the board will know that. I think it is good that the board will be told that the patient does not want to do this anymore, and what the board wants to do with that information is entirely up to it. I think it is actually one of the most helpful things that the board could receive. It will get a plethora of other forms, and I am not sure of the value of some of those forms in this process. But for it to be told that a Western Australian has accessed the system, qualified for certain aspects of it and has said, “No, I don’t want this anymore”, I think is a good thing. It provides clarity for the practitioner. I take the points about data collection, but, as I say, I am not motivated by data collection; I am motivated by patient safety.

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Division

New clause put and a division taken, the Chair casting his vote with the noes, with the following result —

Ayes (5)

Hon Adele Farina
Hon Nick Goiran
Hon Rick Mazza
Hon Charles Smith (Teller)
Hon Aaron Stonehouse

Noes (29)

Hon Martin Aldridge
Hon Ken Baston
Hon Jacqui Boydell
Hon Robin Chapple
Hon Jim Chown
Hon Tim Clifford
Hon Alanna Clohesy
Hon Peter Collier

Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Donna Faragher
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTiernan

Hon Kyle McGinn
Hon Michael Mischin
Hon Simon O'Brien
Hon Martin Pritchard
Hon Samantha Rowe
Hon Robin Scott
Hon Tjorn Sibma
Hon Matthew Swinbourn

Hon Dr Sally Talbot
Hon Colin Timknell
Hon Darren West
Hon Alison Xamon
Hon Pierre Yang (Teller)

New clause thus negatived.

Clause 53: Eligibility to act as administering practitioner —

Hon NICK GOIRAN: Clause 53(1)(a)(ii) allows for the administration of schedule 4 and schedule 8 poisons to cause the death of a patient to be performed by a nurse practitioner. Are nurse practitioners permitted to act as administering practitioners under the Victorian regime?

Hon STEPHEN DAWSON: No, they are not.

Hon NICK GOIRAN: Of the few jurisdictions around the world that allow these types of regimes, do any of them allow nurse practitioners to act as administering practitioners?

Hon STEPHEN DAWSON: I am advised that Canada does.

Hon NICK GOIRAN: The nurse practitioner who acts as an administering practitioner is required under clause 58(5) to be satisfied that the patient has decision-making capacity, is acting voluntarily and without coercion, and that the patient’s request is enduring. Are these assessments under clause 58(5) assessments that a nurse practitioner would regularly undertake in the course of their usual nursing practice?

The CHAIR: Minister, if you want to entertain this question now and deal with it, you can; otherwise, I would have thought it should be reserved for consideration under clause 58, but I will let it go for the moment.

Hon STEPHEN DAWSON: Thank you. I will provide an answer now, and if there are further questions that warrant deferral to clause 58, we can do that. A nurse practitioner is a person registered under the Health Practitioner Regulation National Law (WA) Act in the nurse profession whose registration under that law is endorsed as a nurse practitioner. In order to be so endorsed, the person must first be a registered nurse, educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. They must also have completed an approved postgraduate 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. On top of this, the bill requires that to be eligible as an administering practitioner, a nurse practitioner must have practised for at least two years post-registration as a nurse practitioner and must meet the requirements approved by the CEO. These requirements will include that the nurse practitioner has recent clinical experience that is complementary to understanding the requirements of the VAD process—so, not a management or leadership-type role. Currently, there are 248 nurse practitioners in Western Australia, 43 of whom are practising in WA country regions. It is important to have them potentially involved in the voluntary assisted dying process. They may undertake these assessments, as per Hon Nick Goiran’s question, but they will have completed the mandatory training.

Hon NICK GOIRAN: By way of context for my line of questioning, at this stage I am inclined to seek to remove nurse practitioners as administering practitioners. That would involve the deletion of lines 11 to 15. However, before I move that, I want to be satisfied that there is a role that the nurse practitioner has to play and that they are well equipped to play it before I look to delete that provision, which will then have consequential effects on other clauses such as clause 58. We need to understand what exactly the nurse practitioner will be able to do. If the nurse practitioner is the administering practitioner, will they be capable of responding to any possible adverse reactions to the schedule 4 or schedule 8 poisons?

Hon STEPHEN DAWSON: Nurse practitioners are appropriately trained to prescribe and administer medication and to respond to any adverse event. They will have to undergo appropriate training as per the mandatory training requirements in the bill. During the implementation period, the Australian College of Nurse Practitioners and the Royal Australian College of General Practitioners will be consulted about the training modules. In relation to
general practitioners, the college has offered to oversight and accredit the course to ensure that it contributes to overall professional standing. Nurse practitioners are fundamental to the operationalisation of the bill, particularly due to the geographic spread of the population in Western Australia.

**Hon NICK GOIRAN**: We know that that is not true because in an earlier part of the debate, the minister indicated that his government would guarantee flying up to eight people to any Western Australian who needed it. I specifically asked the minister about the administering practitioner. At no stage did the minister caveat that by saying that it depended on whether the person was a nurse practitioner and whether the nurse practitioner was available. None of that came up at all. The minister said that the government was fully committed to flying the administering practitioner and the interpreter if need be to any Western Australian. I recall giving an example of Kununurra and Hon Robin Scott and I had a discussion about my lack of knowledge about the other remote areas in Western Australia, about which he is far more equipped to speak. The point is this: it cannot be the case that we need to have nurse practitioners when the minister has said that he will fly out the administering practitioners anyway.

The other point I will make before I move my amendment is that it really troubles me that at the very final stage, the patient must demonstrate decision-making capacity and now we are going to subcontract this out to nurse practitioners. This is in the context in which the government’s special adviser, Mr McCusker, on 14 November this year wrote to the Chief Psychiatrist. The Chief Psychiatrist said this in response —

> Psychiatrists and geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate—with the option to refer to a relevant psychologist in complex or challenging cases.

There is no mention whatsoever about nurse practitioners—not by the special adviser and not in any other document that has been presented to us. If the final act is the injecting of a patient with a lethal substance, that person has to demonstrate decision-making capacity. We had a discussion earlier today about an express pathway that some patients can take if the practitioner says that they might be losing capacity within a nine-day period. There is a possibility that the person might lose capacity during the nine-day period. We could put them on the express pathway and the final person who will provide the lethal injection is a nurse practitioner who does not even qualify under the Chief Psychiatrist’s additional categories of individuals, as ascertained by this helpful email from the special adviser. For those reasons, I move —

**The CHAIR**: We will wait to receive a copy of the proposed amendment in writing. However, if any member wishes to make their remarks in response now, they can do so.

**Hon RICK MAZZA**: In considering this amendment and this clause, I would like a bit more information around the eligibility of the administering practitioner and how the government determined who would be eligible and who would not. Clause 53(1)(a)(i) refers to a medical practitioner who is eligible under clause 16(2), which refers to a medical practitioner being eligible to act as a coordinating practitioner. It refers to a specialist who has at least one year of medical profession experience. Clause 16(2)(b) refers to a general registration holder who has at least one year of medical profession experience. It seems to me to be somewhat disproportionate that a GP needs 10 years’ medical experience and a nurse practitioner needs only two. Can the minister explain the rationale for the difference between those two professions and why one needs 10 years’ medical experience and the other needs only two?

**The CHAIR**: Members, I think the amendment has been circulated in written form. Hon Nick Goiran has moved —

Page 33, lines 11 to 15 — To delete the lines.

**Hon ALANNAH MacTIERNAN**: I have not spoken very often, but I want to say that I feel really strongly about this provision, particularly as someone who has special responsibility in regional Western Australia. In Western Australia, we have seen the position of nurse practitioner thrive and prosper. There are far more nurse practitioners in Western Australia than in any other state of Australia and they form an absolutely critical role throughout regional Western Australia. It was a very, very sound choice to encode within this legislation the role of nurse practitioner being able to administer this medical assistance in these remote communities. There are very formal processes that will require two doctors but, at the end of the day, in many of these remote communities, the nurse practitioner has a very personal role with those communities. As I say, the whole development of that class of highly experienced nurses who are able to step up to the next level has proved to be a great success across Western Australia, including in Perth. It is a very important provision within this legislation that says that Western Australia is very different from Victoria. It is a much bigger state. We have a very considerable cohort of nurse practitioners, who have developed a great deal of acceptance in our community. I think it is perfectly appropriate that we allow them this role as administrators of this medical assistance.

**Hon ALISON XAMON**: I rise to indicate that I will not be supporting this amendment. I want to echo a lot of the comments of Hon Alannah MacTiernan. In addition, I would like to say that this amendment underestimates the
degree of expertise our nurse practitioners bring to the medical profession these days. This is a profession that is highly professional. It is also a profession consisting of people who are often, in some ways, better qualified than doctors to perform a lot of the tasks they do. I have had the privilege of working with nurses in a number of capacities over a number of years. I am aware that very often, the senior nurses have a far greater level of expertise than even a lot of junior doctors. I think it is really important to keep this provision to facilitate services appropriately to the regions. It is also important because it is recognition of just how senior these medical practitioners are.

Hon STEPHEN DAWSON: I agree with Hon Alison Xamon. Hon Nick Goiran is mischaracterising the abilities and skills of nurse practitioners. It is well within their skill set to carry out the administering role. A nurse practitioner has to have at least two years post-registration, but prior to that, to even become a nurse practitioner, a registered nurse must have 5000 hours of advanced clinical experience. The issue was canvassed by the Ministerial Expert Panel on Voluntary Assisted Dying. At page 59 of its final report, it states —

The Panel examined existing examples of collaborative models of medical practitioners working with nurse practitioners, including examples in aged care and end of life settings. In Canada, this extends to inclusion in medical assistance in dying … where nurse practitioners can be involved in all aspects of the process (including administration of intravenous medication for the purposes of voluntary assisted dying) and accounts for 6–7% of all cases.

The Panel’s view was that nurse practitioners’ extensive training and scope of practice would enable them to function effectively in this role and would add to the provision of appropriate access to voluntary assisted dying across Western Australia.

A similar view was explored in the submission by the Western Australian branch of the Australian Medical Association, which states in part —

The AMA (WA) contends that doctors do not necessarily need to be involved in the administration of lethal medication and where self-administration is not possible, another nominated person or health practitioner could administer the medication.

I indicate again that we are not supportive of this amendment.

Hon MARTIN PRITCHARD: I have been trying to follow this; I think I am getting a bit brain dead!

In the interpretation division at the front of the bill, under “Terms used”, I am just wondering why “nurse practitioner” is not included within “administering practitioner”. Although it says “unless the contrary intention appears”, it seems to be a bit of an oversight. If it is intended that a nurse practitioner is to act as an administering practitioner, I would have thought it would be included in the interpretation.

Hon STEPHEN DAWSON: Under “Interpretation”, clause 5(b) refers to —

a person to whom the role of administering practitioner is transferred …

That person can be both a nurse practitioner or another medical practitioner.

Hon MARTIN PRITCHARD: I understand that if it is actually going to be a nurse practitioner, a transfer form will need to be filled out.

Hon STEPHEN DAWSON: For another nurse practitioner or another medical practitioner, a form will need to be filled out.

Hon MARTIN PRITCHARD: The clause envisages the coordinating practitioner as being the administering practitioner. If they then get a nurse practitioner to fulfil that role, will a form need to be filled out, as suggested in clause 16(2)?

Hon STEPHEN DAWSON: It could have been included in clause 5, but it is not needed because of the way clause 53 is worded.

Hon MARTIN PRITCHARD: Actually, I do not have a problem with the nurse practitioner fulfilling the role. I just wanted to make sure; I was trying to go through the bill and the amendments. The nurse practitioner would obviously have the right to refuse as a conscientious objection, I presume?

Hon Stephen Dawson: By way of interjection, they would.

Hon RICK MAZZA: I did not get an answer to the question I asked earlier about the rationale behind a nurse practitioner requiring only two years’ experience, whereas under clause 16(2) a medical practitioner requires 10 years’ experience.

Hon STEPHEN DAWSON: The member referred earlier to a general practitioner. A general practitioner is captured by clause 16(2)(a), which provides for a medical practitioner who —

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 …
That would be a general practitioner. Sorry, that clause has been amended, so it is clause 16(2)(a)(i), which is the same as the previous clause 16(2)(a). I had a conversation earlier with the Leader of the House, Hon Sue Ellery, about the suggestion of having a large bill, and that was a good suggestion for future bills. I will certainly take that issue away and encourage that to happen in the future, if it is possible. I think the Clerk advised that work would need to be done by parliamentary counsel, but we will work that out.

Hon Martin Aldridge interjected.

Hon STEPHEN DAWSON: Honourable member, I am indicating that I think it was a good suggestion. I am happy to take it away and see if it might be able to happen in the future.

A nurse practitioner needs to have two years’ experience as a nurse practitioner, but they also must have completed an approved postgraduate master’s degree. In Australia, a 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. That is a significant amount of training that needs to take place.

Hon Nick Goiran interjected.

Hon STEPHEN DAWSON: It is a significant amount of training, and we are suggesting—as others have, indeed, suggested—that it would be appropriate for a nurse practitioner to undertake this role.

Hon MARTIN ALDRIDGE: I refer to a point raised by Hon Rick Mazza with regard to the differential between years of service. The point Hon Rick Mazza raised is that there is a distinction between a practitioner who is assessing a patient, either as a coordinating practitioner or a consulting practitioner, and a practitioner who is administering. This practitioner is not someone who is assessing the patient to make sure they are eligible under the legislation; they are performing a very different function.

Hon STEPHEN DAWSON: The member is correct, but they are still capable of assessing decision-making capacity.

Committee interrupted, pursuant to standing orders.

[page 9552]

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Dr Steve Thomas) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 53: Eligibility to act as administering practitioner —

Committee was interrupted after the amendment moved by Hon Nick Goiran had been partly considered.

The DEPUTY CHAIR: Honourable members, we are dealing with the Voluntary Assisted Dying Bill 2019, it might surprise you to learn. We are currently on clause 53 and dealing with an amendment moved by Hon Nick Goiran; that is —

Page 33, lines 11 to 15 — To delete the lines.

It seeks to delete clause 53(1)(a)(ii).

Hon NICK GOIRAN: At some point, the debate so far seems to have evolved into a contest about who loves nurse practitioners most. I want to make it clear to members that that is not the point of this amendment. The point of this amendment is that we know from the evidence taken at the inquiry that decision-making capacity is inherently complex. We know from the evidence given by the Chief Psychiatrist that the stakes cannot be any higher than a decision made at this point. We also know that the Chief Psychiatrist provided this information to the special adviser on 14 November —

- Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate …

In moving this amendment, I am seeking the highest standard possible. Decision-making capacity is best done by those practitioners. There was an opportunity during the select committee inquiry, with the ministerial expert panel and the special adviser as recently as 14 November to ascertain any different view from that of the Chief Psychiatrist. That has not been provided, so in the absence of that, this is the best evidence before us.

Hon AARON STONEHOUSE: I seek clarification. Clause 53(1)(a)(ii) states —

a nurse practitioner who has practised the nursing profession for at least 2 years as a nurse practitioner and meets the requirements approved by the CEO for the purposes of this subparagraph;

That is very similar language to that used in clause 16(2)(a) and (b) in that there are some requirements approved by the CEO for the purposes of those paragraphs. What will be the requirements approved by the CEO for nurse practitioners?

Hon MARTIN ALDRIDGE: I want to indicate that I will not support the amendment moved by Hon Nick Goiran. Members will be aware that in its final report, the ministerial expert panel recommended that in addition to
what is in the bill, the consulting practitioner could also be a nurse practitioner, which is obviously a position the
government did not accept around the settings of this bill. When we reflect on the members of the ministerial
expert panel, from my cursory look, seven of them have specialist or extensive medical expertise. Although
I did not write down the number of nurse practitioners operating in regional Western Australia—I think the
majority are probably in metropolitan regions—I think there has been significant growth and opportunity for
nurse practitioners to play a much more significant role than they do in the delivery of medical care across
Western Australia. Indeed, we need only travel to Canada and the United States to see the breadth of scope that
nurse practitioners play in those countries. Nurse practitioner anaesthetists and nurse practitioner surgeons are
playing very active roles in medicine in North America. Although I am not convinced that nurse practitioners
will necessarily play a big role in the early delivery of voluntary assisted dying, I think they will have a role to
play in future years as we see more nurse practitioners practising. One of the difficulties for nurse practitioners
is finding a job that recognises their skills and expertise once they qualify. For those reasons and reflecting on
the recommendations of the ministerial expert panel, I am quite satisfied with retaining nurse practitioners as
administering practitioners under the bill.

Hon AARON STONEHOUSE: I am still waiting for an answer from the minister about what the requirements
will be, as approved by the CEO, for nurse practitioners under clause 53(1)(a)(ii).

Hon STEPHEN DAWSON: I am still seeking that advice; I am very happy to provide it to the honourable member.
With regard to the figures referred to by Hon Martin Aldridge, I indicated that there are currently 248 nurse
practitioners in WA, 43 of whom are practising in WA country health regions. That is just for the member’s information.
In answer to Hon Aaron Stonehouse’s question, the bill requires all coordinating and consulting practitioners to have
undertaken approved training prior to conducting any assessment. Only medical practitioners who have successfully
completed the training will be able to take on the role of coordinating or consulting practitioner. The bill also
requires all administering practitioners—medical and nurse practitioners—to have undertaken approved training prior
to conducting the role of an administering practitioner. Only practitioners who have successfully completed the
training will be able to take on the role. The training for practitioners will be developed during the implementation
period, in consultation with professional bodies and medical experts. More specifically, and in line with the
Ministerial Expert Panel on Voluntary Assisted Dying’s recommendations, the training shall include the following
key competencies: an overview of the legislation and its ethical and legal implications for practitioners; evidence
of knowledge of best-practice palliative care; cultural competency, including understanding the perspectives of
people from different beliefs and faiths; guidelines for end-of-life discussions; provision of support for families,
or where to refer them for support; details of the voluntary assisted dying process, including the obligations of the
practitioner at each stage; assessment, including eligibility, decision-making capacity, voluntariness and identifying
coercion, particularly as it relates to groups such as people with disability or mental health issues; pharmacology
and administration of the voluntary assisted dying substance; documentation and reporting requirements; death
certification; and access to psychological and peer or mentoring support.

I will leave that there. That is covered under clause 158, so perhaps if the member has further questions on that,
we can deal with them when we get to that clause.

Hon AARON STONEHOUSE: I am keen to talk a little bit more about the training requirements for the various
practitioners because they are relevant to consideration of this amendment. The minister outlined what will be
included in the training, and it was pretty comprehensive. Will there be training for administering practitioners
that is directed specifically to their role? For instance, they do not necessarily need to know about all the steps in
the process; their role in all this is fairly narrow. I have no doubt that nurse practitioners are very competent and,
in many cases, perhaps more competent than doctors in some regards, when it comes to, for example, administering
intravenous therapy. From my experience, their bedside manner is certainly better. My concern is about assessing
capacity. Will there be different training for nurse practitioners acting in administering practitioner roles, that
perhaps focuses on capacity assessment? Let us keep in mind that the nurse practitioner, as the administering
practitioner, will come in at the end of this process. They have not been involved since day one, when the patient
went into a doctor’s practice and asked for voluntary assisted dying. They do not have that relationship or rapport
with the patient at this point. Their responsibilities are merely transferred to them by a coordinating practitioner.
Can the minister give me any comfort that the training required would address the very different role that the
administering practitioner would have in this instance?

Hon STEPHEN DAWSON: Nurse practitioners will be trained to know and understand the entire process, but
also will be provided training to enable them to carry out their obligations under the bill.

Hon AARON STONEHOUSE: It is a bit tough for me, because I do not know what will go into that training. I
understand that we will obviously have an 18-month implementation phase during which the training will be
developed. It is very difficult to look at this amendment and consider whether it is appropriate for a nurse practitioner
to act as an administering practitioner when we do not know what will go into the training and qualification of the
people who will act in that role. I appreciate that the minister cannot really tell me too much at this point, but it

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does make it very difficult indeed to make a decision about the merits of this amendment. The role of the administering practitioner is fairly narrow. Some risk is involved. However, unless we are contemplating some kind of conspiracy and collusion between coordinating, consulting and administering practitioners, I think the risk is relatively small.

With regard to the amendment put forward by Hon Nick Goiran, I am not sure that nurse practitioners need to be removed at this point. I am close to being convinced, but I am not quite there yet. Therefore, in this instance, I will not be supporting the amendment. I will be very keen to see what we can tease out when we get to the guidelines and the training that is involved for the various practitioners, because I am still not completely comfortable with what may or may not go into the training for those practitioners. I will not be supporting the amendment at this time, because I am not completely comfortable with this yet. I am not sure whether it is necessary to go as far as removing them entirely.

Amendment put and negatived.

Hon NICK GOIRAN: There is an amendment standing in my name at 468/53. I thank the honourable minister for drawing to my attention a more refined way of drafting this particular amendment. Therefore, I move the following, which is a slight variation of that amendment —

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.

By way of brief explanation, members will see that in my amendment 468/53, subparagraphs (i) and (ii) both start with the word “they”. That is lifted to the end of limb (d). There is also some movement of the word “and”. It is merely a drafting difference. Otherwise, the substance of the amendment is identical to 468/53 and has been moved for the same reasons as we have moved similar amendments earlier.

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment, for the reasons outlined by Hon Nick Goiran.

Amendment put and passed.

Hon AARON STONEHOUSE: I want to make some comments generally on this division, and I think clause 53 is the appropriate place to do so. Perhaps the minister can give me some insight into the rationale behind making a provision for an administering practitioner. I apologise if this was canvassed in the debate on clause 1—I do not recall it being canvassed, but the Victorian legislation and our own is based on the Oregon legislation. In my consultation with stakeholders, I was advised that there is no administering practitioner in Oregon; there is instead only self-administration of a voluntary assisted dying substance. When I was engaging with stakeholders, I asked them how that works, because it was put to me by advocates of this bill and of having an administering practitioner that there may be people who have various illnesses or diseases that will prevent them from being able to self-administer. The stakeholders advised me that if someone in Oregon has lost function of their arms, they can be given a straw to use to drink a voluntary assisted dying substance, and that if someone has some difficulty with swallowing, they can be given a stomach pump, which they probably would be using already to take food and water. They could insert the voluntary assisted dying substance into their stomach pump and receive it that way. There were several other methods to self-administer voluntary assisted dying substances, regardless of someone’s impairment.

Given that the Oregon regime does not allow for practitioner administration and has been operating for quite some time now, where is the need for us to allow for practitioner administration? Was the Oregon situation examined and considered? Is there a situation that I am not aware of in which practitioner administration is the only option? I am concerned that practitioner administration could become something that is taken up by patients because it is easier and more comfortable for them, rather than because it is a medical necessity. That may certainly be their right, but if the intention is that it is there not as a rule but as an exception for medical circumstances, then it is a little concerning to me that, from my examination of the bill, it seems that anyone who is uncomfortable with self-administration can apply for a practitioner to administer a voluntary assisted dying substance for them. If patients are going down the route of practitioner administration because they are more comfortable with that, it really calls into question their conviction to some extent. Is this really what someone wants if they are unable to take that final act for themselves and would rather somebody else do it for them? I may be wrong in my assessment, but I am really interested to hear what the minister has to say on this, because it is something that has concerned me ever since I learnt of the provision for practitioner administration.

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Hon STEPHEN DAWSON: I am not sure what the honourable member’s question was in relation to that, so perhaps I can make some comments, unless there is something further that he requires. What I got from what he just said is that he has concerns with it. I am not sure whether he asked a particular question, but I indicate that, yes, there are circumstances in which a patient cannot self-administer. It could be to do with a person’s disability, for example, but it could also be to do with health conditions.

Hon Simon O’Brien: With cancer of the oesophagus or something, it might be a little difficult.

Hon STEPHEN DAWSON: There are examples. Certainly, someone could have a disability or a health condition that precludes them from self-administering.

In relation to why a dual system was included in the bill—that is, self-administration and practitioner administration—it is my advice that the public consultation that occurred in Western Australia supported a system that included both self-administration and practitioner administration.

Hon NICK GOIRAN: That is not surprising at all. In fact, it goes to the very point that the honourable member is making. When practitioner administration is available, people choose it, and the data supports that. The two jurisdictions that I draw to the member’s attention are Oregon and Canada. As the member has quite rightly pointed out, Oregon does not allow practitioner administration. In Oregon, it is the assisted suicide regime and the person has to take the poison themselves. But in Canada, practitioner administration is permitted. I know that there was a lot of discussion about data earlier. In Oregon, deaths by assisted suicide accounted for 0.46 per cent of all deaths in 2018, so half a per cent of all deaths in Oregon were by way of this regime. When that is compared with the rate in Canada, which allows the two methods, the rate jumps up. In Canada, if we exclude Quebec, for the period from January to October 2018, on that data, the rate was 1.47 per cent, but if we include Ontario, the rate was 2.04 per cent and if we include Quebec, the rate was 1.9 per cent. This is the information from 2018–19. Every time we look at the data in those jurisdictions, we see a very significant jump. The best way to understand and explain that is exactly as Hon Aaron Stonehouse has identified: it is because when those options are made available, people end up going towards practitioner administration.

In another example that I can give members, notwithstanding the incorrect information that the Minister for Health provided to the member for Hillarys in the other place on 17 September 2019, I was very interested to see the dialogue between those two members and the response from the health minister suggesting that 95 per cent of patients in Canada choose the practitioner-administered version. I thought that I would check that and it was actually 99.88 per cent. Almost everybody in Canada chooses it. Of the 5,085 deaths that occurred in the period 17 June 2016 to 31 October 2018, 5,079 occurred by physician administration, while only six occurred by self-administration. That goes exactly to the point that the honourable member is making.

Hon AARON STONEHOUSE: I thank the minister and I thank Hon Nick Goiran for giving a little bit of information. Perhaps rather than discussing the policy of having an administering practitioner, I might focus my questions on the criteria for practitioner administration. I think those questions might be more appropriate when we get to clause 55. I flag that I will have a little more to ask about it when we get to that clause.

Clause, as amended, put and passed.

Clause 54: Application of Division —

Hon NICK GOIRAN: Looking at the bill, it seems to me that administration of schedule 4 and schedule 8 poisons may take place once the final review form has been completed but not necessarily lodged with the board. As the coordinating practitioner will have two days to lodge a copy of the final review form with the board under clause 50(4), is it possible that these schedule 4 and schedule 8 poisons can be administered and the patient’s death occur before the board has even received the final review form?

Hon STEPHEN DAWSON: I am advised that it is technically possible, but it would be in very rare circumstances.

Hon NICK GOIRAN: Why would it be so rare? The final decision would have been made and the patient would have let the practitioner know, so they would want to get on with it. The next thing that would need to happen is to make an administration decision. That could certainly happen on the same day. Why would the practitioner and the patient not do that as part of an ongoing conversation? It is highly unlikely that after the final assessment has been done, the practitioner and patient would go away, spend some free time apart, and then come back and say that they should continue this process. That is highly unlikely. It is much more likely and far more probable that this would be part of an ongoing conversation. If they made the administration decision and the patient said, “Let’s get cracking because I have made my final decision”, the coordinating the practitioner would say, “Yes, no problem. Let’s facilitate all this and go off to the pharmacist and make sure that you’ve got the substance”—and presto! Meanwhile, the board would know nothing about it.

I am really concerned about this. A properly constructed safeguard would ensure that administration could not take place until the board had been informed of the final review. It makes a mockery of the narrative that somehow the board will perform a tremendous oversight role when the final review form has not even been provided to it and the patient is dead. At that point, the board would be able to do nothing. I asked the minister earlier about remedies.

Extracted from finalised Hansard
He indicated that remedies would be available only if the patient were alive and that once the patient was dead, no remedies would be available to him or her. The minister indicated that there would be nothing for the patient’s family. This is totally unsatisfactory. Clearly, a properly constructed safeguard needs to be put in place somewhere in part 4. I do not really mind where in part 4 the government wants to put it—the resources of government can be used to find that—but clearly a safeguard needs to be put in place so that the substance could not be taken, either by practitioner administration or self-administration, at least until the board had been informed of the final review. Is that something that the government would be willing to take on?

Hon STEPHEN DAWSON: We do not propose to make that change. I said that it was technically possible because time would still be needed to prescribe and supply the substance. They would still have to make an administration decision and, as I said, dispense the medication. They may need to appoint a contact person and forms may need to be completed. It is unlikely, but it could happen. As I said in answer to Hon Nick Goiran’s question, it is not an amendment that we propose to make.

Hon NICK GOIRAN: The whole point of having a house of review is to look at these unlikely scenarios because they could happen. When the minister says that it is unlikely but it could happen, that is exactly why we are here. If it was not likely and it could not happen, we would not need to have this discussion. It is our job to make sure that if there are any cracks or gaps in this legislation whatsoever, we plug them. The stakes could not be any higher than that. I know that we will recess at some point this evening, but I hope that cooler heads in government will take this on and realise it is entirely inappropriate, even for members who are supportive of this legislation. I would really love someone to explain to me why it is appropriate for us to leave this gap. We have identified it. The minister says that it is a technical possibility that is unlikely to happen, and we will leave it. Let us quickly make sure that we get this all done. We all know this bill will be passed in its entirety in the specified time line, by the end of next week. If that is the goal, why would we not spend a moment to plug this gap? Are we just happy that the board will have no role? The patient will already be dead. The board will know nothing about the final review form and nothing will be able to be done. That should trouble members, irrespective of where they sit on this bill. I hope the government will take this matter on board in the coming days.

Clause put and passed.

Clause 55: Administration decision —

Hon NICK GOIRAN: I notice that the practice guidelines that were issued in the Netherlands in 2012 include at page 14 —

It is of the utmost importance that the patient is not conscious of the effects of the neuromuscular blockers administered … The medication and dosages included in these guidelines ensure that the risk of an insufficiently deep and insufficiently long-term reduction of consciousness is extremely low. However, the possibility exists that the coma induction medication has unknowingly been administered partly periveneously, which will result in a failure to achieve the desired effect.

Is this one of the risk factors that the coordinating practitioner and the patient will discuss when deciding whether to make a self-administration or practitioner administration under clause 55(1), given that what we are talking about here is death by asphyxiation?

Hon STEPHEN DAWSON: We cannot speak specifically to the risks associated with the Netherlands legislation. The medical protocol that will be used in Western Australia will be specifically considered by the clinical panel in Western Australia.

Hon NICK GOIRAN: I am not surprised because, unfortunately, none of the so-called consultation that has happened over the last two years has looked at this stuff. We had a yearlong inquiry by the Joint Select Committee on End of Life Choices, and it did not bother to look into any of this. The panel of so-called experts that the government put together has not looked into this either, and now we find ourselves in a situation in which we are about to pass legislation and we are told that it will be looked at in the next 18 months. Picking up on the theme provided by Hon Aaron Stonehouse earlier, is it the expectation of the government that allowing patients to choose practitioner administration will impact on the rates of voluntary assisted dying in Western Australia so that we will see rates higher, in comparison with Victoria where practitioner administration is restricted?

Hon STEPHEN DAWSON: Can the honourable member ask that question again, please?

Hon NICK GOIRAN: This is really following up on the issues raised by Hon Aaron Stonehouse earlier. I will just pause for a moment to say, and this is not a criticism of the minister, that earlier today the Minister for Health criticised me and others for asking repetitive questions, and this is not the first time that I have had to genuinely repeat the question at the request of the minister. That is not a criticism; that is just me having a crack at the Minister for Health.

Hon Stephen Dawson: I want to make sure that we give you an answer to your question, so if it is appropriate, I will do it.
Hon NICK GOIRAN: I appreciate it. I only wish you were the Minister for Health.

Is it the government’s expectation that allowing patients to choose practitioner administration will impact on rates of voluntary assisted dying in our state, such that we will see higher rates of voluntary assisted dying compared with Victoria, where practitioner administration is restricted?

Hon STEPHEN DAWSON: We cannot speculate on that.

Hon NICK GOIRAN: 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 … is inappropriate …

Can we be assured that this clause will not result in a coordinating practitioner steering a patient into practitioner administration based on their own views of what method is preferred?

Hon STEPHEN DAWSON: This clause is not about steering; it is about good clinical decisions and conversations between the practitioner and the patient. It will follow the constraints of good medical practice and, of course, there will be training in relation to this issue too.

Hon NICK GOIRAN: Referring to clause 55(2), I am interested in what type of method is going to be, if you like, recommended by the practitioner given that practitioner administration can be made only if the practitioner has advised the patient that self-administration would not in effect be appropriate because they have some concerns, as can be seen at clause 55(2)(c), about “the method for administering the substance that is suitable for the patient”. I am interested to know what preferred methods the government intends to recommend to practitioners as part of the guidelines and the training process.

To give context, when we look at the experience in a couple of other jurisdictions, specifically the Netherlands and Canada, we learn this. The Netherlands guidelines state —

Once the patient drinks the drink, the barbiturate is resorbed by the gastrointestinal tract. The faster the resorption, the higher the peak level. If the resorption rate is too slow, then a redistribution of the barbiturate will take place, resulting in an insufficient peak level. As a result, the patient fails to lapse into a coma or can come out of a deep coma.

Even when anti-emetics are administered, the foul taste of the drink can sometimes cause vomiting. As a result, the whole dose is not taken. Another possible problem is that many patients use opioids at the end of their lives. Opioids result in slower gastrointestinal transit, which can mean it takes the patient longer to lapse into a coma.

Due to the aforementioned unpredictability, this method is not the preferred method.

That is what the Netherlands guidelines say. Contrasting that with Canada, its “Fourth Interim Report on Medical Assistance in Dying in Canada” states that Quebec’s legislation permits only clinician-administered MAID. MAID is of course its acronym for medical assistance in dying. In that context, minister, will some guidance be provided to practitioners about the preferred method?

The CHAIR: What we are talking about now clearly sits within clause 57, not clause 55, but because we have invested a certain amount of time already in this, I will allow the minister to respond at this point so that we do not lose continuity. I want to try to keep members on the actual specifics of individual clauses. That is what the Committee of the Whole House expects me to do and that is what I will try to do.

Point of Order

Hon NICK GOIRAN: I seek clarification. My question relates to the method for administering the substance, which is at clause 55(2)(c); whereas clause 57 deals with self-administration. If I have misspoken in any way, minister, I want to be clear that I am not speaking at all about self-administration; I am interested to know about the methods recommended by the government as outlined at clause 55(2)(c). I apologise if I have confused the chamber.

The CHAIR: Member, I do not think there is a point of order, but I hear your explanation. I do think that clause 57, “Self-administration”, which canvasses a range of matters, including self-administration and handling of the substance and so on, is a more appropriate place for this specific question. Nonetheless, it does receive a mention in clause 55(2)(c) as something that a practitioner would have regard for in providing advice, but it is not specifically about methods of self-administration. Be that as it may, I am not the minister at the table anyway, and we are proceeding with it.

Committee Resumed

Hon STEPHEN DAWSON: Thank you very much, Mr Chairman. You may not be the minister, but, of course, you are a very important part of this evening’s proceedings, so we take on board your advice.

Hon Nick Goiran, advice will be provided to practitioners about the appropriate and approved protocols, but we are not recommending self-administration or practitioner administration.

Extracted from finalised Hansard
Hon NICK GOIRAN: I have two further questions on clause 55 before I move the amendment standing in my name. The first question relates to clause 55(3), which invokes a scenario in which a clause 55 administration decision can be made via proposed section 156. If that were to occur, what impact would section 474(29)(a) and (b) of the commonwealth Criminal Code Act have?

Hon STEPHEN DAWSON: Conversations between the patient and the practitioner need to be in person.

Hon NICK GOIRAN: I take it that an administration decision cannot be made in accordance with proposed section 156(2)(a), so should we be deleting that part of subclause (3)(b)?

Hon STEPHEN DAWSON: This is a futureproofing clause.

Hon NICK GOIRAN: If a practitioner or a patient who does not understand that this provision is in the legislation for futureproofing were to proceed to make the clause 55 request under proposed section 156 and were to fall foul of that, what would be the penalty?

Hon STEPHEN DAWSON: There is no penalty for the patient.

Hon NICK GOIRAN: What would be the penalty for the practitioner?

Hon STEPHEN DAWSON: The practitioner will be trained as part of the implementation phase in relation to this issue.

Hon NICK GOIRAN: I will be moving to amendment 207/55 in a moment, but I have one further question. I make this observation on clause 55(3)(b). A practitioner could overlook that or maybe miss that part of the training. They are physically but not mentally present for that moment in the training. Hon Martin Aldridge has returned to the chamber from urgent parliamentary business and would be very interested in this discussion, because he has been pursuing the government for an extended time for advice on this issue. I draw to the attention of members that we have just learnt that clause 55(3)(b) has words in it to do with clause 156, which are in there for futureproofing, according to the government. When I asked what the penalty would be if an administration decision was made effectively by Skype or over the phone, I was told that apparently there would be no penalty for the patient. When I asked what the penalty would be for the practitioner, I was told that the practitioner would be shamed. I think that is just by way of an indication by the minister that actually they are going to breach commonwealth law, because we are going to leave clause 55(3)(b) unamended at the request of the minister, who wants it in there for futureproofing purposes. My final question on clause 55, before I move the amendment standing in my name, is: I note that clause 41 requires the patient's written declaration to be witnessed by two eligible witnesses; why does clause 55 not also include a requirement that the patient’s administration decision be witnessed?

Hon STEPHEN DAWSON: It would be part of the medical consultation between the practitioner and the patient.

Hon NICK GOIRAN: I move —

Page 34, line 22 — To insert after “assisted” —

dying

Hon STEPHEN DAWSON: I indicate that we are supportive of this amendment. I have been advised that it was a typographical error and it makes perfect sense to include, and I am grateful for Hon Nick Goiran moving this amendment.

Amendment put and passed.

Hon AARON STONEHOUSE: I was just looking at the Hansard transcript of the debate in the other place on this clause. I wonder whether the minister can confirm for me my suspicion of what I have gathered from the discussion that took place down there. The language used in clause 55(1) is —

The patient may, in consultation with and on the advice of the coordinating practitioner for the patient —

(a) decide to self-administer … or

(b) decide that a voluntary assisted dying substance is to be administered to the patient by the administering practitioner …

This sounds like there is no requirement for a medical basis for that decision to be made, that it is merely a decision that a patient and a practitioner come to through some kind of discussion or consultation, but there is not actually a need for some kind of medical or physical impairment in the patient that requires them to have that substance administered by a practitioner. And I correct in that assessment?

Hon STEPHEN DAWSON: There is no physical requirement.

Clause, as amended, put and passed.

Clause 56: Revocation of administration decision —

Progress reported and leave granted to sit again, on motion by Hon Stephen Dawson (Minister for Environment).
Legislative Council
Friday, 29 November 2019

VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 28 November. The Deputy Chair of Committees (Hon Matthew Swinbourn) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 56: Revocation of administration decision —

Progress was reported on clause 56.

Hon NICK GOIRAN: Although clause 56 rightly provides for the revocation of an administration decision by the patient, the clause is silent on what is to be done if a self-administration decision has been made and the patient has obtained and is in possession of a voluntary assisted dying substance. What is required to be done with the approved poison if the patient is already in possession of that substance and their self-administration decision is revoked?

Hon STEPHEN DAWSON: The substance must be returned. It can be returned to the coordinating practitioner, or the contact person or authorised disposer can return it.

Hon NICK GOIRAN: Where is that provided for in the bill?

Hon STEPHEN DAWSON: I am advised the issue is covered under clauses 66(1)(d) and 104.

Hon NICK GOIRAN: Clause 66(1)(d) is a reference to a contact person and clause 104 is also referenced to a contact person. Moments ago, the minister mentioned three options: it could be the coordinating practitioner, or a contact person, and I think the third category or class of person that the minister referred to was an authorised—

Hon Stephen Dawson: Disposer.

Hon NICK GOIRAN: An authorised disposer. The two clauses that the minister just referred to me deal only with the contact person. Where in the bill are the first and the third classes of persons provided for?

Hon STEPHEN DAWSON: Clause 74 relates to “Disposal of prescribed substance by authorised disposer”.

Hon NICK GOIRAN: What about the coordinating practitioner?

Hon STEPHEN DAWSON: That is in clause 76.

Hon NICK GOIRAN: If the patient’s contact person is expected to return the poison after the patient’s revocation of the administration decision, how will that contact person be made aware that the patient has revoked their decision?

Hon STEPHEN DAWSON: The patient may inform the coordinating or administering practitioner of the decision to revoke their administration decision and the contact person can be made aware in a number of ways—namely, in writing, verbally, by gestures or by other means of communication available to the patient.

Hon NICK GOIRAN: Clause 56(2) provides that a patient may inform the coordinating practitioner or administering practitioner that they have revoked their self-administration decision, but there is no mention there of the contact person or the authorised disposer. The minister mentioned those three classes of people earlier; it seems as though only one of those classes is covered at clause 56(2). Can the minister clarify that?

Hon STEPHEN DAWSON: The coordinating or administering practitioner, or, indeed, the board, can follow-up with the contact person.

Hon NICK GOIRAN: There is no obligation, as I see it, on the part of the patient to inform anyone of the revocation; it is merely discretionary. They “may” let people know that they have revoked their decision. Is there any requirement in the bill for the coordinating practitioner to follow-up with a patient who has made a self-administration decision, or is the patient issued with the substance and they can store it at home for potentially months until they choose to self-administer, without any follow-up care from their coordinating practitioner? How does the bill deal with that situation?

Hon STEPHEN DAWSON: There is no requirement. Self-administration will take place at a time of the patient’s choosing. Stipulating a time frame for keeping the medication at home risks coercing a patient into taking the substance sooner than they would otherwise choose to.

Hon NICK GOIRAN: Minister, I agree entirely. I have not suggested that in any way. The issue that I have is whether there will be any follow-up by the coordinating practitioner. I do not even want the patient to take the substance, but, be that as it may, that is just my view. The point is that some follow-up care should be provided by
the coordinating practitioner and it is not clear that that is the case. I agree with the minister that the bill does not specify a time limit. For example, there was a time earlier in the debate when I thought to myself that the practitioner would actually say to a patient, “You are going to die within the next six months.” One part of me thinks that it is really quite improper for the patient to then take the substance seven, eight, nine or 12 months afterwards because that is an indication that the doctor got the prognosis wrong. However, there is no solution to that that I can see. I am the last person to want to suggest putting in a time limit here. As the minister says, that could coerce a patient to say, “Look, I’m getting close to the six-month mark. The doctor said I only had six months to live, so I’d better take this poison before it expires.” I do not want that, so I agree with the minister. But that is not what I am talking about; I am talking about when the substance is at the patient’s home and the doctor does not know what is going on once the substance has been prescribed. In order to know whether or not there has been a revocation, will the coordinating practitioner conduct a routine follow-up? This is not a simple issue because, equally, I do not want to see the practitioner also subtly coercing or encouraging the person to take the substance. It is a very complex, tricky situation of providing care for a person while making sure that there is no implied coercion. I am wondering what consideration has been given to walking that very fine line.

Hon STEPHEN DAWSON: There is no obligation in the bill to do a follow-up, but the usual doctor–patient relationship would entail following up with a dying patient. The doctor and other health professionals would have roles in the patient’s care.

Hon NICK GOIRAN: Thanks, minister. I do have an amendment standing in my name, but it is after those by another honourable member, so I will wait to see what happens with those amendments before I move my amendment 88/56.

Hon RICK MAZZA: The amendments standing in my name at clause 56, being 417/56, 418/56 and 419/56, are consequential amendments. Perhaps they could be retained on the supplementary notice paper until we deal with the substantive one.

The DEPUTY CHAIR: The member’s comments are noted. The proposed amendments remain on the supplementary notice paper if the clause is recommitted. The next amendment is that of Hon Nick Goiran, 88/56.

Hon NICK GOIRAN: I move —

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;

Briefly, by way of explanation for members, this amendment is similar to the amendments that I moved to clauses 28 and 49. This amendment requires revocation forms to also include whether a patient was assisted by an interpreter in revoking an administration decision. As members will be aware, clause 160(1) provides that an interpreter can assist a patient in relation to the process for accessing voluntary assisted dying under part 4, and clause 160(2) provides for the accreditation requirements of the interpreter and mandates certain independent standards of the interpreter, such as that the interpreter cannot be a family member of the patient, a beneficiary under the patient’s will, an owner or manager of a health facility in which the patient is being treated or resides, or a person directly involved in providing health services or professional care services to the patient. This amendment to clause 56 requires the name, contact details and accreditation details of the interpreter to be included in the revocation form, and I seek the support of members.

Hon STEPHEN DAWSON: I am happy to indicate to honourable members that the government is supportive of this amendment. I am of the view that it strengthens the bill, consistent with earlier agreed amendments.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 57: Self-administration —

Hon MARTIN PRITCHARD: I note that Hon Adele Farina has foreshadowed an amendment to this clause, so I just want to speak to that for a moment.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, the amendment has not been moved. Normally, we would not speak to the amendment until it has been moved, and it may not be moved by the member. The question before the chamber is that clause 57 stand as printed, not as amended.

Hon NICK GOIRAN: I have some broad questions on clause 57, before we consider some of the very significant matters set out on the supplementary notice paper. In fact, I note that there are five very significant matters on the supplementary notice paper at clause 57 and I look forward to us considering them in due course.

We know that self-administration is available in certain jurisdictions, and a debate took place yesterday about the Oregon model in particular, where self-administration is really the only way to go forward. For example, the “Fourth Interim Report on Medical Assistance in Dying in Canada” tells us that practitioner administration is the
preferred method of administering medical assistance in dying in Canada. I understand from the fourth interim report that only 0.12 per cent of patients have self-administered in that jurisdiction; in other words, more than 99 per cent of patients have chosen practitioner administration. Page 8 of the report also informs us that Quebec’s legislation permits only clinician-administered medical assistance in dying.

I know that the government partly funded Dr James Downar to come to Western Australia to, I think, brief the government but certainly to brief members. Did the government have an opportunity to consult with that individual on why self-administration is not permitted in Quebec; and, if so, what advice was received? Further to that, did the government also have the opportunity to ask him why self-administration rates are so low in Canada? I am interested to know why, in the Canadian experience, more than 99 per cent of patients chose practitioner administration and a mere 0.12 per cent of patients chose self-administration. This follows on from some of the dialogue that took place yesterday between the minister and Hon Aaron Stonehouse about a patient’s decision to choose one method over the other. What type of advice did the government obtain from Dr Downar, whom the government funded to come to Western Australia?

Hon Stephen Dawson: Dr Downar met with the ministerial expert panel and I am advised that the outcome of the discussion is reflected in the panel’s recommendations in the final report. I want to make a further point and that is that it was clear from the public consultation that was undertaken that both options were wanted in Western Australia.

Hon Aaron Stonehouse: Clause 57(7) states —

- An agent of the patient is authorised to —
  - (a) receive the prescribed substance from an authorised supplier; and
  - (b) possess the prescribed substance for the purpose of supplying it to the patient; and
  - (c) supply the prescribed substance to the patient.

Firstly, can the minister tell me who the agent is and whether this appears elsewhere in the bill?

Hon Stephen Dawson: As the member has correctly pointed out, clause 57(7) of the Voluntary Assisted Dying Bill expressly provides authority to any person so selected by the patient as their agent to pick up and deliver the prescribed substance to them. Election of an agent is at the patient’s discretion. “Agent” is not defined in the bill, as it is a commonly used term across the health system that denotes a person chosen by a patient to act on their behalf. In the case of the prescribed substance, the agent will pick up the substance from the approved supplier and provide it to the patient. The use of the term “agent” of a patient is contemplated under the Medicines and Poisons Act in terms of a person whom a patient asks to receive, or pick up, the medication for them and supply, or deliver, to the patient. If requested to do so by the patient, the patient’s agent will collect the dispensed voluntary assisted dying medication from the authorised supplier and deliver it to the patient.

Hon Aaron Stonehouse: The agent and the contact person could very well be the same person; I imagine that would be likely in some cases. An agent might be someone’s carer, or perhaps a family member in this instance. As “agent” is not defined in the bill, unless it is defined in the Medicines and Poisons Act, I believe there is no prohibition on an agent being a family member. Under clause 66, I do not think the contact person is prohibited from being a family member.

Hon Stephen Dawson: No.

Hon Aaron Stonehouse: I think that is appropriate. I wanted to better understand what an agent was in that context.

Hon Charles Smith: I seek further clarification of subclause (7). Can an agent delegate their duties to someone else?

Hon Stephen Dawson: No, they cannot.

Hon Rick Mazza: Maybe I missed this during the debate, but can the minister define the difference between the contact person and the agent? It appears to me that they have the same functions. I do not know that the agent and the contact person are defined separately in the bill.

Hon Stephen Dawson: Clause 66 sets out the role of a contact person. There are similarities between the contact person and the agent. Clause 66(1) states that the agent can —

- (a) receive the prescribed substance from an authorised supplier;

That is essentially the same. Paragraphs (b) and (c) are similar. There is a difference between clause 57(5)(d) and clause 66(1)(d). Clause 66(1) states —

The contact person for the patient is authorised to —

- (d) give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer as required by section 104.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: This has also intrigued me. The contact person is obviously a person. Could an agent be used by somebody in care? The agent could be the aged-care facility or, if the patient is in the care of a public hospital, it could be the public hospital. Could the agent be an institution rather than an actual person? Who appoints or revokes that agency?

Hon STEPHEN DAWSON: The patient has to appoint somebody. The patient can choose the person. It cannot be an institution; they have to pick an individual.

Hon RICK MAZZA: I thank the minister for describing the difference. Except for clause 66(1)(d), the roles of the contact person and the agent are the same. If someone elects to use an agent and there is an unused portion of the prescribed substance, what is the agent required to do to dispose of it? At the moment, the bill provides that the contact person must give the unused substance to an authorised disposer. The bill seems to be silent for an agent.

Hon STEPHEN DAWSON: Under the bill, a patient must have a contact person if they are going to self-administer. They do not have to have an agent.

Hon ADELE FARINA: If it helps, I think that the agent arrangement arises in the event that the contact person is not able to pick up the drug—the patient is able to exercise the collection of that drug through an agent. That is what I assumed from my reading of the bill. The responsibility for getting rid of any unused substance remains with the control person. How does the authorised supplier know that the person who presents themselves and says that they are the agent for the patient is actually the agent for the patient?

Hon STEPHEN DAWSON: Under clause 70, the authorised supplier must authenticate the identity of the person who issued the prescription and the identity of the person to whom the substance is to be supplied. That could be by a letter from the patient indicating that they authorise the person to collect on their behalf, or it could be correspondence from the coordinating practitioner.

Hon ADELE FARINA: Therein lies my concern with this. In the case of the patient appointing the contact person, they need to appoint the contact person, the contact person needs to accept that responsibility, and all of that information needs to be provided to the coordinating practitioner —

Point of Order

Hon STEPHEN DAWSON: We are not dealing with the contact person at the moment.

Hon STEPHEN DAWSON: Sure. If we were going to get into a deep conversation about the contact person, I was going to say leave it until clause 66, or whatever.

The DEPUTY CHAIR (Hon Matthew Swinbourn): There is no point of order. I give the call back to Hon Adele Farina.

Committee Resumed

Hon ADELE FARINA: I am just trying to explain the difference between the two roles. With regard to the contact person, the substance cannot actually be prescribed or dispensed until a contact person is appointed and the coordinating practitioner is aware of who it is and has a form signed by the contact person to say that they agree to take on the responsibility of contact person, so there is a clear bit of evidence about who the contact person is with the contact person’s signature. It is easy enough for the authorising supplier to authenticate a signature on a letter, for example, because the coordinating practitioner will have the signature on the form that the contact person has signed.

In the case of an agent, there is no requirement for the patient to inform the coordinating practitioner that they are appointing an agent to pick up the substance. Even if the patient were to provide the agent with a letter saying, “Please supply this drug to this person who is acting as my agent”, how will the authorised supplier know that that signed letter is legitimately from the patient? They will have had no contact with the patient. I think there is a bit of a gap in the bill with regard to those processes. It becomes extremely difficult for the authorised supplier to fulfil their obligation under clause 70 of authenticating to whom they are providing the substance when that person is an agent of the patient and there has been no paperwork to establish that person as an agent.

Hon MARTIN PRITCHARD: I do not think the minister is going to respond to that, so I will move on.

Hon Stephen Dawson: That was a comment.

Hon Adele Farina: Sorry, I —

The DEPUTY CHAIR: Hon Martin Pritchard has the call; are you still seeking the call?

Hon MARTIN PRITCHARD: I will just quickly ask my question and then Hon Adele Farina can continue, if she wishes.

There is no definition or description of “agent”. The contact person has to be aged over 18, but the agent obviously does not. My concern is not so much with the fact that they may be asked to collect the substance; my concern relates to clause 57(7)(b), which states —

possess the prescribed substance for the purpose of supplying it to the patient …

Extracted from finalised Hansard
Is that while they transfer the substance, or is it considered that they might actually hold onto the substance?

Hon STEPHEN DAWSON: Was the question about whether the agent could hold onto the substance?

Hon MARTIN PRITCHARD: Yes. There is no description, so they could be under 18, for instance. Is it envisaged that the agent would actually hold onto the substance with a view to supplying the prescribed substance at some later stage?

Hon STEPHEN DAWSON: The agent is essentially—I will not say a gofer; I am not being disrespectful—picking it up and delivering it to the patient. It is not about holding onto it. They are required to hand it over, whereas the contact person has a more onerous role.

Hon RICK MAZZA: If I can flesh this out a bit more, please. It would appear to me, from listening to the debate, that the agent is actually an agent for the contact person.

Hon Stephen Dawson: No.

Hon RICK MAZZA: It is not? So the agent could be the agent for the patient? The bill does not define “agent”. I think Hon Martin Pritchard has pointed that out. From what I can see, the only difference in the role of the agent is the disposal of the substance. The agent, who does not have to be over the age of 18, can be asked by, let us say, the contact person or the patient, to run down to the approved dispenser, pick up the substance, take it to the patient, and actually supply it to the patient, without the contact person being there. It does not provide that the contact person must be present. The contact person could be absent from the whole process, and the agent can actually collect it, possess it and supply it. That seems contrary to why we would have a contact person, who has been defined in the bill and is required to have certain qualifications as far as age is concerned, if that can now be substituted by an agent who does not have to undertake the same duties as the contact person.

Hon STEPHEN DAWSON: Agents currently pick up medication outside of this bill, including schedule 4 and schedule 8 substances, on behalf of the patient. Schedule 4 and schedule 8 substances can be picked up by an agent of the patient in real life, outside this Parliament and outside this bill. That happens now. It could be a patient’s family member. In fact, it is usually a family member to whom we say, “You’re going to the shops. While you’re at the shops, can you go and get my prescription?” That happens now. I am advised that the standard prescription form provides for a signature of the patient or the agent. That includes schedule 4 and schedule 8 substances.

Hon ADELE FARINA: That is all well and good in the normal world of prescribing medications. However, clause 70 of this bill requires the authorised supplier to verify the identity of the agent. That is not required for agents who collect prescriptions on behalf of a patient. I go the chemist frequently for my mum and get her prescriptions filled, but it is our local chemist down the road, they know me and they know my mum, and they know that I am collecting her prescription. Clause 70 places a legal obligation on the authorised supplier to identify the person to whom the substance is to be supplied. Without any paperwork having been completed and in the hands of the coordinating practitioner, how can that authorised supplier fulfil that requirement in the legislation?

Hon STEPHEN DAWSON: I think I have answered that in response to an earlier question of Hon Adele Farina. I said that it could be by letter or the patient could ring up and say that they are going to get somebody to collect it on their behalf. The person who hands over the substance will seek a driver’s licence or some sort of identification document to verify that the person collecting the substance is indeed one and the same person as the patient advised would be doing so.

The DEPUTY CHAIR: I notice that Hon Rick Mazza has some amendments on the supplementary notice paper.

Hon RICK MAZZA: Yes, I have, Deputy Chair. I was just going to ask whether Hon Adele Farina will move her amendment first.

Hon ADELE FARINA: I am more than happy to move mine. I just wanted to make sure that everyone had finished that line of questioning. I move —

   Page 36, after line 23 — To insert —

   (2A) At the time of prescribing a voluntary assisted dying substance for the patient, the coordinating practitioner must inform the patient about the following matters —

   (a) the schedule 4 and/or schedule 8 poisons constituting the prescribed substance;
   (b) the method by which the prescribed substance is to be self-administered;
   (c) how to prepare and self-administer the prescribed substance;
   (d) the expected effects of ingesting the prescribed substance;
   (e) the expected time to death after ingestion;
   (f) the potential risks of self-administering the prescribed substance.

Everyone will have experienced going to the doctor and being prescribed medications. The doctor usually tells you exactly what he or she is prescribing. They will talk to you about how that will address your medical problem
and about the possible side effects that you need to be aware of, and also alert you to any problems that might arise with any other medications that you are taking, so that when you are ingesting that medication, you know full well the parameters in which you are required to take that medication and the effect the medication will have on you. If something different happens, you know that you have to go back to the doctor because that was not what was intended. There is a really full discussion. It concerns me that under this bill, the coordinating practitioner will prescribe a voluntary assisted dying substance and the patient will actually not know what cocktail of poisons from schedule 4 and/or schedule 8 are actually in that voluntary assisted dying substance. I find that really unacceptable. I think that patients should be fully informed about what they are going to be ingesting, the method for preparing it if it needs to be prepared, and what they can expect to happen after they have ingested the medication. I think that is incredibly important. The bill does not actually provide for that to happen.

We also need to be aware that all of this is happening outside of a regulated system. The Therapeutic Goods Administration regulates the market in relation to therapeutic goods. The minister informed the chamber in answer to questions about clause 7 that the schedule 4 and/or schedule 8 poisons that form part of the voluntary assisted dying substance do not need to be approved by the Therapeutic Goods Administration, so they could be drugs that have not been tested for human consumption. That concerns me. Clause 7 does provide that the CEO may determine which schedule 4 and 8 poisons are to be used, but there is no obligation on the coordinating practitioner who prescribes a voluntary assisted dying substance to actually prescribe one that has been recommended or approved by the CEO. Also, there will be no offence or penalty if they choose not to. In other jurisdictions that have recommended voluntary assisted dying substances, data that has been collected indicates that a percentage of doctors still prescribe medications to their patients other than the recommended medication as a voluntary assisted dying substance, and in some cases, there have been complications as a result of that. This whole bill will bring us into a completely unregulated market. I think there needs to be some concern about what we are doing. We go to great extents to ensure that we have regulation through the Therapeutic Goods Administration so that people only ingest medications, and at doses that are therapeutic and will not harm their health. I understand that the purpose of the voluntary assisted dying substance is to kill the person, but the whole purpose of this legislation is to deliver a peaceful and pain-free death. It is impossible to do clinical testing for that effect. The only clinical testing that has been done by the Therapeutic Goods Administration is for the therapeutic use of medications. In this case, we are talking about lethal doses. Clearly, there has not been any human clinical testing, because the result of the testing would be that some of the people participating in that trial would end up dead. There have been no human clinical trials for ethical reasons. We are really working in an unknown area. People will use their best assessments, but they are only assessments. There is no guarantee that the dosages that will be selected by the clinical panel and recommended to the CEO will be effective in all circumstances. Whether members support the bill or not, I think it is critically important that at the point the doctor prescribes the substance, they sit down and have a conversation with the patient and say, “Look, this is what’s in the voluntary assisted dying substance. This is what you can expect will happen to you after you have ingested the medication. These are the likely side effects.” I cannot understand why we would want to withhold that information from a patient. Surely, we should all be making decisions on an informed basis, and that is information that we should require the coordinating practitioner to provide to the patient.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of Hon Adele Farina’s amendment. The subject of the amendment is already contemplated under clauses 68 and 71. It is part of the doctor’s duty at common law to provide information to a patient about material risk, and this has been accepted by the High Court of Australia. Furthermore, I am told that it is good medical practice and already part of informed consent that medical practitioners deal with every day.

Hon NICK GOIRAN: Looking at clause 68, where does it indicate the matters that have been outlined in the amendment set out by the honourable member at 479/57?

Hon STEPHEN DAWSON: Clause 68(1)(d) refers to how to prepare and self-administer the substance and clause 71(2)(c) also refers to how to prepare and administer the substance.

Hon ALISON XAMON: I rise to indicate that notwithstanding the assurances given by the minister around clauses 68 and 71, I will support Hon Adele Farina’s proposed amendment. I see that this value-adds to the provisions within clauses 68 and 71. As I read them, they refer generally to how to administer it and provide parameters around how the substance is to be treated, but they do not go into detail about the risks that may be inherent if the substance is not administered properly. This issue is of concern to me. I am not opposed to self-administration. If anything, I prefer self-administration to somebody else administering the substance because we can be assured that this is the will of the person who is availing themselves of this. But I think it is really critical that that person have every single piece of information available to them so that we do not run the risk of mishap. Notwithstanding that, of course, obligations apply, and often, critical information may be missed or overlooked. In this case, the implications of that could be quite dire. It is really important to prescribe this. I do not think that this takes away from anything in the bill. It simply prescribes best practice that we expect to be incorporated within this process.

Hon NICK GOIRAN: I take the point that the minister has identified in Hon Adele Farina’s amendment, which is that proposed subsection (2A)(c) duplicates what the bill already prescribes at clause 68(1)(d), and I accept what
the minister says. However, I make this point: just because one out of six limbs of risks that the honourable member has listed is duplicated elsewhere in the bill does not invalidate the other five limbs. If the minister wants to amend the amendment moved by Hon Adele Farina by deleting the third limb—proposed paragraph (c)—I may well support that. But that does not invalidate proposed paragraphs (a), (b), (d) and (f). The minister will quickly rise in accordance with the advice that he is given and remind us that clause 71(2)(c) indicates that advice needs to be given on how to prepare and self-administer the substance. I suspect that the minister and the minister’s advisers will tell us that this is the same provision as proposed paragraph (c). The same thing applies there. I draw to the minister’s attention that clause 71 states that any information can be provided to the patient. That is duplicative. But it says it can be provided to the contact person or this “famous” agent; I would say “infamous” agent at this point. That will not provide the information and the risks to the patient. In any event, if the government objects to the third limb of the six limbs in Hon Adele Farina’s amendment, I invite the government to amend that. Regardless, members should give serious consideration to the other five limbs. They are appropriate risks that should be provided not to an agent, not to a contact person, but to the person who will be taking the substance at the end of the day.

Hon STEPHEN DAWSON: I make the point that clause 26(1) is also relevant to the issue before us because it addresses some of the issues that Hon Adele Farina has raised.

Hon NICK GOIRAN: Where in clause 26 does it set out the six items of risk that Hon Adele Farina has identified in her amendment 479/57?

Hon Stephen Dawson: I did not say that it addressed all six items of risk.

Hon NICK GOIRAN: Does it identify any of the six; and, if it does, which ones?

Hon STEPHEN DAWSON: Clause 26(1)(d) identifies the potential risks. The honourable member can read it, as I can.

Hon ADELE FARINA: The information outlined in clause 26 will be provided very early on in the process. By the time the patient gets to the point of being prescribed the substance, they may have forgotten or may not fully remember everything they were told at the point that they were told, pursuant to clause 26. In any event, even if they remember it all, it is good practice to reiterate everything at the point of prescribing the substance. I do not understand why the government would have an objection to ensuring that the patient is informed of all the information that they should have.

Hon PETER COLLIER: I am receptive to this amendment. I do not think it in any shape or form impacts on the integrity of the bill or this clause and self-administration. We all know that information is power. At this point of a person’s life, he or she needs to be provided with as much information as they can possibly have. This is evidently a significant decision that they will make. They need to have as much information as possible. I understand the minister’s point about good medical practice, which is captured in clause 71 in how to prepare and self-administer the substance, and there is an assumption that good medical practice will prevail. But making the bill more prescriptive is not only eminently sensible, but also essential. Before I vote on this amendment, I would like to know from the minister’s perspective whether accepting this amendment in any shape or form will impact negatively on the integrity of the bill.

Hon STEPHEN DAWSON: In its current form, it could.

Hon Peter Collier: How?

Hon STEPHEN DAWSON: I am advised that it is not drafted as best as it could be.

Hon AARON STONEHOUSE: If the minister would provide us with some alternative preferred wording, that would be helpful, although I assume that in presenting this amendment to the Committee of the Whole House, Hon Adele Farina has engaged parliamentary counsel.

Hon Adele Farina: interjected.

Hon AARON STONEHOUSE: Okay; perhaps not. If the minister has some alternative wording, I would be interested to see it. Regarding the amendment by Hon Adele Farina, I absolutely prefer self-administration. I spoke a little about this yesterday. Voluntary assisted dying is a voluntary act, of course, and it is someone exercising autonomy and making their own choice. The best way we can be absolutely certain that somebody is exercising autonomy is if they do it themselves. There is a very clear distinction between voluntary assisted dying and voluntary euthanasia, and to stay on the voluntary assisted dying side of this issue, it is important that, whenever possible, people can self-administer. I am concerned that the bill currently provides for practitioner administration not on the basis of a medical need, but on the basis of a conversation between a patient and a practitioner. That has already been determined.

Looking at this amendment, I would be concerned if it in some way deterred people from self-administration. I do not think that is the policy intent of the amendment put forward. Proposed subclause (2A)(f) states —

the potential risks of self-administering the prescribed substance.

Extracted from finalised Hansard
That part might act as a deterrent, but if we are going to say that there are risks involved, and there are some risks involved, it would be wholly inappropriate to hide those risks from a patient just because we want them to take a certain action. All information should be provided to a patient whenever possible so that the patient is empowered to make their own choices. They should be fully informed. If that means a patient decides that they do not want to self-administer, although I would prefer that they do, that information cannot be withheld from them just to steer them to make a decision that we want them to.

It is worth noting that it would be good clinical practice for a medical practitioner to do all these things, and I suspect that they already do. I support this amendment because it merely codifies what would already be taking place and what should take place. It puts an obligation on medical practitioners to carry out their functions properly and to ensure that patients are fully informed. At other clauses of this bill, we go to a lot of effort to ensure that patients are fully informed. It is appropriate, when a patient is making an administration decision whether they want self-administration or practitioner administration, that again the patient is fully informed. On that basis, I support the intent of the amendment, but I am interested to see whether there is some alternative wording that the minister finds more appropriate. If the chamber is to agree with an amendment of this type, I want to make sure that we get the language right.

Hon JACQUI BOYDELL: I, too, am interested in whether the government has a proposed amendment to the amendment. Looking at Hon Adele Farina’s amendment, I would have thought that proposed subclause (2A)(b) is covered already by clause 26(1)(f) and proposed subclause (2A)(c) is also covered by clause 68(1)(d) of the bill. I suggest that proposed subclause (2A)(d) and (e) may be covered by clause 26(1)(e). Proposed paragraph (f) of the amendment would also be covered by clause 26(1)(d). I am not sure why we would need to repeat that. If the member could explain why proposed subclause (2A) is required, I will consider support for it; otherwise, I will not support the amendment.

Hon ADELE FARINA: That was a very fair question. If members look at the way clause 26 is drafted, they will see that it refers to “a voluntary assisted dying substance likely to be prescribed”. At that point, a decision about what is going to be prescribed has not been made, so the conversation is very, very general. It is also very early on in the process. I am asking, at the point when the decision has been made to prescribe a particular voluntary assisted dying substance, or cocktail, that all of that information is relayed about what is actually being prescribed. There is quite a distinct difference between what I am proposing now and what occurs under clause 26, which relates to a more general conversation about a “likely substance” to be prescribed. That is the difference. When a doctor prescribes medication to a patient, it is not about the impact of a likely group of medications that the doctor could prescribe to the patient; it is about what is actually being prescribed to the patient, including its side effects, conflict with other medications and whether it should be taken on an empty stomach or after eating food. All of that sort of stuff occurs. I am asking for all of that to occur at the point the drug is being prescribed.

Hon MARTIN ALDRIDGE: The minister mentioned that a number of clauses are relevant to the amendment before us, which I have given some consideration to. I would like to make a couple of points. I understand the intent of what the mover is seeking to do, but I wonder whether this is the appropriate clause for it to be inserted into. For example, clause 68 relates directly to information to be given before prescribing a substance.

That may be a more relevant clause to enhance because a number of the limbs in the mover’s proposed subclause (2A) are already in clause 68, and we could probably give that area some consideration, too. I have a couple of points about the amendment before us. Before we go to the limbs, it states —

At the time of prescribing a voluntary assisted dying substance for the patient, the coordinating practitioner must inform …

Those words suggest to me that this would require a further consultation with the medical practitioner, because the prescribing of the substance may well occur post the final request. Would the patient requesting voluntary assisted dying then be subjected to a further consultation with a medical practitioner to be informed post the final request if the prescribing of the substance did not occur at the final request? I do not think it can actually occur at the final request because there are some obligations on the coordinating practitioner that follow the final request.

I also want to raise the reference to ingestion in proposed paragraph (e). I am happy to be corrected, but I assume that references to self-administration in the rest of the bill do not refer explicitly to self-administration being ingestion. I think it is assumed that, as the bill stands today, the most likely way a person would take the self-administered substance will be by drinking something, but that may not always be the case. Certainly, that is something we might need to consider.

Hon NICK GOIRAN: I think the observations and analysis provided by Hon Martin Aldridge are good and helpful. I wonder whether clause 68 is a superior option for this very well considered amendment put by the honourable member and that we could perhaps defer consideration of this particular issue until that point. I think there is a lot of sympathy for the thrust of this amendment, including from me. Ultimately, I am somewhat ambivalent about whether it is under clause 57 or 68, but if there is an appetite for a large proportion of the substance of amendment 479/57 finding its way into the bill at clause 68, I am certainly receptive to that.
Hon STEPHEN DAWSON: I indicate that we would be happy to have a similar amendment to clause 68 that deals with the issues raised in Hon Adele Farina’s amendment before us, but we would tighten up the drafting. There are a number of drafting concerns with the amendment as it stands. It is up to Hon Adele Farina, but I indicate that the government would support such an amendment to clause 68. I will have a drafted amendment for clause 68.

Hon ADELE FARINA: I thank all members who have made contributions and commented on this amendment. I am more than happy to withdraw the amendment at this stage and consider an amendment to clause 68. I just want to make clear to the minister that very much a part of my amendment is the patient being told what schedule 4 and/or schedule 8 poisons make up the voluntary assisted dying substance that they are being prescribed. I would hope that any amendment put forward by the government would include that.

Hon STEPHEN DAWSON: Member, I think that the amendment I will move to clause 68 will take into consideration that concern.

Hon ADELE FARINA: I seek leave to withdraw my amendment.

Amendment, by leave, withdrawn.

Hon RICK MAZZA: I have three amendments to clause 57 on the supplementary notice paper. The first two, at 420/57 and 421/57, are consequential, so I ask that they be deferred at this point until we have debated my third amendment, which is at 422/57.

Point of Order

Hon NICK GOIRAN: I would like to raise a point of order with the honourable member. If he is indicating that he will not be moving at this time amendments 420/57 and 421/57, I will be moving an amendment before he gets to amendment 422/57.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Can we get an indication? I will let you finish your contribution, Hon Rick Mazza, on what your intention is on those two amendments.

Hon RICK MAZZA: Thank you, Mr Deputy Chair. In light of the new information that has come forward, I ask that amendments 420/57 and 421/57 that I have on the supplementary notice paper be deferred until after we have debated my third amendment, which is at 422/57.

Committee Resumed

Hon NICK GOIRAN: Thank you, honourable member, and it will become apparent shortly why this is necessary. I move —

Page 37, lines 1 and 2 — to delete “, the contact person for the patient or an agent of the patient.” and substitute —

or the contact person for the patient.

The DEPUTY CHAIR: After some discussion, Hon Rick Mazza, I am going to ask you to seek the leave of the chamber to postpone amendments 420/57 and 421/57 on the supplementary notice paper. If it is your intention to postpone them until later, can you formally seek the leave of the chamber to postpone those two amendments?

Hon RICK MAZZA: It is a pleasure, Mr Deputy Chair. I formally seek leave to defer amendments 420/57 and 421/57.

The DEPUTY CHAIR: Hon Rick Mazza has sought the leave of the chamber to postpone those two amendments.

Point of Order

Hon STEPHEN DAWSON: Are we just deferring these amendments until a later stage of this clause?

The DEPUTY CHAIR (Hon Dr Steve Thomas): Yes.

Committee Resumed

The DEPUTY CHAIR: By clarification, minister, we are proposing, if it is the will of the chamber, to postpone those two amendments initially until after we have dealt with the now moved amendment of Hon Nick Goiran, which is to delete lines 1 to 2 on page 37. After having dealt with that, we will deal with amendment 422/57 on the supplementary notice paper, which deals with lines 3 to 18 of the clause, and then return to the postponed amendments. Hopefully, all members are aware of where we are going with this. Hon Rick Mazza has sought leave to postpone amendments 420/57 and 421/57.

Leave granted.

The DEPUTY CHAIR: That takes us to the amendment to clause 57 that has just been distributed under the name of Hon Nick Goiran, which states —

Page 37, lines 1 to 2 — to delete “, the contact person for the patient or an agent of the patient.” and substitute —

or the contact person for the patient.

Extracted from finalised Hansard
Hon NICK GOIRAN: Members, this is just concluding the debate that happened earlier this morning with regard to the use of an agent. Other members have identified—I give them full credit for doing so—that “agent” is not defined in the bill. As other members indicated earlier this morning, this undefined role of “agent” other than what is set out at clause 57(7) is already captured by the role of the contact person. This amendment will eliminate agents being used; I think that that is in the best interests of everybody, not the least of whom is the agent, because everything is undefined in this legislation. I know that there was some discussion by the minister earlier that indicated that agents are commonly used to pick up prescriptions and so on, but never for a prescription the intended outcome of which, if it is taken, is the death of the patient. That does not happen in Western Australia. This is unique. It should not be the agent who picks this up; clearly it should be the contact person. The contact person will have certain obligations under this statute. The agent will have none and this amendment will tidy up this issue.

If this amendment were to be supported by members, it is my intention at a later stage of this clause to delete lines 13 to 18 on page 37—in other words, to delete clause 57(7). But there is no point in me doing so unless this particular amendment is supported. I hope that clarifies the rationale for this amendment.

Hon STEPHEN DAWSON: I indicate that we do not support this. I have previously talked about the agent and how an agent already exists outside of this bill, if I can put it that way. The removal of the ability of the agent could limit the patient’s ability to obtain the prescribed substance in a timely way. I am told that it is contrary to the common practice of allowing a person chosen by the patient to pick up the substance. It is a common delivery aid for patients at end of life already.

Hon AARON STONEHOUSE: I just want to ask a couple more questions along these lines about the role of an agent. An “agent” is sort of defined outside of this bill. It is fairly common practice currently for a patient to send somebody in their stead to collect their prescription. Is a different procedure in place between pharmacies and dispensaries and agents and patients for different types of drugs or substances? For instance, if someone sends another person to pick up their antibiotics, it is quite different from sending somebody to pick up their schedule 8 substance. I wonder whether there is any difference in the process for how those drugs or substances are handed over in those instances.

Hon MARTIN ALDRIDGE: I am trying to understand the merits of having an agent of the patient. We are sort of having the argument two ways here. We are saying that these are the usual practices that apply when we dispense drugs, but then we are saying that this is not a usual practice because we are actually supplying a voluntary assisted dying substance, and that gives rise to the need for a contact person. I draw members’ attention to clause 66, which defines the role of a contact person, and they have a very limited role. Their role is to receive, possess, supply and return the drug, and, secondly, to advise the coordinating practitioner if a patient dies. They have a very limited function. When I consider the argument about why an agent might be required, I would think it would be in circumstances in which the contact person is not able to perform their function. If that is not the case, I would consider the way the patient can revoke and appoint another contact person, and that does not seem to be very arduous, apart from filling in another form and within two days providing the form to the coordinating practitioner, and then I think the coordinating practitioner has an obligation to supply it within two days to the board. I want to understand from the government why the contact person revocation and appointment process is so arduous that we then require this agent provision in the bill, when it is the job of the contact person to receive, possess, supply and return the substance.

Hon RICK MAZZA: I rise to say that I will also support this amendment, because I have some issues with the agent’s role in all of this. I point out to the mover of the amendment that should my very reasonable amendment at 422/57 be successful, this amendment would become obsolete, so we will remove the reference to the contact person and agent altogether. But to futureproof it in case it does not get up, I think this is a very important amendment, so the contact person, not an agent, is responsible for the substance.

The DEPUTY CHAIR: I will give the call to Hon Adele Farina in a minute. I just want to make a comment from the chair about a procedural issue. It may not have occurred to members, and I want to make this quite plain, that because Hon Rick Mazza’s amendment 421/57 on the supplementary notice paper applies to page 37, lines 1 and 2, and we are currently dealing with another amendment to page 37, lines 1 and 2, there is a procedural issue in that the chamber is unable to agree to an amendment and then try to change it and agree to a second amendment effectively on the same issue. There is going to be an issue here, Hon Rick Mazza, in that if the amendment by Hon Nick Goiran is agreed to, you will be prevented from moving your amendment on the supplementary notice paper. Your option at this point is to seek to amend the amendment of Hon Nick Goiran, but not to make a second attempt to amend lines 1 and 2.

Hon MARTIN ALDRIDGE: Mr Deputy Chair, can I seek your guidance on this matter? I think Hon Rick Mazza intended to defer amendments 420/57 and 421/57 pending the outcome of his substantive amendment 422/57. It would not prevent Hon Rick Mazza from pursuing his intent at 422/57 and if it is successful, in any event, it will require a recommittal of the clause. I am struggling to understand how Hon Rick Mazza would be prevented from pursuing the course of action he seeks.

Hon JACQUI BOYDELL: I am struggling a little with this amendment. I am trying to picture when a patient would appoint an agent. A patient may utilise the services of Silver Chain. Can the minister confirm that a person working for Silver Chain could be an agent? That would be a very likely scenario for self-administration. A person working for Silver Chain could be an agent.
could be being cared for at home by a family member or, indeed, the contact person caring for the patient may not want to leave them. In this scenario, is the patient allowed to ask the visiting Silver Chain person, as their agent, to pick up the prescription? I would have thought that happens now with patients at home. I do not see that that scenario would be any different in this case. If that is the case, I will not support this amendment.

The DEPUTY CHAIR: I will get back to Hon Adele Farina. On the point raised by Hon Martin Aldridge, my advice is that the ruling will stand. The member will be unable at this point to move his amendment on the supplementary notice paper if Hon Nick Goiran’s amendment is agreed to. However, he could move at the end of debate on this amendment for this clause to be recommitted. When you raised “recommittal”, you were accurate. At the end of the process following the report of the Committee of the Whole House, Hon Rick Mazza can move to recommit this clause. I hope that makes sense.

I will go to Hon Adele Farina before the minister because I put her off previously.

Hon ADELE FARINA: Alternatively, Hon Nick Goiran could also seek leave to defer, and that would enable the two to be considered at the same time after the substantive amendment, but that is another option.

I was seeking the call earlier to clarify with the minister who the authorised supplier might be. Will we expect people living in regional WA to travel to Perth to collect the voluntary assisted dying substance, because that will create a whole different complexity to the question we are considering, or will it be delivered to a pharmacy in the town from where it can be collected? I can clearly understand the situation Hon Jacqui Boydell has raised. It is one thing to leave a family member who is dying for a few minutes to go to the local pharmacy and pick up the voluntary assisted dying substance; it is quite another thing to take a trip to Perth to collect it. It also raises questions about the obligations on the contact person to return whatever is not used. It would be good to get some clarification about the location of the authorised supplier and the person who will dispose of the unused substance.

Hon STEPHEN DAWSON: I am going to take the call now before any other questions, because it is a long and growing list. Obviously, I am happy to answer all questions, but I will answer the ones that have been asked so far.

In answer to Hon Jacqui Boydell’s question, yes, the patient could appoint a Silver Chain person as an agent; that would be very appropriate. In answer to Hon Martin Aldridge’s question, the removal of the ability of the agent could limit the patient’s ability to obtain the prescribed substance in a timely way. It is contrary to the common practice of allowing a person chosen by the patient to pick up the substance. The patient agent is a common delivery aid for patients at the end of life. The patient is likely to have someone who usually picks up their medication for them. That person may not wish to take on the onerous role of contact person but may be happy to pick up the medication. The agent allows the patient more ability to obtain the substance. Although the contact person has a legal obligation to return the substance, including a penalty for the failure to do so, the agent is an additional aid to obtain the medication in a timely way, especially at the patient’s end of life. I am further told that schedule 4 and schedule 8 poisons are currently prescribed and dispensed in doses that would be sufficient to cause death if taken by the wrong person or at the wrong dose level. People in palliative care may build high tolerance to opioids and other drugs, so the level required to cause death in one person could be tolerated by another patient.

Hon MARTIN ALDRIDGE: It brings into question the role of the contact person if we are going to have agents. That may be something we will consider down the track. If an agent receives, possesses and supplies the drug or the substance, what obligation is there for the contact person to be notified that the drug has been received, possessed or supplied so that they can fulfil their function under clause 66(1)(d), which is the return of unused or remaining prescribed substances?

Hon STEPHEN DAWSON: I am going to reply to Hon Adele Farina’s last question before I get on to the next one. The definition of “authorised supplier” is set out under proposed section 78(2) of the act. An authorised supplier will be a registered health practitioner—for example, 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 a voluntary assisted dying substance for the purposes of the act. The authorised supplier will be limited to registered health practitioners authorised under the Western Australian Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons. It is likely that the authorised supplier will include a public health service hospital or pharmacy with pharmacists and specialist practitioners who are also authorised under the WA Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons. 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. I note that it is not anticipated that the authorised supplier will be a community pharmacy.

On the dispensing of the medication, it is anticipated that a hub-and-spoke model may work best for Western Australia as a way of balancing appropriate access with appropriate control. For example, for a central pharmacy service potentially based at 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 a central ordering and storage point for approved voluntary assisted dying medications. It would also have governance over the training requirements and certification of any authorised suppliers—for example, pharmacists at regional hub pharmacies who are involved with the supply of VAD medications. The central pharmacy service would also receive prescriptions,
dispense medications and dispose of any unused medication for metropolitan patients. It is anticipated that regional pharmacy hubs with appropriately trained and certified pharmacists would also be approved to supply medications and to dispose of any unused medications for regional and remote patients. These hubs would obtain supplies of voluntary assisted dying medications from the central pharmacy service. The hub and spoke in this model would be authorised suppliers. In this way, an authorised supplier to the central pharmacy may supply the prescribed substance to another authorised supplier that is much closer to the recipient and will actually make contact with the recipient. This will be worked out during the implementation stage of the bill and will help to address the needs of persons in regional and remote areas of this state. In relation to Hon Martin Aldridge’s question, the contact person would be advised by the patient or the agent. If self-administration, then the contact person may be the coordinating practitioner.

Hon ADELE FARINA: A problem for us when we are considering the bill is that we do not know what the hub-and-spoke model is going to look like. From what the minister said, I understood it could well be that, say, a person who lives in Nannup would be required to travel to Bunbury Regional Hospital to collect the voluntary assisted dying substance. It is possible that it might be delivered from Bunbury Regional Hospital to Nannup District Hospital, but until we see the hub-and-spoke model, we cannot assume that it is going to get to the local hospital where the person lives, particularly in small towns. We all know that a lot of towns throughout Western Australia do not have hospitals. Therefore, it seems to me, based on what the minister has told us, that there could be some travelling involved to collect the medication. In those circumstances, if the contact person is a family member, I can see the advantage of having an agent. When my dad was in his final stages of life and I had to go and get medication —

The DEPUTY CHAIR: Members, there is a fair bit of background noise—if we could keep that to a minimum, please.

Hon ADELE FARINA: It gave me some peace of mind knowing that the chemist was a minute and a half down the road. Unless there was a long queue when I arrived, I could get back fairly quickly. If I am going to be gone for half a day or a whole day to collect the substance, that is a completely different arrangement. I still have concerns that the arrangements in the bill for the appointment of the agent are deficient in terms of the obligations of the authorised supplier. Under clause 70, it needs to go through a verification process. I do not see why we do not simply have the same process in which a contact person and an agent are appointed, paperwork is provided to the coordinating practitioner and when the coordinating practitioner is writing out the prescription, they advise the authorised supplier of the person who is going to pick up the voluntary assisted dying substance. It seems pretty straightforward to me.

Hon NICK GOIRAN: As important and excellent as this debate is, I am going to propose to seek leave to defer consideration of this amendment. By way of explanation, this picks up on the proposal put to me by Hon Adele Farina. It strikes me, on reflection, that this is better considered after we consider Hon Rick Mazza’s proposed amendment at 422/57, because if the honourable member’s proposal is supported, what we are currently considering will become redundant. I hope it does not happen, but if the honourable member’s proposal is not supported, we can come back to this important discussion. Therefore, for those reasons, I seek leave to defer.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Honourable member, to make things more workable, I am going to ask you to withdraw the amendment you have moved. You have the capacity to re-move it down the track, but I do not want to have so many postponed amendments sitting here. I think it is going to confuse the debate. Therefore, if you are comfortable with that, I am going to ask you, from the chair, to seek leave to withdraw the proposed amendment. You have the capacity to re-move it at a future point.

Hon NICK GOIRAN: Thank you, Mr Deputy Chairman. I seek leave to withdraw the proposed amendment.

Amendment, by leave, withdrawn.

The DEPUTY CHAIR: Honourable members, the question before the house is that clause 57 stand as printed. Hon Rick Mazza, would you like to move the amendment standing in your name?

Hon RICK MAZZA: I move —

Page 37, lines 3 to 18 — To delete the lines and substitute —

(4A) The administering practitioner for the patient is authorised to —

(a) receive the prescribed substance from an authorised supplier; and
(b) possess the prescribed substance for the purpose of supplying it to the patient; and
(c) supply the prescribed substance to the patient immediately before the patient is ready to self-administer the prescribed substance if the administering practitioner is satisfied at the time of supply that —

(i) the patient has decision-making capacity in relation to voluntary assisted dying; and
(ii) the patient is acting voluntarily and without coercion; and
(iii) the patient’s request for access to voluntary assisted dying is enduring.

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The patient is authorised to —

(a) receive the prescribed substance from the administering practitioner for the patient immediately before the patient is ready to self-administer the prescribed substance; and

(b) possess the prescribed substance for the purpose of preparing and self-administering it; and

(c) prepare the prescribed substance; and

(d) in the presence of the administering practitioner for the patient and a witness, self-administer the prescribed substance.

I will explain to the chamber my reasons for putting this amendment on the supplementary notice paper. We have had a lot of debate and discussion around a contact person; an agent; the security of the substance; and the ability for a contact person or an agent to go to an authorised dispenser and pick up what is, essentially, a lethal substance. That substance is able to be left around a home or in a nursing home or wherever the patient may be, so there is the issue of the security of that substance. If the patient passes away in the meantime or decides to not self-administer, there is the issue of the disposal of the substance. I have a lot of concerns about the security of that substance.

As has already been mentioned, if we are to have this legislation, self-administration is the preferable way, rather than having an administering practitioner. But I think that if someone is going to self-administer, there needs to be security and safeguards around self-administration. This amendment will require an administering practitioner to be present, along with a witness. I would like to see that because, firstly, we need to make sure that the patient is not being unduly coerced in any way. As the bill is currently drafted, the substance will be taken home and the contact person can be a family member. We do not know how much coercion might take place in the self-administration, if the method is self-administration, of that substance. If there is at least an administrating practitioner present — the administrating practitioner being the person who actually acquires and possesses the substance until such time as the patient wishes to take the substance — it will be a good safeguard.

This amendment also requires a witness, so there will at least be an independent witness present at the time, along with the administering practitioner, to make sure that those safeguards are in place and that the patient is willingly taking the substance.

A third issue is of concern to me. Debate has gone back and forth about the fact that taking the substance will not always result in the person’s peaceful passing; things can go wrong. If the substance is not prepared properly, if the person does not take the substance in the way that they should take it, or if there is confusion about the delivery of the substance to the patient that the contact person or the patient cannot resolve on their own, there could be adverse results for the person taking the substance.

I get why it is done this way; there is a bit of privacy for the family when the person passes on. I get that, but I think that is far outweighed by the fact that something could go wrong, and if it does, it could be very, very traumatic for the family and the people around the person, and the person involved. At least if there is an administering practitioner there, things can be managed to make sure that that issue is minimised.

For those reasons, I have moved this amendment. I think it is a very sound amendment to put those safeguards in place and ensure that someone who has opted to self-administer will have those protections around them. At the moment, it is a very loose arrangement — a contact person and an agent; whether someone is there or not there; no witness present at the time. Therefore, I have moved this amendment.

Hon STEPHEN DAWSON: There are a number of amendments on this issue in Hon Rick Mazza’s name — there are the two amendments that we have deferred; there is the amendment that is before us; and I think there is also a linked amendment at clauses 68, 71 and 72. I will make my comments on all those amendments at this stage, just to place them on the record.

Hon Rick Mazza seeks to remove the authorisation of an authorised supplier to supply the prescribed substance to the patient, and instead introduce a new authorisation that the authorised supplier must supply the prescribed substance to the administering practitioner, who must then supply to the patient and inform. The honourable member’s proposal further introduces a new limitation that the supply of the prescribed substance can occur only when the person is ready to self-administer. This is part of his suite of amendments, which also seek to remove the role of, requirements of, and information provided to the constant person in the case of self-administration and require the administering practitioner to be present when a person self-administers.

The government is not supportive of these amendments. These amendments create a fundamental shift in terms of the patient autonomy attached to self-administration. Fundamental to the model of voluntary assisted dying proposed for Western Australia is the concept of patient autonomy and choice with regard to the manner and timing of death. A patient for whom self-administration is deemed to be the appropriate course of action under clause 55 of the bill will now not have freedom of choice in the timing of self-administration and also be forced to have particular witnesses whom the patient may not wish to be there. Operationally, this may also create issues, depending

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on where the patient wants to self-administer. A person may want to return to their home town, and may not be able to access the coordinating practitioner at a time that fits with the notion of self-administration; for example, a time of their choosing. This is distinct from the arrangement that must occur under practitioner administration. Furthermore, to require the administering practitioner to witness is a strange scenario, particularly as this is already the considered option for practitioner administration under clause 55. The patient may request the coordinating practitioner to attend, but to require it legislatively for self-administration defeats the purpose of that option. The requirement for the administering practitioner to be present during self-administration is not required in Victoria, nor was it recommended by the joint select committee. The bill does not preclude the presence of the coordinating practitioner should this be agreed by the patient and the practitioner. Most patients at this end stage have a network of support around them, such as family, palliative care or other support workers, and it is most likely that the patient who is the subject of self-administration will self-administer at home and be supported by family. The patient’s coordinating practitioner will encourage appropriate planning.

I will leave it there.

Hon NICK GOIRAN: I support the amendment that has been moved by Hon Rick Mazza and consider it to be one of the most significant amendments and safeguards on the supplementary notice paper. I note that if this amendment were successful, it would require supervision of the patient’s self-administration of the voluntary assisted dying substance. I would like to draw to members’ attention that this reflects the best practice guidelines in the Netherlands. The Netherlands “Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide” state at page 13 —

During the practice of euthanasia or physician-assisted suicide, —

Remember that the Netherlands’ regime has two options, as does our bill: if the practitioner is involved, it is called euthanasia; if the person takes it themselves, it is called physician-assisted suicide. It continues —

the doctor must remain present. For the oral method (physician-assisted suicide), this can take several hours.

The guidelines go on further to say —

Once the patient drinks the drink, the barbiturate is resorbed by the gastrointestinal tract. The faster the resorption, the higher the peak level. If the resorption rate is too slow, then a redistribution of the barbiturate will take place, resulting in an insufficient peak level. As a result, the patient fails to lapse into a coma or can come out of a deep coma.

Even when anti-emetics are administered, the foul taste of the drink can sometimes cause vomiting. As a result, the whole dose is not taken. Another possible problem is that many patients use opioids at the end of their lives. Opioids result in slower gastrointestinal transit, which can mean it takes the patient longer to lapse into a coma.

Due to the aforementioned unpredictability, this method is not the preferred method.

The period of time between administration and the time of death varies from person to person, but in the vast majority of cases, it takes less than 30 minutes. However, sometimes it can take longer (2–3 hours). Long periods such as these can result in uncomfortable situations.

It is advisable to agree a maximum period of 2 hours with the patient and any next of kin. If the patient has not died by this time, then euthanasia should be administered (intravenously). Beforehand, it is not possible to predict which patients will or will not die within 2 hours. An infusion needle should be inserted in advance as standard for every patient.

These guidelines are borne out of 46 years of experience in the Dutch regime, since the Dutch courts recognised that a doctor could lawfully shorten a person’s life to prevent serious and irremediable suffering. If members do not want to take my word for that, they might give weight to the Joint Select Committee on End of Life Choices’ majority report at page 152. That report from the majority of the committee notes —

Although the Netherlands formally legislated for the practice of voluntary assisted dying in 2002, there had been a long process of incremental change prior to the introduction of the legislation.

That is what the majority report of the committee said at page 152. The honourable minister said that this was not raised by the joint select committee. What the minister did not tell everybody is that that was because the committee was silent on this issue. I note that no mention of the guidelines is made in the “My Life, My Choice” report. A committee looking at the guidelines, wrestling with the information and coming to a different conclusion is a very different thing from a committee not even looking at the guidelines in the first place. Two and a half pages of the 229 pages of the “My Life, My Choice” report are dedicated to considering the Dutch experience. There is more than 40 years of Dutch experience, but only two and a half pages were devoted to it after a one-year inquiry.

The report considers the legislative background of the Dutch model and the most recent statistics on deaths under the Dutch law, but something as significant as these guidelines, including the quotes I have just read, do not even rate a mention. I encourage members to give serious consideration to this amendment at clause 57. The Dutch, with 46 years of experience in practitioner administration and self-administration, mandate practitioner attendance for all cases of self-administration. Why do the Dutch insist on that being the case? It is because of the high rate of

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complications even after years of clinical practice. Why would we reject the guidelines and go our own way, leaving Western Australian patients exposed to the risk of serious complications and suffering when self-administering a voluntary assisted dying substance either alone or in the presence of a distraught loved one? That is the alternative.

The fact is that the amendment moved by Hon Rick Mazza would also strengthen the principle of voluntariness central to the bill. If members look at the amendment standing in the name of the honourable member, and particularly at proposed subclause (4A)(c), they will see that it mandates that the administering practitioner has to assess the patient’s decision-making capacity. We had a lengthy debate earlier on this issue, and the minister acknowledged that there is nothing in this bill that ensures that when the patient self-administers the substance, there is decision-making capacity. There is no protection for that. It is true that there is if they elect practitioner administration; that is one of the options. That is, if we, the voluntary euthanasia option, and that is probably consistent with the model proposed by Hon Robin Chapple some 10 years ago. Under that method—voluntary euthanasia—it is true that there would be an assessment of decision-making capacity. I do not even agree with that, but that is not the point here. The point here is that we are allowing unsupervised access by Western Australians to a lethal substance with no supervision whatsoever over decision-making capacity or coercion. Members should think for a moment; if Hon Rick Mazza’s amendment is not supported, what will the consequence be? The consequence will be that the person will take the poison home with them and leave it to be taken at a time of their choosing. Who is to say that that patient will take it and not somebody else in the home? Who is to say that the patient will not be coerced at that time? Who is to say that one of the carers, family members or a person who is a beneficiary under the will—any of those—will not hurry the patient along? That cannot happen under practitioner administration because the medical doctor will be supervising at all stages. All Hon Rick Mazza is asking us to agree to is for somebody to supervise this process. We keep hearing “my life, my choice”—I am still stressed about the title of that report—but for those members who believe so passionately about autonomy and have equally said that there must be safeguards, can someone please stand and explain to me what safeguards will be in place for self-administration? Why are we about to agree to a Western Australian patient taking the poison home with them with no supervision at all? This is probably the part of the scheme and the bill that distresses me the most. I urge members to give some serious consideration to this well thought out amendment moved by the honourable member.

Hon MARTIN ALDRIDGE: I have some questions I want to ask about this amendment. The amendment uses the language “administering practitioner”, which is interesting because we are dealing with a clause that is about self-administration. I draw members’ attention to page 3 of the bill under clause 5, where “administering practitioner” is defined as —

(a) the coordinating practitioner for the patient; or

(b) a person to whom the role of administering practitioner is transferred under section 62(2);

If members turn to clause 62(2), they will see that it refers to the transfer of the administering practitioner’s role and only applies if—

(a) a patient has made a practitioner administration decision; …

My plain reading of this would be that the administering practitioner must be the coordinating practitioner and there is no ability for that person to be appointed or referred under clause 62(2). It begs the question of why it should not just say “coordinating practitioner” rather than “administering practitioner”, because I think it would confuse the reader of the potential act about the person being referred to. Under this clause, “Self-administration”, the practitioner will not be administering anything. I wanted to raise that as a point for consideration under this amendment to clause 57.

I am a little concerned about the practical implication of this amendment. Keeping in mind that the minister, or one of the other speakers in this debate, talked about the patient’s right to take the substance at a time and place of their choosing, I think that is something that we need to keep in mind in the context of potential new safeguards. I think this would be a significantly limiting factor—more limiting than making a practitioner administration decision. As we know, when a patient makes a practitioner administration decision, further practitioners can be appointed as the administering practitioner, including nurse practitioners, so there is a greater range of flexibility. This amendment, if adopted, would require one person and one person only—the coordinating practitioner—to be available at the time of the patient self-administering the substance. That is my reading. I am happy for it to be reviewed by others, but I think that is particularly concerning from the patient’s perspective. Let us talk about it from a regional perspective. If that coordinating practitioner were in Perth on training for a few days or a week or even, indeed, enjoying a bit of holiday time, that person would have no ability to self-administer whilst the coordinating practitioner were unavailable.

I am also concerned about the burden that it might place on practitioners who are willing to be coordinating practitioners in these circumstances when they ultimately will have to be available 24/7 during the six or 12-month period of eligibility. During that period, there will be a significant obligation on the coordinating practitioner to make themselves available day and night to respond to a request by a patient, without the ability to refer that responsibility to another practitioner if the need arose under clause 62(2), which does not apply to this provision.

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Another thing that Hon Rick Mazza raised that is not reflected in the amendment is something about which I have limited knowledge and something on which I did not really build my knowledge from the briefings on the bill—that is, the risks of administration. What are the likely complications? How often will they occur? Information was not easily accessible because the government does not want to talk about the types of drugs and so therefore we cannot speak specifically about the side effects or the risks. It is hard to make a judgement on whether this will be a one-in-a-million occurrence or more frequent and, therefore, we should give it greater consideration in balancing all these things.

I want to seek some technical advice from the minister. Hon Rick Mazza mentioned that the importance of having an administering practitioner, using the words in the amendment, present at the time of administration is that they have an ability to intervene if things go awry. I question the extent to which that practitioner will have the ability to intervene, other than to provide medical care and assistance. Keep in mind that this patient will have made a self-administration decision, not a practitioner administration decision. If the circumstance arose that the self-administration occurred in the presence of the administering practitioner and things were not going well, I am not sure that the practitioner can lawfully intervene and make sure that the job is finished. I think that the practitioner could intervene and provide medical care and treatment as practitioners are expected to do. I would like to know the standing of that practitioner who will be present on the occasion of self-administration and whether they can intervene in the way in which Hon Rick Mazza has suggested.

Hon STEPHEN DAWSON: In response to that last question, they cannot intervene. The member is correct in suggesting that they could provide care and support for the patient in that circumstance. In relation to an earlier point, I want to make clear again that a person would have to arrange the time to die with the practitioner in their final days. They would not have the freedom to reach a decision to face death at a time and place of their choosing. If this change occurred, it would totally undermine individual autonomy. I draw to the attention of the chamber that this whole issue was canvassed quite extensively when we debated clause 1. Some of the questions that have been asked now were asked at clause 1, so I draw that to the honourable member’s attention.

Hon Nick Goiran: Who has asked questions?

Hon STEPHEN DAWSON: Some of the issues that have been canvassed now, some of the questions that generally have been asked and the comments that have been made now, were also asked as questions earlier in the debate—extensively. I draw that to members’ attention. I am very happy for people to make points and talk against it, but we did canvass this earlier.

Hon MARTIN PRITCHARD: I take up one point that was raised by Hon Martin Aldridge about the administering practitioner. I think at an earlier stage, I raised an issue about the interpretation and I think the response that the minister gave at that time was that that could be any other medical practitioner, including a nurse practitioner. I ask whether that is correct.

Hon STEPHEN DAWSON: That is correct. That is for the purpose of practitioner administration.

Hon RICK MAZZA: Members might note that there is a raft of consequential amendments to this amendment on the supplementary notice paper. I just want to cover off a couple of things raised by Hon Martin Aldridge regarding the administering practitioner. I had something prepared earlier, because I asked this question of Parliamentary Counsel’s Office, which drafted my amendment. If members could bear with me a little, the document states—

“The administering practitioner for the patient is either the coordinating practitioner or a medical or nurse practitioner to whom the role of administering practitioner is transferred under cl. 62. So in every case a reference to the administering practitioner is a reference to the coordinating practitioner unless the role of administering practitioner has been transferred.

Under the unamended Bill, the concept of “administering practitioner” only applies where the patient makes a practitioner administration decision. Under Mr Mazza’s amendments, a patient who makes a self-administration decision also has an “administering practitioner” (see the amendments to cl. 62 which allow for the role of administering practitioner to be transferred even where the person has not made a practitioner administration decision).

The prescription for the VAD substance would still be issued by the coordinating practitioner. This is the same as cl. 58(2) of the unamended Bill in relation to practitioner administration. However, the authorised supplier would supply the VAD substance to the administering practitioner, who is then authorised to receive the substance and (if satisfied of the relevant matters) supply it to the patient for administration in the administering practitioner’s presence.

Mr Mazza’s amendments make cl. 57 consistent with cl. 58, except that the final step is not administration of the VAD substance to the patient by the administering practitioner but rather supply of the VAD substance by the administering practitioner to the patient and self-administration of the VAD substance by the patient in the administering practitioner’s presence.”

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Hon ADELE FARINA: I rise to support this suite of amendments. In my contribution to the second reading debate, I raised my concerns about how things can go wrong during self-administration, and there is plenty of evidence to support that in various reports from other jurisdictions. If our aim with this legislation is to ensure that the person has a peaceful and pain-free death—if that is our objective, and it is the stated objective—surely we want to ensure that a medical practitioner is on hand in the event that there are complications or adverse reactions with the administration of the voluntary assisted dying substance, to ensure that the person has a peaceful and pain-free death. I think what most people expect is the two-hour period that the Netherlands tries to hit with its medication, and that after the patient has taken the substance they will die in a very short time. The reality is that that has not always happened. I think 104 hours was the longest case—or that may be the wrong case. There was the case of David Prueitt in Oregon, which I read up on the other day. He took the voluntary assisted dying substance and three days later woke up and said, “What happened? I’m supposed to be dead.” It happens, and fortunately for him he did not experience any adverse reaction during that period. He just woke up, which caused him some level of shock. He ended up dying 11 days later as the result of the disease. We need to be clear with what we are doing here. If the objective is a peaceful and pain-free death, we need to ensure that we are able to deliver this. The voluntary assisted dying substance that will be prescribed is outside the usual regulatory framework that we have in this country. In our discussions on clause 4, the minister acknowledged that it has to be a schedule 4 or 8 poison and does not need to be approved by the Therapeutic Goods Administration. That means that there have been no scientific trials to ensure that the prescribed dosage will be absolutely correct. The doctors will be making their best educated guess at that, and in most cases they will get it right, but they will not always get it right.

There are also issues about what other medication they are on and how that may impact the effectiveness of the voluntary assisted dying substance. In the report that Hon Nick Goiran read from, it also advises that the person take the voluntary assisted dying substance on an empty stomach to increase the absorption of the substance. In fact, there is some commentary in the case of David Prueitt that he had been on laxatives and that the laxatives may have interfered with the absorption of the voluntary assisted dying substance.

There are a whole lot of things to take into consideration. If our objective here is to deliver a peaceful and pain-free death, surely the best circumstance to ensure that that happens, in the event of any complications or adverse reactions, is to have a medical practitioner present. We are not saying they have to administer the medication, but in the event that something goes wrong—if there are complications or adverse reactions—they could ensure that the distress that could follow to the patient and to the family who are witnessing all of this does not occur because they are able to step in and intervene to complete that process. Surely that is the whole objective of this bill.

In relation to whether it places too onerous a risk on the coordinating practitioner, that has not proven to be the case in the Netherlands because a doctor is required to be present. Also, in the bill before us and the amendments that Hon Rick Mazza has worked out with parliamentary counsel, there is a capacity to transfer that role of administering practitioner if the person assigned as the administering practitioner cannot be available at the time of the person’s choosing. It also enables that role to be transferred to a nurse practitioner. There is heaps of flexibility in this. Surely, if our aim is a peaceful and pain-free death, this is the best way to ensure that that is the result. I do not think it is too onerous; I think it puts the protection of the patient first.

I also raised my concern that without a practitioner present, a carer or family member might administer the voluntary assisted dying substance to the patient without the patient’s consent. By that stage, let me tell members that caring 24/7 for someone who is dying, day after day, by yourself, you are exhausted and you are not necessarily thinking rationally. You might rationalise in your own mind: the person has gone through the process; they have made their decision; this is what they said they want; the drug is here; now is the time that they should be taking it—that is elder abuse, and it is something we should be protecting against. I do not think these amendments are going to place too onerous an obligation; after all, it operates perfectly well in the Netherlands.

The other concern I expressed during my second reading contribution was the safe storage of the medication. Of course, there is nothing about that in the bill. It is very hard for us to make any judgements about that. We are told that it will all be sorted out during the implementation phase. Through these amendments that Hon Rick Mazza has proposed, we do not need to deal with this issue because the administering practitioner will bring the voluntary assisted dying substance with them at the time arranged for the person to self-administer it. I do not think what is being proposed is too unreasonable. It is in the best interests of the patient, which is what we should be thinking about. It is the best way to ensure that the patient has a peaceful and pain-free death.

Hon DR STEVE THOMAS: I will briefly go where angels fear to tread. There is one person in the Parliament who has had reasonable experience with the administration of euthanasia drugs—that is me. The question as to how often untoward reactions occur and what they look like is something that I said during my second reading contribution I was not going to go into in great detail, and I do not intend to go into it in great detail today.

A question asked before was: how often do unusual reactions occur to a barbiturate administration? As someone with 30 years in the game, I think the answer to that is that somewhere between one in 20 and one in 50 of those euthanasia activities do not go exactly to plan.

Hon Colin de Grussa: Was that in humans?
Hon Dr STEVE THOMAS: No, that was not in humans. It might surprise members to know that there is a reasonable correlation between the drugs and reactions in other mammals and in humans. We like to think we are remarkably special, and it is common for the medical profession to suggest that human medicine is significantly different from everything else, but the reality is that there is a huge overlap in the drugs used and the response to the drugs. In fact, in many cases, the veterinary profession led the way for the medical profession. That is certainly the case with the particular topic that the chamber is discussing today.

Frequently, there is a significant reaction to barbiturate administration. Bearing in mind that in the vast majority of cases, when we are doing this in the veterinary profession, ideally we will give a pre-sedative so that the patient is in a fairly relaxed state and then administer intravenously a bolus of a barbiturate, particularly pentobarbitone. The bolus goes in over a second or two. If we are talking about very large animals, for which the dose rate might be hundreds of millilitres, it is obviously more complicated to get it in in that period of time. Oral administration, obviously, is much slower. It is not generally done in the veterinary profession. The equivalent of oral administration is that when a vet cannot get a vein up, they will do what is called intraperitoneal administration; that is, they will place the drug in the abdominal cavity, outside the organs, where it will be picked up in the peritoneal cavity. That process will take, generally, several minutes—not uncommonly a few minutes, but occasionally a little longer. But there is always the opportunity in this process for that to take far longer and on occasions we will get reactions that people are surprised by. I can tell members, because I have done this, that when the family is sitting around watching their beloved family pet being put down after a lifetime of service, it is not an easy thing. A lot of people end up in tears; a few vets do as well. In that process, when a vet has administered a sedative and a bolus dose of a barbiturate, they are hoping that it is not the one in 30 cases that goes astray, but if it is, when that patient sits up and howls in front of the family and the children, it is not the easiest of experiences. There are not infrequent reactions. It is the reason we are very cautious about whether people can be present. I always did; I always liked to have the family present because I think it is a good way for them to say goodbye. I would generally say to the families, “I think you should be there, but you need to be aware that not infrequently pets will have a reaction that is not the prettiest thing to watch”, and people would understand that.

It is my expectation that on occasion something similar will occur. I know that will not change members’ minds about whether they support this bill, but it is about the process of managing that. Hon Rick Mazza’s amendment, with support from members such as Hon Adele Farina, would mean that there could be a medical doctor in place who could be required to manage that process. Again, I will not go into huge detail—I am not here to scare people—but the management of the process is important. I think the provisions in Hon Rick Mazza’s amendment, or an equivalent one, are important to manage the process when things will, inevitably, occasionally not go so well, even with all the best intent in the world and the best knowledge we have. Members have said before that dose rates vary; that is right, particularly if a person has had medications. If a person has a history of opiate usage, for example, or has used a lot of anaesthetics, they will become resistant to them and the dose rate that is required is going to vary significantly. That can be managed by a medical practitioner potentially altering that dose rate. It is not the case that it is always universally going to be a simple and beautiful process—I always wished that it was. It is sometimes like life—a little bit messy, a little bit ugly and sometimes it has to be handled as sensitively as possible. I suspect that the amendment, or an equivalent one, would assist that process.

Hon AARON STONEHOUSE: In considering this amendment and what value it would add to the process, I was listening to the contribution by Hon Nick Goiran, who gave the example of what is done in the Netherlands, where a medical practitioner’s attendance is required. If a patient does not die from taking a voluntary assisted dying substance, the doctor is there to finish the job, so to speak. I know that it was not the member’s intention, but I find that scenario rather distressing, and a rather scary idea. It is comforting to have the minister assure us that an administering practitioner would not be able to do that under this bill. An administering practitioner who is present would be able to provide medical aid, comfort and support to a patient, if they did not die as a result of taking a voluntary assisted dying substance. Looking at it in that context, and understanding that there can be complications in dosage and there can be different reactions to voluntary assisted dying substances, it certainly adds value to have a medical practitioner present at the time of taking a voluntary assisted dying substance.

It is still my preference that patients self-administer, as we can then be certain to at least some degree that it is a voluntary action; it is not a medical practitioner steering the process. The patient has taken that final action that requires the commitment for them to carry through with that action and take their own life, in that instance. I am sensitive to concerns that this would make it rather onerous, and that having to schedule an appointment with an administering practitioner just to self-administer a voluntary assisted dying substance would make it very difficult for the patients, especially those who perhaps require a greater level of care than others, or those in regional areas who may have to travel to visit a practitioner, and a practitioner is not available to do call-outs.

I am leaning towards supporting this amendment. As I see it, the greatest benefit of this amendment is that at least a medical practitioner would be present at the time to ensure that it is not a family member administering a voluntary assisted dying substance and that it is the patient who is self-administering. There is still a risk that a patient who chooses self-administration will take the substance home with them and whoever—a family member,
perhaps a carer or someone close to them—is looking after their day-to-day needs is really in a position to, perhaps at the patient’s request, administer; but even against the patient’s wishes administer. We really will not know what goes on in that final moment. If we can mitigate that risk somehow by having an amendment like this, or similar to this, I see that there is benefit. We would be removing one of the risks that I think is present, which is when someone has the substance at home for an extended period of time and there is the potential that someone else will administer it—force them to take it or give it to them without their knowledge, or perhaps even try to help the patient take it, which, of course, would be inappropriate under this bill. I do see that there is a benefit. It would be more onerous, which is undesirable, but I think in this case the mitigation of risk might outweigh the additional burden being placed on the patient. That is the way I am leaning currently.

Hon COLIN HOLT: I must admit that I agree a fair bit with what Hon Adele Farina had to say about the purpose of this bill, which is—I will paraphrase, obviously—the safe passage of a person at the end of their life to make a choice that they have suffered enough and want to end their life. That is the purpose of the bill. If we think about the process, they will have gone through all those checks and balances to get to that very point. They will have been through a medical process and will now be coming into a much more regulated process. They will have gone through all the first and second requests and written declarations and have finally got the substance—or not got the substance under this amendment—and made the decision: “I want to end my life at the time of my choosing.” That seems absolutely correct in my mind because they want to end the suffering, as dictated in the bill, which is their choice and assessment.

We get to the end point at which the patient has made that decision. I completely agree that there are risks with self-administration in a medical sense. We have had explanations. I think it comes up in clause 26, which provides that the coordinating medical practitioner has to say, “Here are all the risks of self-administration. Here are the risks with the medicine.” They have to actually explain all those risks, just as they have to explain all the risks of medication now. Even in a palliative care setting, when drugs like morphine are prescribed to be administered at home, they will be told about the risks, the potential side effects and what can happen. There are explanations throughout the bill about the risks. If I were in this situation after the passage of this bill, I would probably say that I would like a doctor to be near me to minimise those risks. But that would be my choice as a patient. It would be my choice as a patient to say that I would really like the doctor to be there, or I could go down to Lucky Bay in Esperance and decide to do it there. That would be my choice at the end of my life.

After all the processes that a patient goes through, they might say, “It’s my choice. I would really like to take the substance. I know all the risks. They have been explained to me. I know all about the various stages along the way. I have weighed all that up and I accept that it is my choice.” If one of my family members got into that situation, I would suggest ensuring that the doctor knew of the timing so that if anything did go wrong, they could be called and brought to the place. Again, it is about the choice of the patient. In my mind, this amendment takes away that choice. In fact, the choice of time gets taken away in some respects, because the patient has to wait for the coordinating or administering practitioner to be available to bring the substance. At that point, things are already starting to be taken out of the patient’s hands. I think the underlying value of this bill is the autonomy of the patient in their decision-making—that it is voluntary. That brings autonomy. This amendment takes away some of that and there are other consequences as well. It is about a person at their end stage.

Hon Aaron Stonehouse talked about the risks of someone administering the substance to the patient, because that does not make the process truly self-administered. But let us look at the palliative care setting. In that setting my mum was in control of all the morphine that she had to give to my father whenever he needed it—absolutely. Whenever he called, she gave him some more. Although there might be some arguments that the aim of morphine is pain relief, we know what the side effects are. We are talking about someone towards the end of their life who has gone through the process and finally made a decision that the time is right for them, yet this amendment will bring one more potential hurdle into the bill. That is unacceptable. I cannot support the amendment for those reasons. I think it is about patient autonomy—let them make that decision. It is probably hard enough for them already. I would hate to think that if this amendment passed, someone could have teed up voluntary assisted dying for 10.00 am on Tuesday, have the doctor come, but the person might tell the doctor that maybe they are not quite ready and to come back tomorrow—or whatever scenario might be. There are myriad scenarios, and we have heard myriad scenarios in this debate. I come back to the fact that a person is at the end of the process, they are probably very ill, they have probably had enough and, more likely than that, they have got to their end point. I think it is for them to say when and under what circumstances they take the final step.

Hon ALISON XAMON: I indicate that I am generally torn about this amendment, because it picks up a lot of issues that go to the core of this issue. I absolutely recognise that in an ideal world, people should be able to determine the time they want to die. They should be able to have the people around them they want, and if they wish to do that privately and in a particular setting, that should be the way it is. The difficulty I have is that we are talking about a process of the state assisting in that death. As such, we have an obligation in this place not simply to create laws based on ideal scenarios, but also to foresee where things can go wrong and try to look at the best way to address that. I am genuinely concerned about the possibility of a bad reaction and someone not being there to assist. I am particularly concerned about the impact that could have on any children present. That could be extraordinarily
traumatic, and it is an issue that weighs heavily on my mind. I also remain concerned about the issue of genuine consent. An idea I am attracted to is that by having someone who is independent present, there are checks and balances to determine that there is genuine consent and someone has not been coerced at the very last minute.

I have another concern, which is about protection for the families. A lot of members here talk about their experiences with what I hear as only functional families. That is great; I am really glad. Not everyone has the experience of a functional family. One of the things I do know is that when there are issues around money, wills and death, all the emotions and all the greed come out. All we have to do is go to our courts any day of the week and we will find there are disputes around estates among people who should love each other and be on the same side, but it tears families apart. I am attracted to the idea that an independent person being present will, frankly, lessen the likelihood of people being accused of murder, of having participated in the murder of a loved one. I see it as protection for the family to have, if you like, a witness present. Having said all that, I am really concerned also about the prospect of the independent witness turning up to facilitate and address all these issues, but the person who is availing themselves of the voluntary assisted dying process says, “Actually, I really don’t want to go now.” I would hate the presence of an independent person to be any sort of pressure on someone when they might want another five hours or even five days and have said, “I’ve changed my mind. I really am not ready to go yet; I want to stay.”

I am also very concerned that people’s capacity to access VAD will be limited by the availability of practitioners who can assist. I understand this is particularly an issue for people in the regions, but also I recognise it might be an issue just in terms of appropriate times or even places.

These matters are all weighing heavily on my mind. I am not sure that the amendment as it is drafted can address all my concerns. I am still conflicted about this. I stress again that it is my preference that people self-administer; that is far preferable to having someone administer the substance. However, we need to make sure we get the balance right so that things do not go wrong. I am not sure that the bill unamended will achieve that, but I am not sure that the amendment in front of us can fully address the other concerns I have about access to that independent support.

The DEPUTY CHAIR (Hon Matthew Swinbourn): The honourable Di Guise.

Several members interjected.

The DEPUTY CHAIR: That is! Hon Diane Evers, my apologies.

Hon DIANE EVERS: That is all right; thanks for lightening up the situation!

I agree with Hon Adele Farina that one of our objectives of this bill is to have a peaceful and pain-free death; there is definitely no doubt about it. But another very significant part is the objective to allow the person who is dying and who is in insufferable pain and who wants to end their life to have that choice. That choice is the reason I am standing now. We believe that a person should have the liberty to decide for themselves how they would like to go. I can see a problem if there is a requirement to have an administering practitioner there. From what I can see, in an ideal world—we have had plenty of hypotheticals here—imagine a patient has invited their close friends and family around for lunch, to have a wake or memorial service while they are still there, to speak those last few words to each other. The friends and family have arrived and the patient’s pain is being managed by whatever medication they are on, but the patient has told the practitioner that they intend to complete the process at half past three. The practitioner arrives and the guests are still there, having a lovely time. The patient is still enjoying their company, and it is not the right time; it does not feel like that is the right time. Time is ticking by—now it is five o’clock or maybe half past five. The practitioner is there, and they could even be a friend of the patient, but they want to get home to their own family for dinnertime or they might have to pick their kids up from somewhere. This is not the sort of pressure we want to put on a patient who is in their last few days or hours of life. It is their choice. They want to have their friends and family there; they want to be able to complete the process themselves. Remember that they are dying. Yes, miracles may happen, but, for the most part, they are dying. They are in insufferable pain. They want to be able to make that choice. Yet here we are, trying to legislate something that will put a burden on them to say, “Oh, yes, one last thing. We have to make sure that this person is here at the time that it happens.” Imagine we do not pass this proposed amendment and the patient does not have that requirement. The patient had a lovely day and fell asleep with the pain relief, having had those wonderful thoughts, but they wake up at 9.30 or 10 o’clock, and their partner is with them. The patient says, “Look, we’ve said goodbye. It was a beautiful day. I’m ready now. Let’s do this.” They do not have to wait until the next morning to call up the practitioner, see if they are around still, and have them come back again.

If we want people to be free to do as they please, as long as they are not harming anyone—in this case, they are not; they are the patient; they are the one who is suffering—I would think that we would want the rights of that individual to life, liberty and property to be protected. It should be their right to be able to choose the time of their passing without any of the constraints of this proposed amendment. To say to a patient, “Before you do that, you have to make sure you’ve got somebody there” takes away much of what we are trying to achieve with this legislation. I think that putting such a burden on a patient would really increase their pain by giving them the responsibility of making sure that they choose to die at the time that they have organised for someone to be there. It is just unconscionable. I cannot see why we would put something like that in this bill, without even going into the issues of how difficult that might be in a regional or remote area, or if they choose to go to their favourite holiday place.
or to be completely on their own. Yes, I have heard all the concerns about coercion and abuse, but remember the person is dying. They are not going to be around for another two or three years. The chances are that they will not be too worried about where their property will go afterwards, because they will want that final connection with the people they love to be a feeling of goodwill, love and connection. The person is dying. It just does not make sense.

There is a concern about what would happen should the voluntary assisted dying process go wrong—should the medicine come back up or should it not be sufficient. We have already addressed the fact that the administering practitioner in this case, who has not been given the right to be the administering practitioner and complete the process, has no right to complete it should they be there and it not be final. The family would be in the same situation. The person is dying. They have pain medication around. I do not know the specific issues. We do not know yet, because things are always changing with what drugs can be used and how we can manage that. But remember, the patient is in insufferable pain already. If they were not, they would not be trying to end their life. A practitioner being there to give the patient relief after they have tried to finish their life just puts the patient back in the same place, and they would be in that place whether or not that practitioner was there. It does not actually do anything more in that respect. It does not do anything more to change their situation of being in insufferable pain and death being imminent.

Coercion and abuse—okay, fine; if I work really hard, I can imagine a situation in which a family is just desperate. They want to go on a holiday soon. They know they are going to be getting a lot of money out of the will, and they think, “Let’s knock him off a week before he’s going to go anyway, in insufferable pain for that time.” Wow—okay; let us make a movie out of it, too! That may happen, but that is not the point of this bill. The point of this bill is for those people who have the capacity and the desire to do this. We would put a big hole in the legislation and mess it up for many people who may not be able to manage to organise a practitioner at the right time, just to address the possibility of a really unkind family wanting to knock off a person early. Let us face it; in this world, if somebody is already in that position, there are probably more cases of them asking to be finished off than cases of families wanting to do the reverse. We have heard more cases of people asking over and over, “Please, end it for me. Put a pillow over my head”, or whatever it is. Those are the cases that we are trying to look at. It is possible that it could happen the other way in some other world, or even in this world, but that is not what this is about. What we are trying to do here is create the best legislation so that the people who want to access this choice are able to, and they are able to do that with their friends present and without having to coordinate some other practitioner to be there to assist them. They want to do it on their own and at the time of their choosing. The time of their choosing may not be possible for the practitioner. The time of their choosing may not even be known to them until half an hour or 10 minutes beforehand. Those people should still have that choice. They should still have the liberty to deal with their own life and their own death in their own time, in their own manner, with the people they love around them and in the location of their choice. I think that passing this amendment would take that away from so many people, and it would just be a terrible thing to happen.

Hon NICK GOIRAN: Prior to the luncheon adjournment, I made the case that I would support Hon Rick Mazza’s amendment, primarily because I put to members that the experience in other jurisdictions informs us that complications can arise as a result of taking this lethal substance. I have to confess that I did not expect to come back after the adjournment and hear the response from Hon Colin Holt, and to some extent Hon Diane Evers, that I heard to the concern that I raised about a person at the end of their life taking the lethal substance. Those members said that we need to remember that, above all else, the patient’s autonomy trumps everything. If I understood the honourable members correctly, we need to remember that this is their choice. The honourable members make a compelling case.

Hon Colin Holt: I also said they needed to weigh up the risk, and I was actually responding to Hon Adele Farina.

Hon NICK GOIRAN: Absolutely—Hon Colin Holt, please do not hear my response so far as being critical of what you have said. I am simply indicating that I had not considered that position. I had not anticipated that members would say that, at the end of the day, we need to appreciate that a decision will be made by a patient who will have weighed up the risks, which will also include the risks in what I will call the Farina amendment, which is intended to be moved at clause 68 by the government. The patient will have already been told all of these risks and therefore it will be their choice—my life, my choice. I did not expect members to say that. I had intended to try to persuade members on the basis of the number of complications that can actually happen, but I concede that if a member’s worldview on this issue is that it is the patient’s choice, and if the patient has been told that these complications can arise and they could choke, asphyxiate or whatever the situation is at the end of life and they choose not to have a medical practitioner in attendance, then that is their choice—okay. That goes against my conscience, but I accept that a logical argument has been put by those members. I ask members to consider one thing. They talk about autonomy and “My Life, My Choice”; do they realise that at this particular point in the journey there is no requirement for the patient to have decision-making capacity? There is no requirement; we know that from the answers provided by the minister on several clauses. If the patient chooses “My Life, My Choice” and exercises their autonomy and says, “I want practitioner administration”, this bill that we are going to pass will mandate that the practitioner cannot administer without there being decision-making capacity. I have not heard anyone suggest for a moment that it should be different, but suddenly we are going to take a different approach with self-administration. We are going to say to the person, “You can self-administer. Here you go. You take the poison, and we, as lawmakers, will now wash our hands of whether you have decision-making capacity or not.” The amendment moved by Hon Rick Mazza.
ensures that somebody is supervising at the end of life to say, “This person still has decision-making capacity.” To those members who have passionately made the case for autonomy and “My Life, My Choice”, that is fine; I am not criticising them for having that view at all. But what follows from that is that there is no autonomy and there is no “My Life, My Choice” if the person has lost decision-making capacity. At that point it is no longer their decision. What do we do in that situation? Hon Rick Mazza fixes that. In actual fact, the irony is that if members are passionate about autonomy, it follows that they must be passionate about decision-making capacity. The only way that they will ensure that there is decision-making capacity when the person self-administers is by agreeing with the amendment moved by Hon Rick Mazza. In addition to that I wholeheartedly support the concerns raised by Hon Alison Xamon with regard to the possibility of abuse at the end of life. Again, even though I wholeheartedly support the member on that, I can already foreshadow that some members will say, “No, it’s that person’s choice. If they want to walk through a door where abuse is possible, that’s up to them because of ’My Life, My Choice’.” Okay; again, I do not agree with that, but I accept that that is a possible response. But does the person have decision-making capacity? Before they take the poison, do they have decision-making capacity? That is the issue here. If members are of the view that it does not matter, that at that particular point in time so much has occurred that it does not matter whether they have decision-making capacity or not, they should not support Hon Rick Mazza. I do not know how they can then in all good conscience allow a bill to take place that has practitioner administration that requires decision-making capacity. I do not know why they would then support a government that has consistently said that it is fundamental to this bill that decision-making capacity trump all else. I do not know how they do that. But to those members who keep passionately asking us to support autonomy and “My Life, My Choice” I say it makes no sense in the absence of decision-making capacity. Unless they can persuade me otherwise, I will be supporting Hon Rick Mazza.

**Hon DIANE EVERS:** I have listened intently to Hon Nick Goiran’s comments and I say we have to accept that the person has capacity, if they have gone through the process and got to the point at which they have the substance in their own home. At that point, if they have gone through that process, they have the right to do this. It is hard for me to imagine, but putting myself in the place of a person who has reached that point, they have made all their choices along the way, they know the situation and they know the risks. They know that the substance is in their home and they know that the end is near, whether by natural means or by taking the substance. I think they have done all they need to do; are we to take that right away from them by saying that somebody has to be there to assess their capacity? They have said goodbye to everyone in their life, they are about to go to their final sleep, and we are saying, “No, wait; we still have to do a little assessment of you to make sure you know what you’re doing.” That is highly invasive and just seems wrong to me. I would not want that to happen to me, and a lot of people out there who are definitely in favour of this legislation going through also would not want it to happen to them.

What right do we have as a government or as a medical practitioner to tell that person in those last few moments, after they have jumped through every hoop to make sure that they do this by the book, that somebody needs to be there at the last minute to check to see whether they still have capacity? They have made that choice. They are dying. I have not made up my mind either way, and I am listening to the debate. As an extension of Hon Diane Evers’ comments, in my view, if the person lost capacity, what would most likely occur is that a relation would fulfil their last request. I am not sure whether that is right or wrong, can I say. I am trying to weigh this up. We will never get a perfect situation either way, but it seems to me fairly onerous that a member of their own family would have to make that decision. That is the most likely outcome of losing capacity. What right do we have as a government or as a medical practitioner to tell that person in those last few moments, after they have jumped through every hoop to make sure that they do this by the book, that somebody needs to be there at the last minute to check to see whether they still have capacity? They have made that choice. They are dying.

**Hon MARTIN PRITCHARD:** I have not made up my mind either way, and I am listening to the debate. As an extension of Hon Diane Evers’ comments, in my view, if the person lost capacity, what would most likely occur is that a relation would fulfil their last request. I am not sure whether that is right or wrong, can I say. I am trying to weigh this up. We will never get a perfect situation either way, but it seems to me fairly onerous that a member of their own family would have to make that decision. That is the most likely outcome of losing capacity.

**Hon DIANE EVERS:** I do not see that that is the follow-on outcome of it. Of course, the family member cannot do that of their own choice; it has to be the choice of the patient. If the patient does not say, “Yes, give that to me”, it will stay in the fridge or wherever it is. Capacity is a different thing from a person being able to make the request and having the ability to do it themselves. I am not going to go any further on this, but I do not think that is the only logical outcome of it. I do not see that that all. I still see it being the choice of the patient. But that does not mean that in Hon Nick Goiran’s terms that would be capacity.

**Hon NICK GOIRAN:** Just to clarify, member, in the absence of decision-making capacity, there is no genuine choice. The moment a person has lost decision-making capacity, the person is not making a choice. That is a matter of legality. Maybe the member thinks in her heart of hearts, “No; they’re still making a choice.” But, as a matter of legality, they are not making a choice. That is the issue here. The member knows that I am not agreeable with the whole bill, but at least, if I can give credit where credit is due, the bill talks about decision-making capacity. It talks about that on multiple occasions, including for practitioner administration. The one place in which it is absent is self-administration.

The final point I would make is that members may recall that there is a provision in this bill that allows for the process to be accelerated. The minimum period of time is nine days. However, there is one exception to that. It can be quicker than nine days. It can be as quick as two days—two days is the bare minimum. One of the situations in which a person can qualify for what I have referred to as the express pathway is if their doctor says, “I’m concerned that between now and the nine-day period, you’re going to lose capacity.” The doctor says, “I think patient X is going to lose capacity sometime in the next nine days, so I’m going to put them on the express pathway.” We then

*Extracted from finalised Hansard*
continue with the rest of the process. The person chooses self-administration, because, remember, they still have capacity because they are in that nine-day period. We give them the poison to take home. At that time, there is no requirement for the person to take it in the nine days while they have capacity—no; they have taken it home—but the doctor knows that they are going to lose capacity after nine days. They could take it in 10 days, 12 days, 15 days or five months, and meanwhile the poison is at the person’s home. The doctor knew that the person was going to lose capacity.

Hon Alannah MacTiernan: Balance of probabilities.

Hon NICK GOIRAN: Okay. I will take that interjection.

Hon Alannah MacTiernan: Likely to be.

Hon NICK GOIRAN: I accept that, honourable minister. Under the scenario that I am painting with regard to the express pathway, if we were going to score it out of 100, how many times is that going to happen? I accept the intent of what the minister is saying—that it is not the most likely scenario to eventuate. But the fact is that the reason we are here as the Legislative Council is to make sure that we are plugging these gaps, and one of the ways in which we can plug these gaps is by supporting Hon Rick Mazza’s amendment.

Hon RICK MAZZA: Before this amendment goes to the vote, I want to make a couple of comments about the contributions that have been made. There has been some argument about the availability of practitioners who might be able to assist and be present as an administering practitioner if someone decides to self-administer. One would think that if someone has an ailment that was going to end their life, along the way they would have had consultations with medical practitioners and have access to them, whether they be a nurse practitioner or a general practitioner—whatever the case may be. I think they would have access to those sorts of people, who might be available to attend if the patient wanted to self-administer.

Hon Kyle McGinn: They might not be where they live, though.

Hon RICK MAZZA: They would have had consultations along the way.

I also have heard that there could be allegations against a family member. Hon Alison Xamon raised this issue. If someone is going to self-administer, the substance will be at home. There is no requirement about when they have to take it—whether it is two weeks or three months.

Hon Colin Holt: Some don’t even take it.

Hon RICK MAZZA: Some patients may not take it; that is quite right.

But if a family member is with them, who is to say that other family members will not accuse that family member of administering the substance to the patient. Having been a real estate agent for 20 years, just at that level, I can tell members that what families will do to each other would absolutely curl their hair. To think that this will be happy families all the way and that everyone will gather around when the substance is administered is a fantasy. I have seen people rip their own families apart for financial gain. It is absolutely heartbreaking to see elderly women who are on their own have their children basically kick them out of the house. These things can occur, and I think we need to have safeguards in place to make sure that those circumstances are minimised. I think the amendment I have proposed goes some way towards that.

I get the privacy issue. I get that people would like to just go home to their family and take the substance and, hopefully, peacefully pass away. I get all that. However, in the real world, that will not always be the case, so we need to put safeguards in place. Therefore, I commend this amendment to the chamber.

Division

Amendment put and a division taken, the Deputy Chair (Hon Matthew Swinbourn) casting his vote with the noes, with the following result—

Ayes (13)

Hon Peter Collier
Hon Donna Faragher
Hon Adele Farina
Hon Nick Goiran
Hon Rick Mazza
Hon Michael Mischin
Hon Simon O’Brien
Hon Martin Pritchard
Hon Charles Smith
Hon Aaron Stonehouse
Hon Dr Steve Thomas
Hon Colin Tincknell

Noes (21)

Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Jim Chown
Hon Tim Clifford
Hon Alanna Clohesy
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTiernan
Hon Kyle McGinn
Hon Anna McG走路
Hon Samantha Rowe
Hon Robin Scott
Hon Tjorn Sibma
Hon Matthew Swinbourn

Amendment thus negatived.

Extracted from finalised Hansard
The DEPUTY CHAIR: Hon Nick Goiran earlier withdrew an amendment. Do you wish to still pursue that amendment?

Hon NICK GOIRAN: Yes, notwithstanding that technically we are going back to lines already passed on page 37, nevertheless, subject to whatever supplementary procedure is required, I move —

Page 37, lines 1 and 2 — To delete “the contact person for the patient or an agent of the patient.” and substitute —

or the contact person for the patient.

Hon STEPHEN DAWSON: We have already addressed this amendment, albeit that Hon Nick Goiran withdrew it to allow Hon Rick Mazza the opportunity to have his amendments considered. I have indicated previously that the government is not supportive of this amendment. I hope that there is not extensive debate on the amendment, given that we have essentially debated it previously.

Hon NICK GOIRAN: To remind members, this is related but quite different from the other matter that we have just dealt with. This matter deals with the issue of an agent. Members will recall the debate earlier today when other members identified—I take no credit for this—that the bill does not define “agent”. An undefined Western Australian person will be able to access this lethal medication, albeit on the part of the patient; notwithstanding that, as members identified earlier, the patient already has to nominate a contact person. There is a very significant difference between a contact person and an agent under the provisions of this bill. The contact person is defined and has roles and responsibilities. An agent is undefined and has unspecified roles and responsibility obligations. I think one of the honourable members raised earlier in the debate that this is, if you like, an unregulated aspect of the system, and I agree. The role of this undefined agent is unregulated, whereas the role of the contact person is regulated. We are talking about a person taking into possession a lethal substance. I think the minister and the government’s explanation was that it is routine for agents to be used by patients to collect things. That is true, but that is to heal and care for people; it is not to take a substance that has the express purpose of the death of an individual. That is what makes this unique and that is precisely why the government has elected to insist on the legislation, which I support, that there needs to be a contact person who is able to do various things including account for any disposal at a later stage. For those reasons, I recommend to members that we do not leave this unregulated, undefined and frankly unnecessary aspect of the bill, which is for agents to be involved.

Hon MARTIN ALDRIDGE: I have a question for the minister. If we were to oppose this amendment and retain “agent” in this clause, is there any prohibition on the agent being a person of less than 18 years of age, which was the issue raised by Hon Martin Pritchard?

Hon STEPHEN DAWSON: There is no prohibition.

Hon MARTIN ALDRIDGE: I refer to clause 66, because it is related to this amendment. Clause 66 is “Role of contact person”. Clause 66(1) simply sets out what the contact person is authorised to do, which is receive, possess, supply and return the substance. Obviously, with regard to the first three elements—receive, possess and supply—they have a similar authorisation to an agent. 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).

If the agent, who could be a person less than 18 years of age, is authorised to receive, possess and supply a voluntary assisted dying substance to the patient, how is it that the contact person under clause 66(2) will fulfil their lawful obligation to inform the coordinating practitioner when there is no obligation for the contact person to even know that an agent has been appointed?

Hon STEPHEN DAWSON: When the substance is supplied by the authorised supplier, they must notify the board, including who they supplied it to. The board would let the contact person know. The patient, upon receipt, would advise their contact person and coordinating practitioner. Conversations would take place between the practitioner and the patient prior to prescribing the substance. Further, the contact role will only be accepted by someone who has close contact with the patient and is prepared to be kept informed about the patient’s state of health and decision-making capacity.

Hon MARTIN ALDRIDGE: On the point that the board would notify the contact person if the authorised supplier had dispensed the substance to somebody other than them—for example, an agent—what is the time requirement for the board to advise the contact person, and is that a requirement of the bill?

Hon STEPHEN DAWSON: Under clause 148 of the bill, it is within two business days.

Hon MARTIN ALDRIDGE: I am not satisfied that the bill requires provision for an agent. It certainly is concerning to me that an agent could be a child and that, for the purposes of this bill, a voluntary assisted dying substance could be dispensed to a child. It concerns me that there is no adequate recognition of the connection between a contact person and an agent in terms of the contact person discharging their responsibilities under clause 66 of the bill. I am also not convinced that the provisions in the bill that allow for the patient to revoke a contact person and appoint another contact person are significantly arduous to deal with the problem that is trying to be addressed by the
provision of having an agent. The scope of the agent is very narrow: it is to receive, possess and supply the substance. That is it—they cannot do anything else. If there is a circumstance in which the contact person is unable to fulfil their responsibilities, the patient would not easily be able to appoint another contact person who could do that.

Perhaps another way to do it would be to allow the contact person, with the agreement of the patient, to delegate responsibility, but it would relate directly to the appointment and the powers of the contact person. The way it has been constructed in this bill is that there is no relationship between the agent and the contact person, apart from, as the minister just said, two days after dispensing the drug, the board would make a notification. In that time, the substance could have been consumed and the patient could have died. There is no good reason—in fact, I think there is some good concern—for retaining “agent” in its current form.

**Hon DIANE EVERS:** I am not comfortable with the amendment taking away the right of the agent to collect the medication—the substance. This could be very difficult in regional and remote areas, where it may be that the contact person is a close family member who spends every day and every night with the person at this time and is not in a position to leave them, for whatever time it might take, to drive a significant distance to collect the substance. I can see other situations in which the contact person could be a partner who does not have a driver’s licence; they may not even be able to get there. It again puts a burden on the patient that is unnecessary; as long as we address any issues regarding who the agent is and what they can do.

I seek clarification of one point. I am not sure that it can be answered here, but I would think that our Medicines and Poisons Act would say something about a person having to be 18 to be able to receive medication such as this. I do not know whether that can be answered today, but it seems to me that there would be some sort of age requirement within our poisons act. I see this as a supporting role to be able to get the substance to the person’s home, where they and their contact person can use it.

**Hon JACQUI BOYDELL:** I have to agree with the comments of Hon Diane Evers. I think that an agent could play an exceptionally important role for the patient in managing the choices that they make at the end of their life. This is about the patient maintaining control. The patient will have their contact person. If, for some reason, the contact person cannot pick up the medication, which could occur for a whole lot of reasons, it would still be up to the patient to appoint an agent. They can do that very quickly and easily. This is about the patient’s access to voluntary assisted dying. A mechanism that supports the patient being able to deliver on their decision-making is important in the process.

We have all had contact at some point in our lives with groups, such as Silver Chain, that support families in their homes during the end stages of life. I could very well see an agency such as Silver Chain taking up this role. We want to keep the family together. The contact person would probably be one of the people in the group of people around the patient who is dying. I can understand that person not wanting to leave that scenario. The patient has the right to ask someone else to simply go and pick up the substance and bring it back. That is the only role that person would play, and it is about supporting the patient. I will not be supporting the amendment as put. I think that the agent could potentially play an exceptionally important role for the patient.

**Hon MARTIN PRITCHARD:** I do not really have a big problem with this. I often acted in this circumstance with my parents, picking up their medications and such. I do not particularly have a problem here, but it seems to me, from the way this is drafted, that the agent is an afterthought. It has been drafted in that manner and put into the document. There does not seem to be very much continuity, as there is with the contact person, with the substance and the line of communication between the different points. The only reason I would support the amendment is that it does not seem to gel particularly well with the rest of the bill.

**Hon AARON STONEHOUSE:** I think it is appropriate to provide for someone other than the contact person to collect and supply a voluntary assisted dying substance. I agree with the intent of allowing agents to carry out that function. However, I am very concerned that we have just learnt that someone under the age of 18 could act as an agent. There is no prohibition on a person under the age of 18 collecting, carrying and supplying a schedule 8 poison—a barbiturate. That is potentially quite dangerous. A 12-year-old child could be sent down to the dispensary—it probably will not be a community pharmacy; we have heard that—and there is nothing stopping them from being able to do that. It may be appropriate for someone under 18 to carry out certain functions at times, but we are talking about something potentially very dangerous. It is a barbiturate that is used not only as a poison, but also recreationally in some cases. We are putting a lot of responsibility on somebody under the age of 18 in this instance.

There will also be statutory obligations for contact people that will rely upon the agent carrying out their function. We are putting a contact person potentially in a dangerous situation in which they have an obligation to return any unused voluntary assisted dying substance, but they have no control over how that voluntary assisted dying substance is delivered or supplied to the patient. The contact person has these obligations and these responsibilities under clause 66(2), but who knows what the agent is doing? The contact person obviously is over the age of 18; they have to consent to becoming a contact person, and they are a responsible person who is opting into this. They have the option to opt out, and that responsibility can be transferred to someone else. The agent can be whoever the pharmacy or dispensary is advised will be coming to pick up the prescription. That concerns me.

*Extracted from finalised Hansard*
There should be provision in the bill for someone other than the contact person. That is appropriate. There can be scenarios, as outlined by Hon Diane Evers, in which the contact person is the full-time carer of the patient and it is impossible for them to leave the patient, who needs intensive care, to go and collect the prescription, especially if they have to travel a great distance to do so. However, I am really concerned about what appears to be a pretty loose framework and regulation around the agent and how the agent behaves, and the requirements for an agent. I do not think it necessarily needs to be spelt out in the legislation, and it does not need to be too onerous, but the lack of an age limit concerns me. Maybe the minister can tell us more about the current practice in the Medicines and Poisons Act and how pharmacies work with agents, to help us understand how this relationship works, but based on what we have been told so far, I am very concerned.

Hon MARTIN ALDRIDGE: In response to my question, the minister said that there is an obligation under clause 148, “Board to send information to contact person for patient”, for the board to notify the contact person. It reads —

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

(b) outlines the support services available …

That does not say that the board has to, within two days, advise the contact person that a substance has been dispensed. It says that the board has to provide information to the contact person within two days of their appointment as a contact person.

Hon AARON STONEHOUSE: I will just pile more on the minister’s plate while he is preparing his answer on that point Hon Martin Aldridge raised. If the board does have some role in notifying the contact person that a substance has been collected, what information is retained by the pharmacy or the disposer about the agent? Is the agent’s identification collected? Is a contact number collected for the agent? If any information is collected and provided to the contact person, what information is collected? How is the contact person going to be able to get in contact with the agent in this case to ensure that the substance is delivered appropriately? Ultimately, the contact person is responsible at this point—they are the person with the obligation to return any unused substance and to notify the board when the patient dies. What information is retained? What requirement is there in the legislation that it is retained and passed on?

Hon STEPHEN DAWSON: There are a couple of questions floating around, so I am hopefully going to provide answers to all of them. I turn to the question from Hon Martin Aldridge. The board knows, ahead of the substance being prescribed for self-administration, that a contact person exists. This is because the substance cannot be prescribed before a contact person is appointed. If the patient’s agent picks up the medication, the authorised supplier must verify who they are giving the meds to—that is, who the agent is. This information will then be on the database that will be available to the board. The board will see that an agent, not the contact person, has picked up the medication. The board will then let the contact person know, who will verify by calling the patient to check.

In answer to Hon Aaron Stonehouse’s question, the issue of ages was canvassed previously. I make the point again: there is no prohibition at the moment on a 17-year-old collecting a schedule 8 or schedule 4 substance outside this legislation. It was discussed previously that many medicines, if taken incorrectly or if too much is taken, may cause death, outside schedule 4 or schedule 8 substances.

Hon Martin Pritchard suggested that it was an afterthought to include “agent” in this bill. I assure him that it was not an afterthought; it is consist with the Medicines and Poisons Act.

Going back to what Hon Aaron Stonehouse said, the patient will send a trusted person. They will have a trusted person as their agent, not a random person. The patient will not send someone they have no confidence in; they will send someone whom they understand will be able to do the task of collecting the substance and will bring it back and give it to them.

Hon MARTIN ALDRIDGE: We have established that clause 148 does not apply, but we have an understanding that the board will notify the contact person that it is not a requirement of the legislation that that occur. I do not have a problem with the idea that a contact person may not be available to do certain things, so some other person will be required to undertake those functions. My problem is that it is completely disconnected from the provisions of the legislation. I would not use the same words as Hon Martin Pritchard to say that “agent” is an afterthought, but perhaps two ideas have been developed in isolation. Maybe that is because the government started drafting the bill before it received the ministerial expert panel recommendations. Perhaps the government’s position on the ministerial expert panel recommendations and bringing it all together has resulted in some of these issues. It was interesting to hear some people’s comments about the agent. The contact person may not have a driver’s licence; therefore, we would need an agent to drive to pick up the drugs. I remind members that it is the responsibility of the contact person to return the unused substance. Where is members’ concern that we should expand the provisions of the agent to include the return of the drug?

Hon Diane Evers interjected.
Under clause 70, “Authorised supplier to authenticate prescription”, sub clause (c) provides that the authorised supplier must confirm “the identity of the person to whom the substance is to be supplied”. Based on what? Unlike the contact person, an agent does not have any eligibility requirements or nomination forms. Nothing will be reported to the board on the appointment of an agent. Does somebody just rock up and say, “I’m the agent for the patient. Give us your drugs”? How does the authorised supplier identify the person as the agent of the patient? It is interesting that if we compare the powers of an agent with the powers of a contact person, the only two differences are that the contact person, additionally, is required to return the drug and notify the coordinating practitioner of the death. They are the only two differences. The contact person has two tasks to undertake after the death, whereas the agent will receive, possess and supply the substance.

Notwithstanding that, we could compare the numerous clauses that relate to a contact person’s powers, how a patient appoints a contact person, the contact person appointment form, the role of the contact person and the fact that the contact person may refuse to continue. A whole range of clauses that relate to the operation of a contact person do not relate at all to an agent, who has very, very similar functions. It concerns me that although the minister has indicated that the Voluntary Assisted Dying Board will do something when they are notified within two business days that the authorised supplier has dispensed the drug, it is not a requirement of the bill that they notify the contact person. As I said before, within those two days, the substance could have been supplied and the death could have occurred.

I do not have a violent objection to having an agent; I just think that the drafting of this clause is very ill-considered. As I said before, perhaps the better way to do it would be to allow the contact person, if they were unable to fulfil their powers, to appoint an agent in consultation with the patient. Perhaps that would be a better way of dealing with it. But I agree with Hon Martin Pritchard; I think there has been a bit of a haphazard approach to the intersection of an agent and a contact person in the bill.

Hon NICK GOIRAN: I want to add, to make it clear to members, that like Hon Martin Aldridge, I do not mind if there an agent is involved in this regime, but if there is going to be an agent in the regime, it cannot be in the current form that is in the bill. If the government genuinely and passionately says that it is very important that we have an agent for the reasons that some members have said, fine, but make amendments accordingly to regulate the role of the agent so that it is at least comparable with the regulation around the contact person. Do not leave an unregulated, undefined person in the legislation. That is the issue I have. If at some later stage the government wants to move an appropriate amendment to regulate the role of the agent—obviously, I have not seen the wording yet—in principle, I would support that.

Hon RICK MAZZA: I rise to say that I will support this amendment. Listening to the previous speakers, I get the idea of an agent. I think Hon Jacqui Boydell spoke about Silver Chain maybe going into town and being able to pick up the voluntary assisted dying substance, particularly if some distance is involved, and provide it to the patient or the contact person. However, I start to have some problems with the other functions that the agent can undertake, which Hon Martin Aldridge also articulated. It is not just being able to receive the prescribed substance, bearing in mind this person could be 16 years of age or younger, but also they can possess it and supply it. Clause 71(2) refers to what the authorised supplier needs to do when providing the substance to the person collecting it. I will not go through it, but the supplier has to advise the person who receives the substance of a whole list of different things that they can do. If that person is young and has not really been involved very much in the process for the patient, they may not be able to retain that information or understand their obligations under that clause. I think that the proposed amendment before us is actually quite a sound amendment. If there were amendments further on that the agent will be able to simply pick up the substance and then provide it to the contact person, I could live with that, but I think that the way the clause is drafted at the moment gives the agent far too much scope.

Hon ADELE FARINA: Did I hear the minister say earlier that the issue of the establishment of the agent being able to pick up medicines is actually under the Medicines and Poisons Act; and, if so, which section? I have been quickly flicking through it and I have not been able to find it. That raises the issue that even if we delete the agent from this provision, and if it is still in the Medicines and Poisons Act, the patient will still be able to appoint an agent.

Hon STEPHEN DAWSON: I am told that section 7(3)(b)(ii) of the Medicines and Poisons Act currently provides for agents to be supplied with schedule 4 or schedule 8 poisons.

Extracted from finalised Hansard
Hon NICK GOIRAN: Given the wording in clause 57(4), is it the case that the authorised supplier at clause 57(4)(c) can supply the substance only for those persons listed, notwithstanding anything in any other legislation?

Hon STEPHEN DAWSON: This supersedes other acts, but we are seeking to make consequential amendments to the Medicines and Poisons Act 2014 through an amendment at clause 173(3) of this legislation to fix the inconsistency with that act.

Hon ADELE FARINA: I just had a look at that section in the Medicines and Poisons Act and it applies only if the poison is prescribed for therapeutic use. I do not know that it could be argued that the voluntary assisted dying substance is prescribed for therapeutic use.

Hon STEPHEN DAWSON: We are making consequential amendments to the Medicines and Poisons Act that will cover that. The amendment I have identified at clause 173(3) will deal with the issue at section 7(3) of the Medicines and Poisons Act.

**Division**

Amendment put and a division taken, the Chair casting his vote with the ayes, with the following result —

Ayes (14)

- Hon Martin Aldridge
- Hon Nick Goiran
- Hon Martin Pritchard
- Hon Colin Tincknell
- Hon Peter Collier
- Hon Rick Mazza
- Hon Charles Smith
- Hon Ken Baston *(Teller)*
- Hon Donna Faragher
- Hon Michael Mischin
- Hon Dr Steve Thomas

Noes (21)

- Hon Jacqui Boydell
- Hon Sue Ellery
- Hon Kyle McGinn
- Hon Darren West
- Hon Colin de Grussa
- Hon Diane Evers
- Hon Samantha Rowe
- Hon Alison Xamon
- Hon Jim Chown
- Hon Laurie Graham
- Hon Robin Scott
- Hon Pierre Yang *(Teller)*
- Hon Tim Clifford
- Hon Colin Holt
- Hon Matthew Swinbourn
- Hon Alannah MacTiernan
- Hon Dr Sally Talbot

Amendment thus negatived.

The CHAIR: We now return to the question that clause 57 do stand as printed.

Hon ADELE FARINA: Clause 57(5) refers to the patient being authorised to “prepare” the voluntary assisted dying substance. What sort of preparation will be required by the patient?

Hon STEPHEN DAWSON: They could be required to mix the substance with a sweetener to make it more palatable, or mix it with water to take.

Hon NICK GOIRAN: What would happen if the patient does not have the ability to do that?

Hon STEPHEN DAWSON: In that case, self-administration would not be the appropriate course of action; practitioner administration would be the one they should take.

Hon MARTIN ALDRIDGE: What is the mechanism for a patient to appoint an agent?

Hon STEPHEN DAWSON: They would ask someone to do it and they would have to say yes or no.

Hon MARTIN ALDRIDGE: It would be a verbal agreement between the patient and the agent. How will a dispenser verify that a person is acting as an agent for a patient?

Hon STEPHEN DAWSON: We dealt with that question earlier today.

Hon Nick Goiran: You gave one example.

Hon STEPHEN DAWSON: No; I gave the example of a letter—I gave multiple examples.

Hon Nick Goiran: What were the other ones?

Hon STEPHEN DAWSON: It could be by phone call.

The CHAIR: Order! The minister is trying to answer the question, members.

Hon STEPHEN DAWSON: I will say it again. We have spent an inordinate amount of time dealing with the same thing multiple times over the last five weeks. With great respect to the members in this place, people have to pay attention to the debate if there is any commitment to dealing with this bill. It is not fair and it is disrespectful to keep asking the same questions over and again. I dealt with this earlier today. I gave the examples that it could be by letter or it could be by phone call. Those are two examples. I do not think it is fair to continue to ask the same question, albeit after a lunch break or a day or two. It is very important that people pay attention. It is not appropriate for me to keep repeating myself.

*Extracted from finalised Hansard*
Hon MARTIN ALDRIDGE: I take offence at the minister’s suggestion that members are not paying attention to this matter.

Hon Nick Goiran interjected.

Hon MARTIN ALDRIDGE: It is a very serious issue —

The CHAIR: Order! Members, let us remember that it has been a long week for everybody—all involved. A little bit of tolerance all around is what we require at this time as we invite Hon Martin Aldridge to continue his remarks.

Hon MARTIN ALDRIDGE: Given the concerns of members about retaining the provision for the agent in this clause, which contemplates a circumstance in which a contact person is unable to travel and therefore unable to deal with the logistics of receiving, possessing and supplying the substance, why is it that the government has not given consideration in this provision to also include within the agent’s powers the ability to return to the authorised disposer any unused or remaining prescribed substance?

Hon STEPHEN DAWSON: It is an undertaking that the contact person must make.

Hon MARTIN ALDRIDGE: In a circumstance in which a patient dies, the contact person cannot change and is fixed. The patient is no longer living, so can no longer revoke or appoint a new contact person. In the circumstances described by members who just voted to retain the provision for the agent in this clause, how will the substance be returned?

Hon STEPHEN DAWSON: I am advised that the coordinating practitioner can act as the contact person.

The CHAIR: Members, we are contemplating clause 57. Before we proceed, noting the two amendments on the supplementary notice paper standing in the name of Hon Charles Smith, one would presume that because they deal with matters that have been substantively dealt with, the member may not be proceeding with these. Could you confirm that, Hon Charles Smith?

Hon CHARLES SMITH: Thank you. Yes, I withdraw the next two amendments.

The CHAIR: Thanks. That gives us a scope of the work.

Hon NICK GOIRAN: At clause 57, “Self-administration”, subclause (5)(d) gives the power to the patient to self-administer the prescribed substance. What should the patient do if they experience difficulty in self-administering the approved substance?

Hon STEPHEN DAWSON: They should contact the coordinating practitioner and make a new administrative decision.

Hon NICK GOIRAN: How will somebody do that when they are in the middle of taking the poison? They may have difficulties. They may be incapacitated and cannot get to a phone and no-one else is there. We just agreed that there will be no supervision. What will happen in that situation? What will the patient do?

Hon STEPHEN DAWSON: The coordinating practitioner would most likely have had this conversation with the patient and would have encouraged them to have support from family, friends or a carer when they self-administer. In the member’s example, if the person is by themselves and not with anyone else and cannot take it, the reality is that they will wait for someone else to come along to help them.

Hon Nick Goiran: They may have already started taking it.

Hon STEPHEN DAWSON: That would be a consequence of their decision and them exercising their autonomy.

Hon NICK GOIRAN: How will the medical practitioner respond? What will the medical practitioner do when they are present at the scene, ensuring that the patient's wishes are carried out? In the example where the patient has self-administered, has family and friends there as recommended by the minister, the government, the guidelines and the practitioner, has had complications arise and is suffering—will the patient’s family and friends be permitted to call the paramedics; and, if they do, what can the paramedics do in that situation?

Hon STEPHEN DAWSON: In relation to the question about a prohibition on them calling the paramedics—I think that was the word the member used—there is no prohibition. If paramedics attend, I am advised that they are bound by professional obligations to provide assistance to the patient if there is medical distress.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: The minister responded to my question a few moments ago that the coordinating practitioner can act as the contact person. Could the minister advise me which clause of the bill he is relying upon for that advice?

Hon STEPHEN DAWSON: This issue was raised, and I am happy to give it to the chamber again; it is under clause 64(3).

Hon MARTIN ALDRIDGE: Clause 64(3) states —

Without limiting who can be appointed as the contact person, the patient may appoint their coordinating practitioner, their consulting practitioner or another registered health practitioner.

The problem is that it does not automatically appoint the coordinating practitioner as the contact person. The circumstance around which I just framed the question is relevant to this clause, Mr Chair, because I am considering clause 57(7) and why the government has chosen to omit within the powers of the agent the return of any unused substance. I appreciate the views expressed by the chamber. The scenario that I put to the minister is that there could be circumstances in which a contact person will not be able to travel to facilitate the receipt, possession and supply of the substance. I accept that and the chamber has agreed that we need to keep “agent”. My question is whether we need to include the return of that substance. As I said a few moments ago, a situation that would be quite possible is that the patient dies and the contact person, as described by several members in this chamber, continues as the contact person. That person cannot revoke that position and a new contact person cannot be added because the patient is dead. That person has an obligation to return the substance. In that circumstance, which has been accepted by the chamber as the reason we need to keep “agent”, why is it then not appropriate for us to consider including in the powers of an agent, to keep it consistent with those of a contact person, that the agent is empowered to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer as required by clause 104? Maybe the minister can point me to some other provision that might deal with that, or he might entertain including that within an agent’s role; but, what power will the coordinating practitioner have if they are not the authorised contact person, firstly, to possess the substance and, secondly, to return the substance?

Hon STEPHEN DAWSON: The contact person will commit an offence if they fail to return the substance, hence formal appointment is required. The state can facilitate medical retrieval if necessary. I will give an example. If the contact person is out of the country or is ill, they can advise that that is the case. The CEO can assist the contact person in fulfilling their obligations.

Hon MARTIN ALDRIDGE: The contact person has a lawful obligation. For those members who were concerned about helping the contact person by having an agent, would it not be helpful, to assist that contact person, to include it, or would the government accept the inclusion of a subclause 7(d) to allow the agent to return the substance? If we are allowing the agent to receive, possess and supply the substance—that is the position that has just been settled by the chamber—would that not naturally extend to its return?

Hon STEPHEN DAWSON: We would not countenance the insertion of a subclause (7)(d). Under our bill, the agent has a different role from the contact person. We are happy with the distinction between the agent’s role in clause 57 and the contact person’s role in clause 66(1)(d).

Hon MARTIN ALDRIDGE: This is the last time I will seek the call on this clause, Mr Chairman. I want the record to reflect that that may well be the government’s position, but for those members who just stood during discussion on the clause and said, “We have great concern that the contact person may not be in a position to fulfil their functions because they may not be able to travel and may not be able to do the things required of them; therefore, that is the reason we need an agent”, the agent as described in clause 57 is deficient, in my view, in line with their argument with regard to the return of the drug. The minister just said that they have a legal obligation; I think he even went as far as saying they would be committing an offence if they did not return the drug.

For those members who expressed that view in the consideration of the amendment moved by Hon Nick Goiran, if we leave this clause unamended, we are putting contact persons in the position of having a legal obligation to return the drugs and they will be committing an offence if they do not discharge their responsibility to return the drugs.

Hon NICK GOIRAN: I endorse entirely the comments made by Hon Martin Aldridge on that line of questioning. I have a final question on clause 57, subject to any supplementary questions that might arise. Will the prescribed substance have a use-by date?

Hon STEPHEN DAWSON: I am advised that all medications have a use-by date.

Hon NICK GOIRAN: What mechanisms are in this clause, “Self-administration”, or any other clause, to indicate what should be done with the prescribed substance if it has reached its use-by date?

Hon STEPHEN DAWSON: The guidelines will be developed during the implementation phase, and that includes this issue.

Clause put and passed.
Clause 58: Practitioner administration —

Hon ADELE FARINA: Mr Chair, I will not be moving my amendment to clause 58. It will be dealt with as part of the government’s alternative wording to clause 68.

The CHAIR: Thank you for that advice, member. The question is that clause 58 do stand as printed. Hon Charles Smith, do you have an amendment to move?

Hon CHARLES SMITH: Mr Chair, I seek to remove amendment 41/58.

The CHAIR: We will delete that amendment from the supplementary notice paper. Thank you, member, for clarifying that.

Hon NICK GOIRAN: Who is an authorised supplier under clause 58(3)?

Hon STEPHEN DAWSON: It is the same as the authorised supplier that we identified earlier. I am happy to give the member further information if required, but I believe that question was last asked on clause 57 before lunch. Does the member require information? No.

Hon NICK GOIRAN: Is the administering practitioner required to have any history of providing medical care to the patient or to have participated in any step of the request and assessment process, or might the time of administration be the first time that the administering practitioner has ever met the patient?

Hon STEPHEN DAWSON: Possibly, this could be the first time that they have met the patient, but clause 58(5) suggests that an administering practitioner needs to be satisfied at the time of administration that —

(a) the patient has decision-making capacity in relation to voluntary assisted dying; and

(b) the patient is acting voluntarily and without coercion; and

(c) the patient’s request for access to voluntary assisted dying is enduring.

Hon NICK GOIRAN: Why has clause 58(5) been deemed important for inclusion?

Hon STEPHEN DAWSON: In circumstances in which practitioner administration is deemed the appropriate administration decision, it would be necessary to determine these matters. An example would be if a person is on—to use the member’s language—the express pathway, to ensure that they have decision-making capacity. Also, it is important because the patient is not self-administering, and may change their mind.

Hon NICK GOIRAN: Who is eligible to witness the practitioner administration of the prescribed substance to the patient?

Hon STEPHEN DAWSON: Clauses 61(a) and (b) deal with that matter.

Hon NICK GOIRAN: Why is a witness for this practitioner administration required?

Hon STEPHEN DAWSON: We believe that the requirement for a witness during practitioner administration is another safeguard in the voluntary assisted dying process. It reflects the voluntary nature of voluntary assisted dying. It is fundamental to the WA model, and the decision to access death must be enduring.

Hon NICK GOIRAN: But it is not so fundamental that it applies to self-administration—correct?

Hon STEPHEN DAWSON: In the case of self-administration, the patient demonstrates capacity, voluntariness and enduring nature by taking the medication themselves.

Hon NICK GOIRAN: That is nonsensical. That is utterly nonsensical. There is no witness, no-one else is present, and the patient, who could have lost capacity, demonstrates the voluntariness of everything by taking the substance themselves. Did I mishear that? Does that require correction in any way?

Hon Stephen Dawson interjected.

Hon NICK GOIRAN: I heard that correctly. I note for the benefit of Hansard the furious agreement of the minister that I heard correctly.

Hon Stephen Dawson: The nodding of the minister.

Hon NICK GOIRAN: It was the polite nodding of the minister.

I find that extraordinary; is the practitioner required to remain with the patient up to the point of death?

Hon STEPHEN DAWSON: I am advised it is good medical practice.

Hon NICK GOIRAN: If it is good medical or clinical practice, is there any objection by the government to codifying that good medical practice?

Hon STEPHEN DAWSON: We would not countenance that change. I am told it is good medical practice. To make the change could undermine professional judgement. The medical practitioner may wait in the next room, because the act taking place would suggest that they need to be there and would have a concern.
Hon NICK GOIRAN: To understand it correctly then, the scenario that is being contemplated is that practitioner administration could involve the practitioner administering the substance to the patient, walking to the next room and waiting, and having no knowledge about what else is happening in the other room. Would that scenario be what we would describe as good medical practice?

Hon STEPHEN DAWSON: I am told that the patient may wish the practitioner to wait in the next room and prefer that a family member wait with them, but to get the practitioner if required. It would be unusual, though.

Clause put and passed.

Clause 59: Coordinating practitioner to notify Board of administration decision and prescription of substance —

Hon NICK GOIRAN: Clause 59(1) provides that the coordinating practitioner must provide the board with the administration decision and prescription form within two business days after the coordinating practitioner has provided a voluntary assisted dying substance. The only requirement is that the prescription has to be issued and the relevant form completed and provided to the board for notification. Where in clause 59 does it state that the board must be notified before the death of the patient?

The CHAIR: Members, noting the time and that the minister is taking advice —

Hon Stephen Dawson: There is no afternoon tea today, Mr Chair. There is obviously afternoon tea for those members who wish to partake.

The CHAIR: These are unruly interjections! As I was saying, noting the time, I will ask whether the minister wants to respond to the question.

Hon STEPHEN DAWSON: I do wish to respond; I will take advice from the advisers.

There is no requirement, honourable member, but I am advised that the information will be captured in a database that is accessible by the board.

Hon NICK GOIRAN: Will it be captured in a database before the death of the patient or could it happen after the death of the patient?

Hon STEPHEN DAWSON: It could happen after the patient’s death.

Hon NICK GOIRAN: So much for board oversight. What is the board required to do with this administration decision and prescription form? Will it be received by the board pre or post death?

Hon STEPHEN DAWSON: The intent of this provision is to ensure that the board is notified progressively of the person’s participation in the voluntary assisted dying process, including the outcome of each assessment to monitor that the correct process is being followed in each case of voluntary assisted dying and to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

Hon NICK GOIRAN: Does the board have any oversight of the administration of the substance?

Hon STEPHEN DAWSON: Can I ask the honourable member to clarify what he actually means by that?

Hon NICK GOIRAN: In response to my last question, the minister indicated that the board can do certain things. I asked what the board was required to do with the administration decision and prescription form and the minister listed various things. I am wondering whether the board has any oversight of the administration of the prescribed substance.

Hon STEPHEN DAWSON: No, it does not.

Hon NICK GOIRAN: Clause 59(2)(b) requires that the administration decision and prescription form include only the coordinating practitioner’s name and contact details. There appears to be no requirement for the practitioner’s qualifications, skills or training or any of those other things to be included in the form. Why is it not required to be included in the form and is such information required in any other jurisdiction at this point?

Hon STEPHEN DAWSON: Clause 16 sets out the requirements for eligibility to act as a coordinating practitioner. The requirements have already been satisfied at this stage, but also the person has already done the training. In relation to other jurisdictions, I do not think I have that information before me, but if it comes to hand, I will provide it.

The DEPUTY CHAIR (Hon Adele Farina): To the extent that it may help the chamber, under clause 28, the first assessment report form that would be provided to the board at that time must contain a statement confirming that the coordinating practitioner meets the requirements of section 16(2).

Hon NICK GOIRAN: Clause 59(2)(f) requires that the administration decision and prescription form include the date that the prescription for the voluntary assisted dying substance was issued. For patient safety, should the board also be informed on the form about any use-by dates for that substance?

Hon STEPHEN DAWSON: I am advised that the authorised supplier may be best placed to keep a record of medication that is near expiration via the proposed database.

The DEPUTY CHAIR: Members, I note that there are some proposed amendments on the supplementary notice paper. Would members indicate whether they intend to move those amendments? Hon Rick Mazza has indicated that he will not move proposed amendment 423/59. The question is that clause 59 stand as printed. Hon Nick Goiran.
Hon NICK GOIRAN: Thank you, Madam Deputy Chair. I will definitely move the amendment standing in my name at 89/59 on the supplementary notice paper. I move —

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;

Hon STEPHEN DAWSON: I indicate to the chamber that the government is supportive of this amendment for reasons given previously when similar amendments were moved.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 60: Certification by administering practitioner following administration of prescribed substance —

Hon NICK GOIRAN: If the practitioner administering the drugs is different from the coordinating practitioner, how can that practitioner be sure of the voluntariness and lack of coercion and that the request was enduring? How exactly will the practitioner test for capacity at the point of administration?

Hon STEPHEN DAWSON: The administering practitioner will have conversations with the patient and the coordinating practitioner, and may look at the patient’s history.

Progress reported and leave granted to sit again, pursuant to standing orders.
**Hon NICK GOIRAN:** Yes, minister, and clause 60(2)(b) states that the administering practitioner has to certify that they are satisfied that the patient has decision-making capacity. They will also undertake an assessment at that particular point in time, precisely as they will be required to do an assessment under clauses 25 and 36, yet the bill is silent with regard to referral at this point in time. Is it the case that an administering practitioner, who could be a nurse practitioner, might not be confident or satisfied that the patient has decision-making capacity at the time and, according to the minister, would then have to refer the patient to another person? What powers exist in the bill for the nurse practitioner to refer in the circumstances that they are not satisfied that the patient has decision-making capacity, or will they not have that ability to refer?

**Hon STEPHEN DAWSON:** I am told that no power need be specified for referral or inquiry. Good medical practice will guide the practitioner as per the nurse practitioner standards for practice.

**Hon NICK GOIRAN:** This clause provides for certification by an administering practitioner whereby practitioner administration occurs. What certification is required under the bill when patient self-administration will occur?

**Hon STEPHEN DAWSON:** None.

**The CHAIR:** Members, the question is that clause 60 do stand as printed. There are several amendments proposed on the supplementary notice paper 139, issue 16, which is the latest edition. The earliest of those stands in the name of Hon Charles Smith.

**Hon CHARLES SMITH:** I seek to remove the amendment at 43/60.

**The CHAIR:** Hon Charles Smith has moved that at page 39, after line —

**Point of Order**

**Hon STEPHEN DAWSON:** I believe the honourable member said he was “removing” the amendment as opposed to “moving” the amendment. I think he does not intend to move the amendment. Perhaps we could clarify that.

**Hon CHARLES SMITH:** I withdraw that particular amendment.

**The CHAIR:** You are not going to proceed with it. Thank you for that clarification.

**Committee Resumed**

**Hon ADELE FARINA:** I move —

Page 40, lines 9 and 10 — To delete the lines and substitute —

(d) the date and time when 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, for example —

(i) the patient regained consciousness after the administration of the substance; or

(ii) the period of time that lapsed between the administration of the substance and the patient’s death was longer than 2 hours; or

(iii) the patient had difficulty ingesting the substance or regurgitated the substance; or

(iv) the patient suffered any other kind of adverse reaction to the substance;

We have learnt through consideration of the bill that the schedule 4 and schedule 8 poisons may be approved as voluntary assisted dying substances by the CEO. We know that the schedule 4 and 8 poisons may not have been approved by the Therapeutic Goods Association for use by humans; therefore, the VAD substance does not need to be approved by the TGA for use by humans. When animals are euthanased, the substance is injected directly into the bloodstream, so it is quick and effective. Under this bill, people are required to ingest the substance; it is a much slower process, and it does not always go as planned. We know that the substance is very bitter and that even when taken with the syrupy substance, people experience difficulty ingesting the whole of the substance. We know that people can sometimes regurgitate the substance or drink it so slowly that they fall asleep before taking the entire dose. In 2012, the Netherlands recommended that the dosage be doubled from, I think, nine grams to 15 grams, due to 23 per cent of patients taking longer to die than was considered desirable—that is, within two hours. Despite this, between 2014 and 2018, between seven per cent and 13 per cent of patients were not dead within the desired two hours and were euthanased. The 2018 data collection summary from Oregon indicates that 17.5 per cent of people took more than 30 minutes to die, and in 3.6 per cent of cases it took more than six hours, with the longest time being 104 hours. There has also been a least one case of a patient regaining consciousness.

A study published in the journal *Anaesthesia* in 2019 warned that there is a significant likelihood that in some cases there will be a persistence of awareness, called “accidental awareness” under general anaesthetic in a surgical...
context. Despite the patient having an apparent loss of consciousness, they are actually aware of what is happening. These prolonged deaths can be very distressing for the family and possibly painful for the patient; they are definitely shocking if the patient comes out of the coma. These are not peaceful and painless deaths as is being promised by the legislation.

I do not have an in-principle objection to voluntary assisted dying, but I do have some real concerns about the process we are seeking to adopt through this bill by which it is not able to be guaranteed that every death is going to be peaceful and pain-free. For that reason, when we were considering Hon Rick Mazza’s amendment, I was keen that a medical practitioner be present during the process so that if something went wrong, there would be someone who could assess what was going wrong and intervene. However, judging from the views expressed around the chamber, not all members shared that view, and that debate was had and lost. We move on from that. This amendment seeks to ensure that if something goes wrong or if there are complications when the VAD substance is being administered by a medical practitioner, the medical practitioner will record those details and the information will be collected. Through the collection of that information, we can then review the scheme and make whatever amendments are needed to ensure that those complications are either eliminated or at least reduced in the future. If it were not for the Netherlands requiring a medical practitioner to be present at the time of self-administration, we would not be across the sorts of complications that have been experienced. We would not understand the situation. If that information had not been brought back and assessed in the Netherlands, they would not have been able to evaluate that the dosage, effectively, needed to be doubled.

All this amendment seeks to do is to use the best science, consider the ethical best standards and at least ensure that when something goes wrong, it is reported to the board for assessment and evaluation. The first part of my amendment 481/60 outlines the details that should be recorded by the medical practitioner. My next amendment, which is subsequent to this one, will require the medical practitioner to provide information in the required form to the board so it has the information. It is a very simple amendment.

We always talk about making decisions based on good science. One of my strong issues with this bill is that we appear to be using humans as guinea pigs. If we are to go down this path, let us at least make sure that we collect the data so that if there are complications, we can take appropriate steps to reduce or eliminate the likelihood of those complications in the future. I think this is a best practice model. It does not harm the bill in any way; it can only serve to improve it and improve our knowledge about whether what we are doing is effective in delivering a peaceful and pain-free death for all the people who opt to go through this.

Some people might be of the view that because only a small percentage of people experience complications whether we can really justify this extra measure My response is: if they were in that small percentage of people who experienced complications, their view would be, yes; it is completely appropriate to have this additional measure to ensure it does not happen to other people in the future. I ask for members’ support for this amendment.

Hon STEPHEN DAWSON: I want to touch on one of the issues that Hon Adele Farina raised early in her comments and make the point that the substance is not yet determined in Western Australia. What the substance will be will depend on recommendations of the clinical expert panel on implementation. However, regarding the amendment as written, would Hon Adele Farina be amenable to this: the government could support her amendment from proposed paragraphs (d) to (dc), but it wants to enable the administering practitioner to more broadly capture complications, rather than focus on the four examples that Hon Adele Farina has given, which my advisers tell me would inevitably occur. Also, the terms used in proposed paragraphs (dc)(i) to (iv) may not be relevant in practice, for example, “2 hours”, or “adverse reaction”. If Hon Adele Farina would be open to this, I would be happy to move an amendment on the amendment. I acknowledge that the government would support it as it stands, but I would insert a full stop after “substance” and delete the examples (i) to (iv).

The CHAIR: Minister, are you moving that amendment at this stage?

Hon STEPHEN DAWSON: I will do so, but I first want to hear the view of Hon Adele Farina.

Hon NICK GOIRAN: I indicate that I support the amendment that stands in the name of Hon Adele Farina. I have some sympathy with the remarks that have just been made by the minister, and I leave it to the mover of the amendment to indicate her view on that. I just want to add one further thing for the consideration of Hon Adele Farina, the minister and members; that is, at proposed paragraph (d), where it is proposed to indicate the date and time when the prescribed substance was administered, I think it would be good practice to indicate the location at which the prescribed substance was administered. Proposed paragraph (d) could, in my view, read —

the date, time and location, when and where the prescribed substance was administered;

This is for the same reasons of good data collection, and the possibility of any investigation that might need to take place at a later stage. Apart from that, the substance of what is proposed by amendment 481/60 has my support.

Hon MICHAEL MISCHIN: I indicate that I have an enormous amount of support for the proposal of Hon Adele Farina. This sort of information is essential for monitoring the operation of the legislation, and to

Extracted from finalised Hansard
see that it is being applied properly and not improperly. I also think that the suggestion made by Hon Nick Goiran has merit. One does not wish to become too bureaucratic about this, but these are the sorts of pieces of information that, in most cases, would not be required, but under a regime of this nature, it is important that more information, rather than less, is of advantage to not only the Voluntary Assisting Dying Board but also the State Coroner and others. I understand what the minister has said, but I do not see a problem with the way Hon Adele Farina has formulated this. These are examples, by way of guidance, of the sort of information that is required. Simply leaving at large details of any “complications relating to the administration of the prescribed substance” leaves it open to the interpretation of the practitioner or others who are providing the information. Specifying these examples—in some places they may not be applicable, but in other cases they will be—indicates the sort of information embraced by the idea of complications relating to the administration. It is important that those examples be specified to ensure that there is full collection of relevant information, rather than simply a practitioner, for example, taking the view that, although the patient regained consciousness, that was not really a complication; it is just one of those things that happens from time to time, so they will not report it. These examples focus on the sorts of difficulties and problems that Hon Adele Farina is concerned about, and I think that they should be included by way of examples.

Hon JACQUI BOYDELL: I rise to indicate my support for the arguments raised by Hon Adele Farina. Also, if the minister were to move an amendment on the amendment, I would be supportive of that, because it does not limit any of the issues that may arise. I think that, under proposed paragraph (dc)(iii), particularly where there is difficulty in ingesting the substance, for future use of whatever substance is determined in the first instance for patients, if it is not working, that needs to be reviewed. In particular, it needs to be a process that the patient, having gone through the whole procedure, can ingest the substance that is prescribed. I will be supporting the amendment, and if the minister wants to move an amendment on the amendment, I would also support that.

Hon COLIN TINCKNELL: Very briefly, once again, I also support this amendment. It is good to see that the minister is looking at supporting most of the idea behind the amendment—to get that detail. We must learn from the rest of the world, where assisted dying, for want of a better term, has been practised, and the science has told us a few things. It is important that we learn from that, and I applaud the member for putting this amendment up. The idea of location being included as well as date and time is a very important addition. It would be interesting to hear from the honourable member about the government’s proposed changes.

Hon ADELE FARINA: I have no issue with the proposed amendment on the amendment by Hon Nick Goiran to include location. I more than happy with that amendment. I am willing to accept the minister’s suggested amendment on the amendment if the minister can give me some assurance that those examples will be included in any practitioner guidelines that will be prepared, so that we can ensure that these are the sorts of things that are actually being picked up as complications. I am prepared to make it simpler for the legislation, but we need to ensure that medical practitioners understand the sort of information we are asking them to obtain, and what constitutes a complication.

Hon STEPHEN DAWSON: I am happy to indicate to Hon Adele Farina that those examples will be captured by the guidelines—those and more, so that we are not limited to those guidelines—so that we are collecting data that is helpful. I will move an amendment on the amendment moved by Hon Adele Farina, and I will take into consideration the proposed amendment of Hon Nick Goiran. I move—

proposed paragraph (d) — to delete “and time when” and substitute —

, time and location where

proposed paragraph (dc) — to delete all words after “substance” and substitute —

.

The CHAIR: Members, I want to move quickly on this, while we are all in furious agreement, so we do not miss the moment. In the first instance, I am going to frame the question, and then if members want to make a contribution to that, they can do so. I am going to do this in two parts. Firstly, we are going to contemplate the proposed amendment on the amendment, to delete after “date”, the word “and” and insert after “time”, the words, “and location”. So the question is that the words proposed to be deleted be deleted.

Hon STEPHEN DAWSON: I have just been given further advice, Mr Chair, that rather than say “and location”, we should say “and where”.

I have moved an amendment that says “the date, time”. The amendment circulated says “and location” but I have been advised that it is better to read “and where”. I think that clears it up, Mr Chair.

Hon MICHAEL MISCHIN: I do not think it reads right. We are looking at “the date, time, and where when”. It does not make sense.

Hon STEPHEN DAWSON: Let me clarify. It should read, “the date, time and location where the prescribed substance was administered.”
The CHAIR: Order! Members with some further input from the clerks—I note Hon Robin Chapple is seeking the call; I will come to you in just a moment—the first question we need to consider is in proposed paragraph (d) where the proposal is to amend the amendment of Hon Adele Farina by deleting “and time when” and substituting after “date” the words “time and location where”. Therefore, it will read —

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

I think, minister, that is the position.

Hon Stephen Dawson: Thank you.

Hon ROBIN CHAPPLE: I have two questions arising from this. Firstly, what level of public availability will the certificate or practitioner administration form have? Will it be confidential or in the public domain? Secondly, arising from that, when we refer to the location, is it the address of the individual place where the patient resides? I am concerned that if that information got into the public arena, it might not be in the best interests of the family.

Hon STEPHEN DAWSON: It will be confidential information. It will go to the board, and the board will not disclose the location.

Hon ADELE FARINA: In those jurisdictions where they collect location information, it is usually home, hospice or hospital; that is the sort of data collected. It is just the type of location in which the death occurred.

Hon MICHAEL MISCHIN: I still think the amendment is ungrammatical. We are saying, “the date, time and location where the prescribed substance was administered;” it should read “the date and time, and location where, the prescribed substance was administered”. Date and time are not “where”.

Hon ADELE FARINA: Alternatively, we could just stick to “the date, time and location the prescribed substance was administered”. I do not know that “where” adds anything to it, but that is just my humble view.

Hon Michael Mischin: Date, time and place.

The CHAIR: Members we are all free to put in any amendments to amendments that you wish. I can only deal with what I have before me and what I have before me is what is proposed and that is —

Proposed paragraph (d) — To delete “and time when” and substitute —

, time and location where

Amendment on the amendment put and passed.

The CHAIR: We now move to the second part of the minister’s amendment on the amendment, which is —

Proposed paragraph (dc) — To delete all words after “substance”.

That is, “for example”, and then proposed subparagraphs (i), (ii), (iii) (iv). The semicolon would remain, but that is a clerk’s amendment. I think we can all approach that without getting too bound up on it.

Amendment on the amendment put and passed.

The CHAIR: The question now is that the amendment as amended be agreed to. We are returning to the amendment proposed by Hon Adele Farina that has been amended in several ways. For clarification, the amendment now is —

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.

Amendment, as amended, put and passed.

The CHAIR: I think proposed amendment 44/60 will fall away as it has been accommodated in effect.

Hon ADELE FARINA: I move the amendment standing in my name at 482/60 —

Page 40, lines 17 and 18 — To delete “administering the prescribed substance,” and substitute —

the patient dies,

I point out that on this occasion I went to parliamentary counsel to get these amendments drafted. Parliamentary counsel advised an amendment was needed to this clause as well to delete “administering the prescribed substance” and substitute “when the patient dies” as the point at which time the medical practitioner is required to provide the information. Reading it now, in circumstances in which the patient might not die, that might be a bit of a problem, so perhaps the advice I received from parliamentary counsel was not good on this occasion. The whole point of the amendment was to deal with complications, and one of those complications could be that the person comes out of a coma. On the strength of that, I am going to withdraw that proposed amendment.

Amendment, by leave, withdrawn.

Clause, as amended, put and passed.
Clause 61: Witness to administration of prescribed substance —

**Hon Nick Goiran**: Clause 61 provides for a witness to the process of physician administration. Why has this inconsistent approach been taken whereas no witness is required for self-administration?

**Hon Stephen Dawson**: The administration of the voluntary assisted dying substance by the coordinating practitioner to the patient must be made in the presence of a witness. The requirement of a witness during practitioner administration is yet another safeguard in the voluntary assisted dying process. It reflects that the voluntary nature of voluntary assisted dying is fundamental to the Western Australian model and that the decision to access death must be enduring.

The second part of Hon Nick Goiran’s question is why a witness is not required for self-administration. Self-administration is at the time and place of the patient’s choosing, so we determined that it was not appropriate to include it there.

**Hon Nick Goiran**: Why are the eligibility requirements of witnesses to the patient’s written declaration more onerous than the eligibility requirements seen fit to be included at clause 61 for witnesses to the administration of a prescribed substance that will cause the death of the patient?

**Hon Stephen Dawson**: I am advised that the eligibility requirements are not onerous, but are for another person administering to the patient. One is about practitioner assessment and the other is about self-administration.

**The Deputy Chair (Hon Adele Farina)**: Members, there are a number of amendments on issue 16 of the supplementary notice paper and I notice that there are two in the name of Hon Rick Mazza. Do you intend on moving that amendment?

**Hon Rick Mazza**: No.

**Hon Nick Goiran**: Noting that Hon Rick Mazza does not intend to move the two proposed amendments standing in his name, I move the amendment standing in my name at 487/61. I move —

Page 41, line 5 — To insert after “appeared to be” —

free, voluntary and

By way of explanation to members, I note that the Victorian equivalent of clause 61, which is section 65 of the Victorian Voluntary Assisted Dying Act, requires a person to bear witness to not only the administration of the prescribed substance, but also the making of the patient’s administration request. This is analogous to the patient’s administration decision made under clause 55. The bill before us does not require a person to bear witness to a patient making an administration decision under clause 55. In this respect, my respectful submission is that it falls short of the safeguards that the Parliament of Victoria saw fit to include in its act. Clause 61 requires a person who is eligible to act as a witness under the witness eligibility requirements of clause 61(2) to witness the administration of the voluntary assisted dying substance to the patient by the administering practitioner in circumstances in which a practitioner administration decision has been made. I note that the witness’s certification requirements as required by clause 61(3) are different from or substantially less than those found in “Certification of witness to signing of written declaration” prescribed under clause 43(3) of the bill. I draw clause 43(3)(a)(i) to the minister and members’ attention. We, as a chamber, have agreed with the government’s mandate that a witness to the signing of a written declaration by the patient or by another person on behalf of the patient must certify in writing that, in the presence of the witness, the patient appeared to freely and voluntarily sign the declaration, which members can find at clause 43(2)(a). Alternatively, the witness must certify in writing that the patient appeared to freely or voluntarily direct the other person to sign the declaration on their behalf, which members can find at clause 43(3)(a)(i). It is unusual that a witness to the administration of the prescribed substance, which is ultimately the very last act to take place and directly causes the death of the patient, is not required to certify that the patient was acting freely and voluntarily, although a witness to the signing of a written declaration earlier in the process is required to do so. My amendment to clause 61 seeks to address this anomaly by inserting the same witness certification that is found in clause 43(3)—that the witness certify that the patient’s request for access to voluntary assisted dying appears to be free and voluntary as well as enduring.

**Hon Stephen Dawson**: I indicate that the government will support this amendment.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 62: Transfer of administering practitioner’s role —

**Hon Nick Goiran**: Clause 62 provides for the transfer of the administering practitioner’s role from the original administrator to another administering practitioner called the new practitioner. In what circumstances might this transfer be made, and why was this clause deemed necessary for inclusion?

**Hon Stephen Dawson**: The ability to transfer the role of the administering practitioner will ensure that a patient is not disadvantaged when the original administering practitioner is no longer able to perform the role due to unforeseen circumstances, such as illness, injury or for other reasons.

*Extracted from finalised Hansard*
Hon NICK GOIRAN: Clause 62(1)(c) provides that this transfer can be made if the original practitioner “is unable for any reason to administer the prescribed substance to the patient”. Could this transfer be made if the original administrator changes their mind and no longer wishes to proceed with the process of administering the poison that will cause the patient’s death?

Hon STEPHEN DAWSON: No. This is about them being unable to perform the role—for example, if they have family obligations or there is a death in the family, or they could be out of the country. If they were unwilling to do something, that would be captured by the conscientious objection clauses.

Hon NICK GOIRAN: That being the case, in that scenario, would they be able to transfer under clause 62?

Perhaps to facilitate progress, maybe I could ask the minister, while he is considering this matter, whether in clause 62, at page 41, line 17, after the word “unable”, he would be agreeable to me moving an amendment to add the words “or unwilling”?

Hon STEPHEN DAWSON: Honourable member, we would be happy to accept that amendment. My advisers tell me that if somebody said that they were “unable” to do it because they now have an objection to it, that would cover it. But I think it would be clearer to insert the words “or unwilling”, and so we would accept that.

Hon NICK GOIRAN: I move—

Page 41, line 17 — To insert after “unable”—

or unwilling

Amendment put and passed.

Clause, as amended, put and passed.

Clause 63: Application of Division —

Hon NICK GOIRAN: Minister, why does division 3 apply only when the patient has made a self-administration decision?

Hon STEPHEN DAWSON: The short answer is: the patient is required to engage a contact person only for self-administration.

Clause put and passed.

Clause 64: Patient to appoint contact person —

Hon NICK GOIRAN: The explanatory memorandum states that 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. Clause 64 provides that the patient is to appoint their own contact person. What training or information will be required to be provided to the contact person to assist them in fulfilling their role of monitoring the voluntary assisted dying substance and its use or disposal?

Hon STEPHEN DAWSON: I am advised that clause 148 outlines that the Voluntary Assisted Dying Board must send the contact person information about the contact person’s role when it receives the appointment form. In the implementation phase we would anticipate that a range of support materials will be developed for provision to the contact person to carry out their role. It is expected, and in line with good clinical practice, that the contact person will be part of discussions between the patient and the coordinating practitioner about their role as a contact person. When a person accepts the role of contact person, they will be required to make a statement that they understand their role under the act. They will be made aware that the board will be providing information to them and will be able to discuss aspects of their role with the coordinating practitioner and the board if they so require. The contact person will also be able to liaise with the coordinating practitioner for information.

Hon NICK GOIRAN: Clause 64(2) requires only that the contact person be a person who has reached 18 years of age. Is the government satisfied that this important role of contact person can be fulfilled by anyone so long as they have reached 18 years of age?

Hon STEPHEN DAWSON: As Hon Nick Goiran pointed out, the bill sets out that the contact person must be at least 18 years of age. It may be the patient’s coordinating or consulting practitioner, or another registered health practitioner. Thus, the patient will be able to choose a family member or other person to be their contact person as long as they are at least 18 years old. In practice, the contact person will need to be a person who maintains close involvement with the patient to enable them to effectively undertake the role. It is likely that the contact person will be a close and trusted carer, family member or friend of the patient and will be involved in the discussions with the coordinating practitioner and the pharmacist, including receiving instructions about storing the voluntary assisted dying substance in a safe manner. The coordinating practitioner will have an important role to play in guiding the patient through the process. From that perspective, it is reasonable to expect that they will want to make sure that the contact person will be able to function under the act. The coordinating practitioner will discuss the requirements of the contact person with the patient so that an appropriate person can be chosen. Should they have concerns, it will also be possible for the coordinating practitioner to take on the role of the contact person.
Hon NICK GOIRAN: Clause 64(5) provides that the patient may revoke the appointment of the contact person. If the patient does not comply with clause 64(6)(c), can self-administration still proceed?

Hon STEPHEN DAWSON: In practice, it could proceed, but the patient will most likely tell the coordinating practitioner. If the coordinating practitioner was aware, they could take steps to make sure that the act will be followed.

Hon NICK GOIRAN: Could the contact person who has been revoked not be the coordinating practitioner?

Hon STEPHEN DAWSON: Yes, it could be the same person. If they were told that their position had been revoked, they would make sure that another contact person was appointed.

Hon NICK GOIRAN: Clause 64(6)(c) states —

the patient must make another appointment under subsection (1).

If there were a falling out between the patient and the coordinating practitioner, and the patient were to say, “I revoke your authority to be the contact person; I’ve already got the prescribed substance at home”, and the coordinating practitioner said, “Well, you’re within your rights to do that under clause 64, but I just remind you, even though you’re not listening to me anymore, that you have to make an appointment of another contact person”, the patient may say, to use an expression, “Well, up your jumper! I’m not going to do that anymore.” The problem I have is that the prescribed substance would be, presumably, in the home of the patient, and if they had a falling out with the coordinating practitioner, nobody would be there to monitor the disposal of the substance. I am concerned about that. Maybe one solution, albeit not perfect, would be to insert a time frame in clause 64(6)(c) in which the patient must make another appointment under subclause (1). It seems open-ended at the moment. It is all very well for us to say that they must do it, but when must they do it? Self-evidently, it must be prior to death, but would the government be agreeable to inserting a time frame? For what it is worth, in my view it should happen immediately—that is, the patient must immediately, after informing the person of the revocation, make another appointment under subclause (1).

Hon STEPHEN DAWSON: We would not support inserting a time frame. I am further advised that if no time frame is specified, the meaning is “as soon as practicable”. Section 63 of the Interpretation Act states that it should be “done with all convenient speed.”

Clause put and passed.

Clause 65: Contact person appointment form —

Hon NICK GOIRAN: Clause 65(1)(e) provides that the contact person must provide a statement that they understand their role, including the requirements under clause 104, to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer. Who is required to explain to the appointed contact person the responsibilities and obligations of the contact person role?

Hon STEPHEN DAWSON: The requirement is on the coordinating practitioner or the patient. But certainly after someone has been appointed as the contact person, the coordinating practitioner is required to provide the contact person appointment form to the Voluntary Assisted Dying Board. It should be noted that the Voluntary Assisted Dying Board must, within two business days after receiving a copy of the contact person appointment form, send information to the contact person that explains the contact person’s requirements under the bill and outlines the support services available to them.

Hon NICK GOIRAN: I am concerned that there are some pretty onerous requirements on the contact person, and although it could be a coordinating practitioner who should have some expertise and proper training, it could also be a layperson. Clause 65(e) states that the appointment must include —

a statement that the contact person understands their role under this Act (including the requirements under section 104 to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer);

The minister will see that in the bracketed part of clause 65(1)(e) is a non-exhaustive list of information that needs to be provided to the contact person. I support that, but I think we need to go one step further to ensure that the contact person is aware of the penalties for the offences under proposed section 104. When we look at proposed section 104, which is referred to in this clause, we can see that some of the penalties include imprisonment for up to 12 months. For those reasons, and on the understanding that Hon Rick Mazza is not moving the amendment in his name, I move —

Page 44, line 3 — To delete — “disposer;” and substitute —

 disposer and the penalties for offences under that section);

Hon STEPHEN DAWSON: It was certainly the intention of government to provide information to the contact person about the penalties associated with this area of the legislation, but certainly we have no issue with accepting the amendment moved by Hon Nick Goiran.

Amendment put and passed.

Extracted from finalised Hansard
Hon Nick Goiran: I move —

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;

Hon Stephen Dawson: I indicate that the government is supportive of this amendment as per similar amendments moved earlier.

Amendment put and passed.

Hon Nick Goiran: I move —

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.

By way of explanation, this amendment is a simple mechanistic amendment to clause 65 to address a flaw found in subclause (2). Although clause 65(2) seeks to provide for the event in which a patient cannot complete their own contact person appointment form, it does nothing more than state that another person can complete the form on the patient’s behalf. I ask the minister and members to compare clause 65(2) with another clause that we agreed to earlier, specifically clause 41. Clause 41(4) provides for the event in which a patient is unable to sign their own written declaration and allows another person to sign the written declaration on behalf of the patient if the patient directs the person to sign the declaration — members can see that at clause 41(4)(b) — and the person has reached 18 years of age, as found at clause 41(4)(c)(i). My amendment seeks to insert at clause 65(2) the same prescriptions as appear in clause 41(4)(b) and 41(4)(c)(i). Without this amendment, clause 65(2) does not require direction on the part of the patient or that the other person who completes the contact person administration form is to be an adult.

Hon Stephen Dawson: This is consistent with some actions that we took earlier on. The government will support this amendment.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 66: Role of contact person —

Hon Nick Goiran: Clause 66(1) provides that the contact person can receive the prescribed substance, possess the prescribed substance and supply the prescribed substance to the patient. Can the contact person also assist the patient in preparing the substance for self-administration?

Hon Stephen Dawson: No, they are not authorised to do that. I am further advised that if the patient is not able to prepare the substance, they should be advised that self-administration is not for them.

Hon Nick Goiran: I agree; that is my reading as well. Why is this not explicitly stated in clause 66(1) so that there is no doubt on the part of the contact person that they are not able to assist in preparing the substance? In fact, I would even go further to say that they are not able to assist the patient in self-administering the substance.

Hon Stephen Dawson: The clause sets out what the contact person can do. I am advised that it is not appropriate to include a list of what they cannot do, but that information will be sent to the contact person in the information that is provided to them.

Hon Nick Goiran: Earlier, clause 57(7) provided that an agent of the patient can receive, possess and supply the prescribed substance. Is there any requirement in this clause or another part of the bill for the contact person to be made aware that the substance has been received by and is in the possession of an agent?

Hon Stephen Dawson: When the agent picks up the medication, the authorised supplier needs to verify and enter the information onto the database. The coordinating practitioner and the Voluntary Assisted Dying Board will be made aware of this and can advise the patient and contact person.

Hon Adele Farina: I move —

Page 45, after line 3 — To insert —

(1A) The contact person for the patient must —

(a) be present when the patient self-administers the prescribed substance; and

(b) witness the self-administration.

Division 3 details the role and obligations of the contact person, which includes the disposal of any unused or remaining voluntary assisted dying substance. The minister told us in answer to earlier questions that the expectation is that the contact person will be a close family member or carer and will more than likely be present when the patient
that they will be put in jail for up to 12 months if they do not return the substance within 14 days of the date of the
process. We need to have a process by which that information comes back to us and we are able to assess it and
just pass this bill and then put our heads in the sand about any possible complications that may occur during the

Perhaps the minister or somebody else, if they intend to oppose the amendment moved by Hon Adele Farina, can
explain to me how it is appropriate for a Western Australian to be made a contact person and then to say to them
look at subclause (2), which says —

I am a little concerned about how this amendment would actually operate. As the minister pointed out, there is no
mechanism for the contact person to know when the patient will want to

patient. The only thing the agent cannot do is to dispose of any of the substance that remains. My only concern

(self-administers. However, there is no requirement in the bill for that to be the case. This is a deficiency in the bill
because the bill places a significant penalty on the contact person for failing to comply with his or her obligations to
return any unused or remaining voluntary assisted dying substance to the authorised disposer. I do not understand
how the contact person can be certain in his or her knowledge as to whether there is unused substance unless the
contact is person is present when it is self-administered. I have been told on a very reliable basis that the quantity
of the substance that is being dispensed in Victoria is similar to that in the Netherlands and Oregon, and is sufficient
in some cases to kill two people. We also know that all of the substance is not always ingested by the patient. It is
critically important that the contact person is present at the self-administration so that they are able to secure any
of the unused substance and comply with their requirements under the act. The very fact that the contact person
will be present will provide us with an opportunity for the contact person to collect the same data that we agreed
the medical practitioner should collect in cases that involve complications. Is it ideal for the contact person to do
that rather than a medical practitioner? In my view, no. It would be preferable for a medical practitioner to do that,
but this chamber has determined that it does not want to include in the bill that a medical practitioner be present
when a person self-administers. The sorts of things that we are asking the contact person to record include the date
and time when the substance was administered, the location — accepting the amendments made to the previous
clause — and whether there were any complications. A person will not need to have a medical degree to record and
report those observations. In fact, if members are a little bit concerned, I draw their attention to clause 149 of the
bill, which provides —

(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 any of its functions.

In my view, the amendment I have proposed will cause no harm. It is in two parts. The part I have moved relates
to the contact person being present. If that is agreed to, a subsequent amendment will deal with information that
needs to be collected and provided to the board. In my view, the amendment does no harm to the bill. Again, it
will help us to make good science-based decision-making in the future and will ensure that if complications are
experienced, those issues can be addressed and eliminated, or at least we can avoid a recurrence of those complications.
I think it is a reasonable proposition. I ask members to support it; not supporting it would be negligent. We cannot
just pass this bill and then put our heads in the sand about any possible complications that may occur during the
process. We need to have a process by which that information comes back to us and we are able to assess it and
make the necessary decisions that need to be made as a consequence of the assessment.

Hon STEPHEN DAWSON: I indicate that we do not support this amendment. I recall there was a debate on this
issue last week, during which I spoke about self-administration and the fact that it is the patient’s choice. We do not
believe it is appropriate to require the patient to have a particular witness or contact person with them in a private
place at the time of self-administration of the prescribed substance unless the patient wishes to do so. To require
this would create a fundamental shift in the patient autonomy attached to self-administration. I am further advised
that the problem with this amendment is that the patient may decide to self-administer alone, and that to require
the contact person to be present would mean that he or she could be committing an offence if not present.

Hon RICK MAZZA: I absolutely agree with the sentiments that have been put forward by Hon Adele Farina, but
I am a little concerned about how this amendment would actually operate. As the minister pointed out, there is no
mechanism that will require a contact person to be present. If the contact person is simply going to get possession
of the substance and provide it to the patient, the patient can take it without the contact person even knowing about
it. The other issue, too, of course, is the agent. The agent can collect the substance and can also provide it to the
patient. The only thing the agent cannot do is to dispose of any of the substance that remains. My only concern
with this amendment is that there is no mechanism for the contact person to know when the patient will want to
self-administer. What will happen if the contact person is not present and the patient just decides to self-administer
without anybody being there at all? I am just a bit concerned about how this would operate.

Hon NICK GOIRAN: I rise to support the amendment that has been moved by the honourable member. I draw to
the attention of members and the minister the penalties for a contact person found in part 6 of the bill, “Offences”.
I recall that at clause 104 there is an offence that deals with the contact person. I think it is useful in particular to
look at subclause (2), which says —

If a patient who has made a self-administration decision dies —

Remember, the clause the honourable member is trying to amend deals with self-administration —

and the patient’s death occurs after an authorised supplier has supplied a prescribed substance for the patient,
the contact person for the patient must, as soon as practicable and in any event within 14 days after the
day on which the patient dies, give any unused or remaining substance to an authorised disposer.

Penalty … imprisonment for 12 months.

Perhaps the minister or somebody else, if they intend to oppose the amendment moved by Hon Adele Farina, can
explain to me how it is appropriate for a Western Australian to be made a contact person and then to say to them
that they will be put in jail for up to 12 months if they do not return the substance within 14 days of the date of the

"Extracted from finalised Hansard"
patient’s death. As Hon Rick Mazza has just pointed out, there is not necessarily a mechanism provided for making sure that the contact person knows about the death, let alone for them to be present. Hon Adele Farina is trying to ensure that this person, who could be put in jail for up to 12 months, is at least aware of the death. Indeed, the member is going one step further and saying that the person should be present to witness the process. I think there are good reasons for that in order to deal with complications. We had that discussion earlier and there was a view by some members that if there are complications, so be it; the patient has been advised of those risks, and if they want to choke, asphyxiate or any of those things as a result of those complications, they have been warned. I remain entirely uncomfortable about that, but, as has already been discussed, we have had that debate. The reason to support this amendment is that if we do not do this, the contact person faces a potential penalty of up to 12 months in jail despite the fact they know nothing about the death. The honourable member is at least endeavouring to improve a current deficiency in the bill.

Hon AARON STONEHOUSE: I am concerned that this amendment will further complicate an already pretty complicated obligation on a contact person. It is true that a contact person will be responsible for returning the prescribed substance or any unused or remaining prescribed substance. That will be a rather onerous requirement, because they may not know when the patient has taken the substance, where they left it or where they put it. We are putting an obligation on the contact person that may be very hard to comply with. The amendment goes further and puts on the contact person a new obligation that will be very hard to comply with in the sense that they will have to withhold the prescribed substance from the patient until the patient is ready to take it in order to be absolutely certain that the patient does not take it when the contact person is not present. I fear that the contact person may be put in the position of having to make that choice; that is, they can either give the substance to the patient now, and the patient can call them when they are ready so they can be with the patient and witness the patient take the substance; or the contact person must hold the substance until they know when the patient is ready to take it. Ideally, there would be an understanding between the patient and the contact person, but the contact person will have no power to facilitate the compliance with that obligation. I think the contact person could be put in a very, very difficult situation. Perhaps if clause 66 were amended to allow the contact person to hold and retain the substance until the patient was ready to take the substance, much like a medical practitioner would in the case of practitioner administration, it might at least ensure that the contact person was able to comply with their new obligation. Merely putting an obligation in place for the contact person and not having a way for the contact person to ensure that the patient facilitates it, puts them in a very difficult situation. I think that this amendment would further complicate things. I understand why it has been put forward, but I think it might make it more difficult rather than easier for a contact person in this instance.

Hon STEPHEN DAWSON: There is a difference between requiring the contact person to be a witness to self-administration and requiring them to return the medications. The purpose of the contact person is to safeguard the return of the medications. The contact person will be aware of the death, will be a person close to the patient, and will be advised that the patient has died if they are not there at the time of self-administration. The contact person is aware of their responsibilities when they agree; therefore, they should maintain close contact with the person so that they know what is happening. Furthermore, under clause 104(3), the contact person has to know about the substance, and I also make the point that the CEO would have discretion about whether to commence prosecution or not.

Hon ADELE FARINA: It was not my intention to require the contact person to hold onto the substance. I think members need to take a step back and think about what we are doing here. We are actually placing an obligation on the contact person to return any unused substance, and if they do not, and if another person, in their grief, ingests the remaining substance, the contact person is liable to 12 months’ imprisonment. We know that the quantity that has been given for people to ingest is more than is understood to be needed to kill someone, and may be sufficient to kill two adults. We also know that people have difficulty ingesting the substance. There will be circumstances in which an unused portion of the substance needs to be returned, and that is clearly understood; otherwise, we would not have all these provisions in the bill. . . When I asked how they would know that there was an unused substance, I was concerned that the minister could not, on the one hand, say that it is expected that the contact person would be a family member or a carer who would be present, and then say that it was too onerous an obligation for that family member or carer to be present when the person self-administered. The likelihood is that they will be present. I do not believe that this provision places any additional burden on the contact person, because I agree with the minister: the contact person is more than likely to be a family member or carer who is there caring for the patient and will be there in any event. It is critically important for us to understand that there is every likelihood that a portion of the substance is not used. It is a lethal substance, and it needs to be secured and returned to the authorised disposer, and securing it needs to be done as quickly as possible. In my view, this is all best achieved if there is a requirement that the contact person is actually present when it is being self-administered. If it is a family member, they are more than likely to be present anyway. The minister has told us that that is the expectation. I understand the argument that people have about personal autonomy, but it is not infinite. There must be limits for the protection of other people in the household, and this amendment simply seeks to do that. I do not think it is an unreasonable imposition. Let us not forget that if the contact person does not return the substance, they will go to jail for 12 months. That is a very onerous imposition. I urge members to support the amendment.

Extracted from finalised Hansard
Hon AARON STONEHOUSE: Just to try to provide a little more clarity, I am concerned about exposing the contact person to further liability. The contact person has no control over where or when the patient may take the substance. They may take the substance, and the container may get lost or whatever. We do not know where that will end up, and we do not know who might be present at the time of self-administration. The contact person will have no control over that. It will put a further imposition on the contact person to be a witness to the person taking the substance; again, the contact person will have no control. In some sense, in trying to address a concern that the contact person will be exposed, we are now introducing a new element by which they may be additionally exposed by not being present when the patient takes a substance. I am worried about that. We are putting the contact person in a situation in which they have no control over when the patient takes the substance, which is why I said that we may end up creating a situation in which a contact person is reluctant to hand over the substance, and may say, “Okay, if I give this to you, you’d better make sure you call me when you take it, because if I’m not there, I’m going to be liable for breach of the act for not being present when it’s taken.” I understand that the contact person is already exposed to risk due to the obligations they have under clause 66(1)(d), but we will be inserting a new element here by which contact persons will be further exposed. That is my concern.

Hon JACQUI BOYDELL: I understand the premise of the amendment, but I find myself probably not being able to support it. If I flick the situation, the contact person, in this regard, as Hon Aaron Stonehouse has said, almost becomes the person in charge of when the patient can determine to self-administer, because they have to be present. If the patient makes a decision that their children might be visiting them on Saturday, and wants to self-administer at that point, and if the contact person says they cannot be there on that day, how about doing it on Thursday instead, is that coercion or a concern for the patient that they lose control at that point? We have set out such a process to allow the self-administration decision to remain with the patient, and I think that is fundamental to the process of closing the loop—that this has been voluntary assisted dying and not a process that has been determined by someone else being able to be there. For those reasons, I cannot support the amendment.

Hon MARTIN ALDRIDGE: I understand the problem that Hon Adele Farina is trying to address, and I share her concern, particularly in light of the debate and division that occurred last week about agents. But even if this amendment passes, I do not think it will address the concern fully. I think this is a concern that is not easily mitigated. If a patient makes a self-administration decision, the drug can be supplied to the patient. The patient is not required to use a contact person or an agent. My preference was that we do not have agents, but we do, and although the contact person is authorised under this clause to receive, possess, supply and return the substance, a patient could still receive the substance themselves and not involve the contact person in either the awareness that the patient has the drug or that the patient is about to ingest the substance. It does not address fully the issue of the contact person being able to perform their legal obligations to return the substance. I thank the minister for pointing out that clause 104(3) limits clause 66(2) with respect to a contact person having some knowledge that the substance is unused or remaining after the patient’s death. I guess that is something that we will consider further in due course, but I am concerned that having a contact person present when the patient self-administers as well as witnessing the self-administration could be contrary to the requests or the views of the patient. In balancing that, I am not sure that this amendment would fully resolve the issue. Noting that we have already had a debate about agents that has made things much more messy, I think the risk remains about dealing with a substance after the fact. I think some other members have asked what the appropriate mechanism is.

Given that no-one has been able to articulate what that is, in some ways, it is probably symptomatic of the difficulty of respecting a patient’s right to ingest the substance at a time of their choosing and dealing with the substance after that time, knowing that nobody may know that the patient has ingested the substance. To fully mitigate that issue, we will probably have to go much further than this amendment in not allowing the patient to receive the substance in the first place. We could probably go as far as saying that only the contact person can receive, possess and supply the substance. That would be the only way to fully mitigate the risks because the patient could not then receive the substance until they were ready to ingest it, so there would be no way the contact person would receive the substance. The patient’s intent or the patient’s death and, therefore, would be fully able to comply with their lawful responsibilities under the legislation for the return of the substance.

Hon ADELE FARINA: I think members seem to be missing the point. The contact person will be a carer or family member who is caring for the patient in that last period of their life. They will be with the patient. The patient is not likely to put out an ad seeking someone to apply for the job of contact person because I doubt they would receive many applicants if they did. I think people are being a little overly concerned about the extent of the obligation that this is placing on the person. In response to a question asked earlier, the minister indicated that it is the expectation that a family member will be caring for the person or a carer who will be a contact person will be caring for the person. They will be present; they will have gone gently in all their advocacy for this legislation and talked about being surrounded by family and friends at the point of deciding to self-administer. Now members are telling me that no family and friends will be present; the person will administer on their own. I am having a problem with the picture we are trying to paint here.

It is a matter of balancing things. I think in balancing, ensuring that the unused substance is secured and returned as quickly as possible is very important. The other aspect to this, which will be moved in a subsequent amendment,
is that it is with self-administration that we see the majority of the complications. Therefore, it is reporting those complications with self-administration that is absolutely critical to collecting that data so we can make science-based and ethical decisions into the future. Because this chamber chose not to have a medical practitioner present for self-administration, the only other option open was to assign that task to the contact person. As I have pointed out, under clause 149 the board can ask for that information from the contact person in any event. All I am seeking to do is to put in place some greater protection so that we can deliver on what we promised Western Australians—that is, through this scheme, they will have a peaceful and pain-free death. The only way we can be sure of that is by getting back data, evaluating it and making improvements along the way. The reality is that everyone is making their best assumptions here, but that is what they are, assumptions. No clinical testing of lethal doses has been undertaken. The mere fact that people are taking a very bitter substance and are unable to ingest it is when complications can arise. I am seeking to ensure that we can make science-based decisions into the future if not straightaway. I do not think this is an onerous obligation. There is every likelihood the person would be present in any event.

**Hon MARTIN PRITCHARD:** I think we are all trying to work out what best protections the bill requires. However, I will take it from the very start. We are talking about a person who is in intolerable pain or suffering and cannot access voluntary assisted dying at that moment. We are trying to introduce different views about what protections are required. I am supportive of this amendment, but I go back to a situation in which a patient is in intolerable pain or suffering and we require them to go through all the precursors to get to that point. I think I mentioned in a previous debate—I know a lot of people disagreed—that I think it is quite onerous to require a person in that situation to have to go through the coordinating practitioner and the consulting medical practitioner. I am in favour of this protection because I agree with Hon Adele Farina that a contact person will not be unknown to the patient. The person who will take on that role is likely to be a family member, a close friend or someone involved in the process. I think there is nothing worse than encouraging patients to take the substance by themselves. I do not think a loving family will always be around the patient, but there would be nothing sadder than encouraging a patient to take the substance on their own.

Having a guarantee that someone is there is worthwhile. I think the contact person will have such onerous responsibilities that it will be appropriate to have them there so they can fulfil all their functions. However, I do not think we should get away from the fact that the patient will have to do some things in order to access voluntary assisted dying. Whether, like me, members think it means having to go through two doctors and exactly the same process twice or having someone present when they take the substance, there will be some responsibilities on the patient to access this, and this is one I support.

**Division**

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

Ayes (8)

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<tr>
<th>Hon Adele Farina</th>
<th>Hon Martin Pritchard</th>
<th>Hon Colin Tincknell</th>
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<tr>
<td>Hon Rick Mazza</td>
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<td>Hon Nick Goiran</td>
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Noes (27)

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<th>Hon Martin Aldridge</th>
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Amendment thus negatived.

Clause put and passed.

**The DEPUTY CHAIR:** I am sorry, Hon Adele Farina, I should have checked that you were not going to move the proposed amendment in your name at 484/66 on issue 16 of the supplementary notice paper, and that it fell out with the first one. Can I confirm that?

**Hon ADELE FARINA:** Yes.

Clause 67: Contact person may refuse to continue in role —

**Hon NICK GOIRAN:** In what circumstances might a contact person wish to refuse to continue in the role of contact person?

**Hon STEPHEN DAWSON:** I am advised that there are a number of different circumstances. They may be out of the state or they may be ill, for example.

**Hon CHARLES SMITH:** Does the voluntary assisted dying process stop if a patient’s contact person refuses to assist?

**Hon STEPHEN DAWSON:** No, because another appointment of a contact person must be made.
Hon NICK GOIRAN: Could one of the circumstances in which a contact person may refuse to continue to perform their role be because they are observing coercion and duress being exercised by family members upon the patient?

Hon STEPHEN DAWSON: There are a variety of reasons that the contact person may refuse to assist, and this is one of those reasons.

Hon NICK GOIRAN: In those circumstances, could the patient still have access to the lethal substance while not having appointed another contact person?

Hon STEPHEN DAWSON: In such a hypothetical situation, the contact person would be expected to tell the coordinating practitioner and the coordinating practitioner would tell the board.

Hon NICK GOIRAN: The minister indicated earlier that the contact person could be the coordinating practitioner.

Hon STEPHEN DAWSON: In which case, the coordinating practitioner would advise the board directly.

Hon RICK MAZZA: I have a question on the provision that the person must inform the patient of the refusal. What method of conveyance can that be? Could it simply be verbal? Can the contact person simply say to the patient, “I don’t want to be your contact person any more”, and that is the end of it?

Hon STEPHEN DAWSON: I am advised it could be as simple as that.

Hon RICK MAZZA: If the contact person simply says to the patient, “I’m not going to be your contact person anymore today”, what time frame does the patient have to reappoint a new contact person?

Hon STEPHEN DAWSON: I thank the honourable member. I have answered this already. It should be done as soon as practicable. I answered this earlier.

Hon ADELE FARINA: It is possible that a contact person could refuse to continue to act as contact person of a patient who already has the voluntary assisted dying substance and the patient elects to take that substance before appointing another contact person? Is that correct?

Hon STEPHEN DAWSON: The answer is yes.

Clause put and passed.

New clause 67A —

Hon ADELE FARINA: I intend to move new clause 67A, which will fit into division 4, “Prescribing, supplying and disposing of voluntary assisted dying substance”, just before clause 68. I apologise for the late notification. I have been furiously debating with myself all morning about the best location to put this provision and I have decided to go with putting in a new clause at this point. The chamber attendants have copies and I am sure they will distribute them. I move —

Page 45, after line 19 — To insert the following new clause —

67A. Coordinating practitioner for a patient must not prescribe a voluntary assisted dying substance that is not therapeutic good registered

(1) The coordinating practitioner for a patient must not prescribe a voluntary assisted dying substance for the patient unless the substance is a therapeutic good registered in the Australian Register of Therapeutic Goods under the Therapeutic Goods Act 1989 of the Commonwealth.

(2) An authorised supplier who is given a prescription for a voluntary assisted substance must not supply the substance in accordance with the prescription unless the substance is a therapeutic good registered in the Australian Register of Therapeutic Goods under the Therapeutic Goods Act 1989 of the Commonwealth.

Hon STEPHEN DAWSON: Mr Deputy Chair, this is a significant amendment at a very late stage, so I ask that you leave the chamber until the ringing of the bells.

The DEPUTY CHAIR (Hon Robin Chapple): I will leave the chair until the ringing of the bells.

Sitting suspended from 12.21 to 12.46 pm

Hon STEPHEN DAWSON: I indicate to the chamber that the government does not support this amendment. I am advised that it is not appropriate to limit the schedule 4 or schedule 8 substances that may be prescribed to the patient because it may result in a substance that is less clinically efficacious than required. It would be up to the clinical panel to determine the relevant medical protocols during the implementation stage. We do not wish to be unduly restrictive and limit the protocols at this stage. I make the point that just because a product is not on the Australian register of therapeutic goods that does not mean that there is not appropriate evidence of efficacy and safety for the proposed use. It means that the manufacturer has not applied to the Therapeutic Goods Administration to have it assessed. It is a costly and lengthy process and, ultimately, is a commercially driven decision. I am also advised that there are medicines that are made from scratch from raw ingredients that do not need approval from the TGA.

Extracted from finalised Hansard
Hon ADELE FARINA: I will speak to my amendment. Normally, drugs for use in humans need to be approved by the Therapeutic Goods Administration. It is a national scheme that we have signed up to be part of so that we know that when we ingest a drug or it is given to us by injection, it has been clinically tested and is safe for human use. In this case, we will not know what the drug is or what side effects the drug is likely to have.

We know that the voluntary assisted dying substance will be a schedule 4 or schedule 8 poison or a combination of them. We have been told by the minister that the schedule 4 and schedule 8 poisons that will be used to make up the voluntary assisted dying substance do not need to be approved by the TGA. In my view, we have established the Therapeutic Goods Administration for a very important reason—that is, to provide us advice and to make sure that we do not use human beings as guinea pigs, but run all the proper clinical trials to ensure that drugs are fit for human use. I think it is vitally important in this situation that we also require the voluntary assisted dying substance to be assessed by the Therapeutic Goods Administration and put onto the register. Clearly, the list of schedule 4 and schedule 8 drugs is very long, so there will be plenty of options on those two lists. There is no reason that the voluntary assisted dying substance cannot be made up of those that have already been approved for human use.

We have made the decision in this place not to have a medical practitioner present during self-administration, or even to require the contact person to be present, because the majority view is that the autonomy of the individual—the patient—is paramount. However, we also know that there is substantial research out there that these drugs are not effective in 100 per cent of cases. There are complications, and those complications can be painful, distressing and can prolong death. Surely, we do not want to make the situation worse. The whole point of this bill is to try to alleviate suffering and bring about a more peaceful outcome. I do not think that can be achieved by using poisons that have not been approved by the Therapeutic Goods Administration. If people are not going to be present to assist patients who run into complications when they self-administer, it is absolutely critical that, at the very least, we choose the scientifically based option of deciding which poisons to use as a voluntary assisted dying substance and do what is ethically right—that is, not ask people to ingest a substance that might bring about unintended side effects and outcomes.

Through this amendment, I am suggesting that the drug would need to be registered as a therapeutic drug in order to be prescribed. The Therapeutic Goods Administration ensures that drugs have their intended effect. Without a review by the Therapeutic Goods Administration, we can expect there to be a range of problems with the drug—whatever it might be—and the likelihood is that it will increase suffering rather than decrease suffering. The minister is right that there are drugs that operate without the approval of the Therapeutic Goods Administration, however, those drugs are for only very specific purposes and are tailored to the individual. If, for example, a person has a rare topical skin infection and it is not economical for a major pharmaceutical company to produce a very specific agent, a pharmacist can mix it up after the doctor prescribes it off-label. In those very specific individual circumstances, there is capacity for exemptions to apply with no formal requirement for a TGA review of the final product. However, that is an exception, and it is not intended to be used to produce a drug for a group of patients as is proposed with the voluntary assisted dying substance. Government policy is that drugs have to be TGA reviewed, and there is no reason why this drug should not be TGA reviewed like every other drug. The TGA review helps to ensure that the drug works as intended and does not increase suffering. It is a safeguard. I am really struggling with aspects of this bill, and this is one of them; that is, we are proposing to prescribe a substance for someone to ingest knowing that the substance can cause problems and complications. No-one has to be present when a patient self-administers to assist them through that process if there are complications. At the very least, we should make sure that the substance is TGA approved so that any side effects are not greater than they need to be or so that there are no side effects at all. It is not an onerous obligation. We should be making scientific-based and ethical decisions. We should not use people as human guinea pigs.

Hon NICK GOIRAN: I rise to support the amendment. I entirely agree that one of the safety mechanisms in Australia is that the TGA authorises what can and cannot be used on humans. I was thinking what would be the best evidence to present to members in support of this amendment moved by Hon Adele Farina, and so I will go to some of the complications that arose in Washington state, which I touched on in my minority report. Washington state is one of a few jurisdictions around the world that has an assisted suicide regime, which is not to be confused with voluntary euthanasia in which the practitioner fulfills the act. I refer to an article on page 138 of the minority report, which states —

The first Seconal alternative turned out to be too harsh, burning patients’ mouths and throats, ... causing some to scream in pain. The second drug mix, used 67 times, has led to deaths that stretched out hours in some patients—and up to 31 hours in one case. [Twenty per cent] of the cases were 3 hours or more before death, which we think is too long,” said Robert Wood, a retired HIV/AIDS researcher who volunteers with the advocacy group End of Life Washington, in an email. The longest was 31 hours, the next longest 29 hours, the third longest 16 hours and some 8 hours in length. “Patients and families are told to expect sleep within 10 minutes and death within four hours.

When it takes far longer, family members get worried, even distressed, …

Extracted from finalised Hansard
I stop there. This is why the amendment moved by Hon Adele Farina is important. Let us remember that this is a rare practice around the globe and if we spend a moment to study the few jurisdictions that have done this, we know that they have had to experiment with the drugs that are used because they are not really sure whether they will work on a particular person. Over the journey, many people have said to me, “Oh, look, euthanasia already happens in the western world because, nudge-nudge, wink-wink, the doctor just ups the morphine.” That myth is perpetuated time and again, but the best speaker against it is none other than Dr Philip Nitschke. Dr Nitschke said in a hearing of the committee that I was on—I was on it for a year and was the only member who attended every meeting and every hearing—that it is, and I am paraphrasing here, actually very hard to kill someone with morphine. Dr Philip Nitschke said that the worldwide myth—nudge-nudge, wink-wink, that doctors up the morphine rate and take care of business that way—is much more complicated than that. We know it is much more complicated because if it is that easy, why not use morphine? We will not need to have a clinical panel and all those kinds of things; let us just use morphine and move on. We know that that is not the case. The government is going to implement a clinical panel. We know that because in other jurisdictions they have had to experiment with different drugs. At least with this amendment, we will have the confidence to know that the TGA has approved the substance for use, which is its remit and job. For those reasons, I support the amendment.

Hon ADELE FARINA: I omitted to mention when I rose earlier that I have made an error in subclause (2), lines 2 and 3. It reads “voluntary assisted substance” and it should read “voluntary assisted dying substance”. I do not know whether that requires a formal amendment to my amendment or whether the chamber is happy to accept that that is what was intended.

The DEPUTY CHAIR (Hon Robin Chapple): Hon Adele Farina seeks leave to alter her new clause 67A.

New clause, by leave, altered.

Sitting suspended from 1.00 to 2.00 pm

Hon STEPHEN DAWSON: During the lunchbreak we had a conversation with the Chief Pharmacist and can confirm the following matters that are important to bring to the chamber’s attention. The main role of the Therapeutic Goods Administration is to make sure that medications are being manufactured well. Not all medications currently prescribed are available on the Australian register of therapeutic goods. On many occasions, a medical practitioner will request that a specific medication be compounded by a pharmacist. Normally, this would be done for medications that are not available in Australia such as when there is sufficient evidence for a medication to be used but it has not been made commercially available in Australia. An example of this is some hormone replacement therapies. Pharmacists have the specific skill set and expertise to do the compounding, which is governed by Pharmacy Board of Australia guidelines. If the clinical panel recommends such a substance, only approved pharmacies would do this for the voluntary assisted dying substance.

Division

New clause, as altered, put and a division taken, the Deputy Chair (Hon Martin Aldridge) casting his vote with the noes, with the following result —

Ayes (7)
Hon Adele Farina
Hon Rick Mazza
Hon Aaron Stonehouse
Hon Colin Tincknell
Hon Ken Baston (Teller)

Noes (26)
Hon Martin Aldridge
Hon Stephen Dawson
Hon Kyle McGinn
Hon Matthew Swinbourn
Hon Jacqui Boydell
Hon Colin de Grussa
Hon Michael Mischin
Hon Dr Sally Talbot
Hon Robin Chapple
Hon Sue Ellery
Hon Simon O’Brien
Hon Darren West
Hon Jim Chown
Hon Diane Evers
Hon Martin Pritchard
Hon Alison Xamon
Hon Tim Clifford
Hon Donna Faragher
Hon Samantha Rowe
Hon Pierre Yang (Teller)
Hon Alanna Clohesy
Hon Laurie Graham
Hon Robin Scott
Hon Peter Collier
Hon Colin Holt
Hon Tjorn Sibma

New clause, as altered, thus negatived.

Clause 68: Information to be given before prescribing substance —

Hon NICK GOIRAN: Clause 68 requires certain information to be provided by the coordinating practitioner to the patient before the substance can be prescribed. How will the substance be required to be stored under clause 68(1)(c)?

Hon STEPHEN DAWSON: The advice is that the substance must be stored in accordance with the information provided by the authorised supplier of the substance.

Hon NICK GOIRAN: Why is the requirement for secure storage in a locked box not included in the bill as it is in section 61 of the Victorian scheme?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: The bill does not specify the use of a locked box as this may not always be the most appropriate method for securely storing substances. It is not a default position to have it in the bill as the use of the locked box is not best practice and may confirm a misplaced sense of security or contravene national and Western Australian guidance about the safe storage of medication in the home. Specific medication protocols will be developed and implemented to ensure the safe storage, preparation, administration and disposal of unused prescribed substances.

Hon NICK GOIRAN: Could a locked box be one of the methods set out in clause 68(1)(c)?

Hon STEPHEN DAWSON: I am advised it is impossible to say. I cannot forecast that.

Hon NICK GOIRAN: Is that because nobody has turned their mind to this issue as yet or because the government has not received any advice from the Chief Pharmacist, the ministerial expert panel or the joint select committee? Is it because nobody has turned their mind to this and it will just be left to the implementation period?

Hon STEPHEN DAWSON: I am advised that we have turned our minds to it and considered it, but it is not the best default position.

Hon NICK GOIRAN: What is the best default position?

Hon STEPHEN DAWSON: The default position that we believe is best is as the bill reads. It enables individual and personalised storage solutions.

Hon NICK GOIRAN: How is the schedule 4 or 8 poison to be prepared and self-administered under clause 68(1)(d)?

Hon STEPHEN DAWSON: I am advised that it would depend on the make-up of the substance.

Hon NICK GOIRAN: I take it that we do not know at this stage what that is.

Hon STEPHEN DAWSON: The honourable member is correct.

I am going to move the amendment standing in my name. It is on a supplementary piece of paper that was circulated to honourable members before we broke for lunch. I give my apologies, because this was an issue I took on board last week; however, I did not receive the properly drafted amendment until just before lunch today. I apologise to the chamber for the late presentation of it. I provided it before lunch during the last debate to at least give honourable members the opportunity to read it. It came about because at an earlier stage of the debate, Hon Adele Farina had intended to move amendments to this effect at clauses 57 and 58. I gave an undertaking that the government would move an amendment on this issue, and I am doing that now, so I so move.

The DEPUTY CHAIR: Minister, I might get some clarification from you, because there are not any amendments standing in your name. You circulated some draft amendments. I think the safest approach would be for you to move your amendment and then I will put the question.

Hon STEPHEN DAWSON: I move —

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.

Hon MARTIN PRITCHARD: Would proposed subclause (1A) come before subclause (1) in this circumstance? I thought we had determined that subclause (1A) would come after subclause (1). I just ask for clarification.

Hon STEPHEN DAWSON: I am advised that because it is proposed subclause (1A) with a capital A, it comes before.

The DEPUTY CHAIR: To your point of clarification, Hon Martin Pritchard, that will be addressed as a clerk’s amendment.

Amendment put and passed.

Hon NICK GOIRAN: The next amendment on the supplementary notice paper is at page 45, line 24, so I will need to move my amendment at this stage. I move —

Page 45, line 24 — To insert after “patient,” —

including

My amendment at clause 68(1) would also be complemented by a subsequent amendment by me at clause 68(2) in the event that the chamber was agreeable to this first one. It supports the principle of informed consent that is central to the operation of the bill. My amendments would ensure that the information is not only documented in writing, but also, much more importantly I suggest to the minister and members, communicated to the patient in a way understood by the patient. As clause 68 is currently drafted, the very important information to be provided to the patient need only be provided in written form. This does not account for the fact that the patient may be

Extracted from finalised Hansard
In earlier parts of this legislation, the government has quite rightly enshrined a desire to ensure that information is communicated to the patient in a format and a way that is understood by the patient. That is quite right. By inserting these words, all we would be doing is saying that the information needs to be communicated to the patient, including in writing, rather than the implication here that it be only in writing. I accept, and it may be a retort from the government, that nothing in this clause as currently drafted prohibits the practitioner from communicating to a patient in a form other than in writing. That is true, but I do not want a practitioner slavishly following clause 68(1), and simply providing this information in writing, and indicating that they have satisfied clause 68. Let us make sure that the patient is properly informed and understands the information. If they receive a document in writing, that is all well and good, but, as I said, I suspect, and I would not be at all surprised, that a person in the end-of-life situation is not going to spend an inordinate amount of time reading every single thing that the practitioner has given them. They are far more likely to absorb the information and retain it if it is communicated to them verbally, and if time is taken by the practitioner to step the patient through the process and make sure that they clearly understand everything that is being communicated to the patient at this time. This would be in the best interest of the patient and consistent with the principle of informed consent.

**Hon STEPHEN DAWSON:** We are not supportive of the amendment as it stands. The bill clearly and properly provides for the provision of information. The amendment to the clause is slightly confusing. Clear guidelines will be provided. It is an operational issue that will be dealt with during the implementation phase of the bill.

**Hon NICK GOIRAN:** In respect of the alleged confusing nature of the amendment, it seeks to include one word—"including"—so that the clause would read—

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, including in writing, of the following—

It then sets out the parameters, as per the government’s proposals at paragraphs (a) to (f). What is confusing about the insertion of the word “including”?  

**Hon STEPHEN DAWSON:** My advisers tell me that it does not read well.

**Hon NICK GOIRAN:** I have no objection if the government has a preferred form of wording. The spirit of the amendment is to ensure that the patient understands the information, and it is communicated to them in a form that will be understood. I am not confident that simply providing a stack of brochures or prescribed information will ensure that the patient understands—

(a) that the patient is not under any obligation to obtain the substance;
(b) that the patient is not under any obligation to self-administer the substance;
(c) that the substance must be stored in accordance with the information provided by the authorised supplier who supplies the substance;
(d) how to prepare and self-administer the substance;
(e) that, if the patient decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal;
(f) that, if the patient dies, their contact person must give any unused or remaining substance to an authorised disposer for disposal.

Some patients, if they are given all that information in writing, may well understand all of it and may well then proceed by providing informed consent, but I very much suspect that, for some, providing the information in writing will be a useless exercise, and that some other form of information—for example, verbal—would be far more appropriate. I note that that is consistent with many other provisions in the bill. This strikes me as potentially the only provision in the bill in which we limit the information. We prescribe that it is to be provided in writing, whereas the phrase that is used in the rest of the bill is that the practitioner inform the patient. Here, at clause 68, we suddenly take a different turn and say that the practitioner must inform the patient in writing. I am not confident that that is in the best interests of the patient. If there is an alternative wording, I would be very happy to consider it.

*Extracted from finalised Hansard*
Hon STEPHEN DAWSON: I do not have alternative wording, but my advisers tell me that it is not necessary to amend this clause. Department of Health practice and good clinical practice means that information given in writing by a doctor is also explained orally, or in some other way. This clause serves to emphasise that the information must be provided in writing, but not to limit it to this method only.

Hon NICK GOIRAN: Is there agreement from the government that my amendment would not limit it only to writing?

Hon STEPHEN DAWSON: Yes.

Division

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

Ayes (13)
Hon Martin Aldridge  Hon Nick Goiran  Hon Charles Smith  Hon Ken Baston (Teller)
Hon Jacqui Boydell  Hon Rick Mazza  Hon Aaron Stonehouse
Hon Donna Faragher  Hon Simon O’Brien  Hon Colin Tincknell
Hon Adele Farina  Hon Martin Pritchard  Hon Alison Xamon

Noes (20)
Hon Robin Chapple  Hon Stephen Dawson  Hon Colin Holt  Hon Robin Scott
Hon Jim Chown  Hon Colin de Grussa  Hon Alannah MacTiernan  Hon Matthew Swinbourn
Hon Tim Clifford  Hon Sue Ellery  Hon Kyle McGinn  Hon Dr Sally Talbot
Hon Alanna Clohesy  Hon Diane Evers  Hon Michael Mischin  Hon Darren West
Hon Peter Collier  Hon Laurie Graham  Hon Samantha Rowe  Hon Pierre Yang (Teller)

Amendment thus negatived.

Hon STEPHEN DAWSON: I move —

Page 45, after line 24 —To insert —

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

Amendment put and passed.

The DEPUTY CHAIR: Hon Rick Mazza, can I confirm that you will not move the amendment standing in your name on the supplementary notice paper?

Hon RICK MAZZA: Just by way of explanation, all the remaining amendments I have on the supplementary notice paper are consequential to my amendment at clause 57; therefore, I will not move any of those amendments.

The DEPUTY CHAIR: Thank you for that clarification.

Hon STEPHEN DAWSON: I move —

Page 46, after line 4 — To insert —

(da) the method by which the substance will be self-administered;
(db) the expected effects of self-administration of the substance;
(dc) the period within which the patient is likely to die after self-administration of the substance;
(dd) the potential risks of self-administration of the substance;

Hon NICK GOIRAN: To what extent does the list the minister is proposing to insert differ from that proposed by Hon Adele Farina in the amendment that was the genesis of these amendments?

Hon STEPHEN DAWSON: My advisers tell me it is the same issue as Hon Adele Farina raised.

Hon NICK GOIRAN: Just to clarify, I had understood that the government’s objection to the honourable member’s amendment was that there could be some different wording and the like. If it is the same, why did the minister not agree to the earlier amendment?

Hon STEPHEN DAWSON: It is the same substance, but it has been drafted slightly differently.

Hon Nick Goiran: Okay.

Amendment put and passed.

Hon STEPHEN DAWSON: I move —

Page 46, after line 14 — To insert —

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

Amendment put and passed.
Hon STEPHEN DAWSON: I move —

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;

Amendment put and passed.

Clause, as amended, put and passed.

Clause 69: Prescription for substance —

Hon NICK GOIRAN: At clause 69(5), it states —

The prescription cannot provide for the prescribed substance to be supplied on more than 1 occasion.

I note that the guidelines in the Netherlands for the practice of euthanasia and physician-assisted suicide mandate that practitioners should carry with them an emergency set of euthanatic agents whenever administering euthanasia to a patient. The Dutch guidelines state —

Even for the most experienced doctors, things can sometimes go wrong. For this reason, the doctor must bring an extra set of intravenous euthanatic agents and materials for the preparation and administration of the agents.

Will the operation of clause 69(5) impact on the ability of the CEO to mandate that a similar emergency set be carried by Western Australian administering practitioners in line with the Dutch guidelines?

Hon STEPHEN DAWSON: The purpose of this clause is to ensure that there are no repeat scripts.

Hon NICK GOIRAN: Will the CEO be able to mandate?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: They are not able to? In other words, if the administering practitioner runs into trouble when administering the substance to the patient, so be it. They will have to just cope with it. Whether they asphyxiate, choke or whatever happens as a result of that, the practitioner can do nothing about it.

Hon STEPHEN DAWSON: They can provide care to the patient but they will not be able to provide drugs.

Hon NICK GOIRAN: Why does clause 69(4) prohibit the prescription from being in the form of a medication chart?

Hon STEPHEN DAWSON: The prescription for the voluntary assisted dying substance cannot be in the form of a medication chart. The medication chart is the chart that records the medications used for a patient in a hospital or care facility. It serves as a communication tool between doctors, nurses, pharmacists, other health professionals and hospitals regarding the patient’s medicines. It is used to direct how and when drugs are to be administered and as a record of their administration. It would not be prudent to allow a voluntary assisted dying substance to be prescribed in this manner. All prescriptions of voluntary assisted dying substances by the coordinating practitioner will go directly from the medical practitioner to the authorised supplier. This provision overrides any ability for the use of a medicine chart under the WA Medicines and Poisons Act 2014.

Hon NICK GOIRAN: Why must the prescription include a statement certifying that the request and assessment process has been completed in respect of the patient in accordance with this legislation? Is there a duty upon the authorised supplier to verify that the matter is certified, including that the request and assessment process has been completed?

Hon STEPHEN DAWSON: There is a duty. As well as the obligations under clause 70, it is a mechanism to ensure that the proper process for voluntary assisted dying is being followed.

Hon NICK GOIRAN: As we discussed earlier, clause 69(5) provides that the prescription cannot be supplied on more than one occasion. A dialogue took place in the other place on 17 September between the member for Darling Range and the Attorney General on this issue. If the patient has not self-administered the substance by the use-by date, will the patient be required to go through the entire request and assessment process again in order to acquire a new prescription?

Hon STEPHEN DAWSON: Given the six-month eligibility criteria, it is unlikely that a patient will delay the decision to the point at which the medication goes out of date. However, should this occur, this could be proactively managed and picked up by the authorised supplier. This will be looked at operationally during the implementation phase.

Hon NICK GOIRAN: The minister can say that it might be unlikely, but that is not the experience in Oregon. In Oregon, there have been many occasions on which a patient has taken the substance well after the six-month original
prognosis. That being the case, it does not provide me with any confidence that the government says that it will deal with this under the implementation phase. Nevertheless, I note that under clause 69(6), there is a requirement that the coordinating practitioner must give the prescription directly to an authorised supplier. Are there any other substances for which a practitioner is required to provide the prescription directly to the supplier rather than to the patient?

Hon STEPHEN DAWSON: Is the honourable member asking outside of this bill before us?

Hon NICK GOIRAN: I am just looking at clause 69(6), which says —

The coordinating practitioner must give the prescription directly to an authorised supplier.

Clause 69(6) will mandate by law that that is the only person to whom the coordinating practitioner can give a prescription. That seems irregular to me, because I think that it is ordinarily and routinely the case that a practitioner gives a prescription directly to a patient. Here, we are doing something different. Clause 69(6) says no, they must give it directly to the authorised supplier. I am clarifying whether that happens with any other substance that is used in Western Australia, or will this be the first time we are mandating this type of supply chain?

Hon STEPHEN DAWSON: I am not aware of any other instance, but this is an additional safeguard in the bill.

Hon MARTIN PRITCHARD: I read the same clause and was a little bewildered by it, particularly how it might actually work in the country, where we are looking at the hub-and-spoke method. Are we saying that the doctor will have to actually travel to the supplier, or would that be by electronic means, possibly?

Hon STEPHEN DAWSON: It is through a database, honourable member.

Hon CHARLES SMITH: I have just a quick question. In relation to clause 69(6), has the government actually decided yet who shall be an authorised supplier?

Hon STEPHEN DAWSON: No, not yet.

Clause put and passed.

Clause 70: Authorised supplier to authenticate prescription —

Hon NICK GOIRAN: Minister, how will an authorised supplier confirm the authenticity of the prescription under clause 70(a)?

Hon STEPHEN DAWSON: I am advised that the contact details are on the prescription, so 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 above.

Hon NICK GOIRAN: How will an authorised supplier confirm the identity of the person who issued the prescription in accordance with clause 70(b)?

Hon STEPHEN DAWSON: I am advised that they can speak to the prescriber.

Hon NICK GOIRAN: An authorised supplier can speak to a person who issued the prescription, and that is somehow intended to be sufficient to identify the person. If someone rang the minister later today and said to him on the telephone, “This is Hon Nick Goiran speaking”, because the minister has been hearing my voice for quite some time during the course of this debate, he would be able to identify —

Hon Stephen Dawson: I would hope so!

Hon NICK GOIRAN: — through that experience whether that voice sounded anything like me. But in this context, an authorised supplier might never ever have heard the voice of the practitioner who writes the prescription, yet the minister indicates that speaking would be sufficient to confirm the identity of the person. I suspect that that is not going to be sufficient to satisfy the provisions of clause 70(b), and I wonder whether the minister has any supplementary advice to give us on this point.

Hon STEPHEN DAWSON: I am advised that the prescription will come through the database and only particular people can access that database.

Hon RICK MAZZA: Under clause 70(c), the authorised supplier is to identify the person to whom the substance is to be supplied. How is it envisaged that that will take place? We have heard through this debate that that could be the contact person or an agent such as Silver Chain going into town to pick up the substance. If the contact person says, “I can’t get in to pick this up from the authorised supplier”, does the authorised supplier need something in writing to say that the agent will collect the substance? How is it envisaged that this will operate?

Hon STEPHEN DAWSON: I am reminded that this issue has been asked about and answered previously. However, the patient can call ahead or provide a letter. They can contact the patient to ascertain the identity.

Hon RICK MAZZA: Just to confirm that, someone can just call ahead—a phone call is sufficient—to the authorised supplier to say that Joe Blow will come and pick it up at four o’clock this afternoon, so a telephone call on its own will be sufficient.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: There is a requirement that the authorised supplier will have to confirm the identity, so they might ask for identification.

Hon ADELE FARINA: What happens if an agent who is under the age of 18 goes to collect the medication? What proof of identification would that person have?

Hon STEPHEN DAWSON: They may have to provide a passport or a student identification card.

Clause put and passed.

Clause 71: Information to be given when supplying prescribed substance —

Hon NICK GOIRAN: Clause 71(2) requires certain information to be provided when a prescribed substance is supplied by an authorised supplier. This information does not include information on adverse reactions or complications arising from self-administration and what the patient should do in the event that an adverse reaction or complication does arise. Why is this information deemed unnecessary for provision to the patient and is left out of clause 71(2)?

Hon STEPHEN DAWSON: I am advised that that discussion will have already been raised by the coordinating practitioner with the patient.

Hon NICK GOIRAN: Clause 71(3) requires that if the poison and the information provided under clause 71(2) is received by a recipient who is not a patient, the information must be passed on by that recipient to the patient. There is no requirement in the bill for the authorised supplier or coordinating practitioner to provide this information directly to the patient or for either the authorised supplier or the coordinating practitioner to follow up with the patient to confirm that they have received the necessary information with their prescribed substance. How can the authorised supplier be sure that the patient has received the relevant information at the time that they received the prescribed poison, particularly given that the self-administration of the substance is intended to and will most likely cause the death of the patient?

Hon STEPHEN DAWSON: The onus of passing on the information then falls to the agent. This agency is a relationship between the patient and the person they have elected as their agent.

Clause put and passed.

Clause 72: Labelling requirements for prescribed substance —

Hon STEPHEN DAWSON: I move —

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.

The amendment is to correct a technical error in the bill. As currently drafted, the subclause requires that, amongst other things, the label or statement 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 the contact person; however, under the bill, only the contact person is obliged to return the substance to the authorised disposer, and faces a penalty for failure to do so. Although a patient may also return the substance, they are not obliged to do so under the bill nor will 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.

Hon NICK GOIRAN: Minister, why would we want to take the patient out of this clause? I understand that there will be many scenarios in which the patient is maybe not in a fit state to do it and therefore the contact person will do it. But, equally, minister, let us remember that what happens here is we have a person who qualifies for the scheme because they have been told by a doctor that they have only six months to live. We know of many circumstances in which doctors get that wrong. There have been many medical negligence cases as a result of that. What happens at a later stage if the doctor informs the patient that they no longer have a terminal illness and no longer qualify for this, and the patient says, “This is excellent news and I now wish to return the substance”? Why would we have any issue with them returning it? It seems unnecessary to delete the patient from this, so my question to the minister is: why is the proposed amendment 462/72 that the minister is moving necessary?

Hon STEPHEN DAWSON: The patient is not under an obligation, so a label that states that the patient “must” do something is incorrect.

Hon NICK GOIRAN: Minister, by saying that, are we saying that a patient has the liberty and licence to retain the substance, notwithstanding the fact that they have no intention of using it?

Hon STEPHEN DAWSON: No, they may return it. But, on further advice, the statutory obligation is with the contact person.

Amendment put and passed.
Hon NICK GOIRAN: What are the labelling requirements under the Medicines and Poisons Act 2014 that relate to clause 72?

Hon STEPHEN DAWSON: The labelling requirements are in addition to stringent labelling requirements under the Medicines and Poisons Act 2014, WA—noting that where the two are inconsistent, the Voluntary Assisted Dying Act will prevail. All labels for medicines and poisons have to comply with extremely detailed requirements under part 2 of the Standard for the Uniform Scheduling of Medicines and Poisons, known as the poisons standard, including minimum size requirements for labelling. The label of the VAD substance will clearly identify that it is a voluntary assisted dying substance to make it distinguishable from other medications.

Hon NICK GOIRAN: We know from a statement that was made by the Attorney General in the other place when he had interim carriage of the bill that the voluntary assisted dying substance will have a date by which it should be used, or else it is to be disposed of. The Attorney General said this on 17 September. Assuming that that is correct, why are the dates not included in the labelling requirements under clause 72?

Hon STEPHEN DAWSON: The Medicines and Poisons Act requires a use-by date and these are in addition to the requirements of the Medicines and Poisons Act.

Hon NICK GOIRAN: The Netherlands guidelines state —

Following delivery of the euthanatic agents, the doctor must ensure that they are properly stored in order to prevent any accidents at the patient’s home or elsewhere.

Earlier we discussed that section 61 of the Victorian legislation mandates a locked storage box to ensure secure storage of these poisons. Given that this bill does not mandate a locked storage box like the Victorian legislation, what proper storage requirements will the government be including in the approved form of clause 72(2)?

Hon STEPHEN DAWSON: That information will be decided during the implementation phase; we do not have an answer to it yet.

Clause, as amended, put and passed.

Clause 73: Authorised supplier to record and notify of supply —

Hon NICK GOIRAN: I note that under clause 73, the authorised supply form will not certify that the patient received the substance, only that the substance was supplied to a person, who, of course, may be a contact person or an agent of the patient. Where does the bill provide for the board to be notified that the substance has in fact been received by the patient—that is, that the contact person or agent has actually provided the substance to the patient?

Hon STEPHEN DAWSON: We do not ordinarily require a pharmacist to ensure that prescribed substances have been received by the patient. The board can contact the contact person at any stage. We do not want the board to be seen to be influencing the use of the substance. If a patient does not receive the substance, they would advise their coordinating practitioner.

Hon NICK GOIRAN: Could it be the case that the board knows who the patient is, who the coordinating practitioner is and who the contact person is, but it has no idea who the agent is who has the substance in their possession?

Hon STEPHEN DAWSON: Clause 73(2)(d) says that the name and contact details of the person to whom the prescribed substance is supplied needs to be on the authorised supply form, so it would know.

Hon NICK GOIRAN: The authorised supply form requires the authorised supplier to also certify that they provided the information required to be provided under clause 71 to the person who received the substance, who might be, as we have discussed, a contact person or indeed an agent of the patient. Where does the bill provide for the board to be notified that the information has in fact been received by the patient—that is, that the contact person or agent has actually provided the requisite information to the patient?

Hon STEPHEN DAWSON: There is no obligation on the pharmacist to check whether the information they have given the contact person or the agent has been passed on, but it is a statutory obligation that the information be passed on.

Hon NICK GOIRAN: Clause 73(3) requires that the authorised supply form be provided to the board within two business days after the prescribed poison has been supplied. What will the board be required to do with this form, and what oversight function will the board notification serve if the patient self-administers the prescribed substance within the time frame of two business days and before the board even receives the form?

Hon STEPHEN DAWSON: The intent of this provision is to record the details that are relevant to the supply of the prescribed substance; ensure that the Voluntary Assisted Dying Board is notified progressively of the patient’s participation in the voluntary assisted dying process, including the outcome of each assessment; monitor that the correct processes are being followed in each case of voluntary assisted dying; and maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia. These requirements will be in addition to any notification requirements under the Western Australian Medicines and Poisons Act 2014, noting that if the two acts are inconsistent, the Voluntary Assisted Dying Act will prevail.

Clause put and passed.

Extracted from finalised Hansard
Clause 74: Disposal of prescribed substance by authorised disposer —

Hon NICK GOIRAN: What requirements of the Medicines and Poisons Act 2014 referred to in clause 74(4) will apply to the disposal of prescribed substances under this legislation?

Hon STEPHEN DAWSON: I am told that there are provisions in part 9 of the Medicines and Poisons Regulations 2016.

Hon NICK GOIRAN: Yes, but what requirements would apply under this legislation?

Hon STEPHEN DAWSON: We are looking for more information, but I will provide some. The Department of Health has issued a table of recommendations for the disposal of schedule 8 medicines, which is available on the Department of Health website. For the disposal of any small quantities of schedule 8 medications—for example, the disposal of any unused or remaining voluntary assisted dying substances—the administering practitioner can request disposal by community pharmacies in their return of unwanted medicine bins; dispose of the medications specifically in their medical facility or practice; or remove all packaging, crush and disperse contents, and dispose of it as clinical waste in a sharps or clinical waste container, for incineration. These methods can also be used to destroy other schedule 4 voluntary assisted dying medications.

Hon NICK GOIRAN: Why must the authorised disposer dispose of the prescribed substance “as soon as practicable after receiving it”, not immediately after receiving it?

Hon STEPHEN DAWSON: The intent is that they would do it as soon as possible, but it would depend on what else they are doing at the time; whether they are consoling family members, or other things.

Hon NICK GOIRAN: The language used in clause 74(3) is “as soon as practicable”. I understood from the minister earlier that there were particular provisions in the bill in which that phrase was not used and it was to be read in accordance with the Interpretation Act. Why have we chosen to use it in this particular provision and not in others?

Hon STEPHEN DAWSON: This is how it has been drafted by the parliamentary draftspeople. It is to make the intention clear at this stage.

Clause put and passed.

Clause 75: Authorised disposer to record and notify of disposal —

Hon NICK GOIRAN: Unlike the supply and disposal provisions in the Victorian act, the authorised disposer does not have to be the authorised supplier who supplies the prescribed substance. In that case, why is it that there is no requirement under clause 75 for the authorised disposer to advise the authorised supplier of the disposal of the substance, to adequately monitor and track the whereabouts and use of the substance prescribed and supplied?

Hon STEPHEN DAWSON: I am advised that they may be one and the same; both advise the board. The information is on the database and can be accessed by both. Ordinarily, a pharmacist who disposes of returned medication does not notify the person who prescribed the medication of the disposal.

Hon NICK GOIRAN: The voluntary assisted dying substance disposal form in schedule 1 of the Victorian legislation requires substance-specific or poison-specific information to be included in the form, including the type of substance and the quantity returned. Why is this information not required to be recorded in the authorised disposal form under clause 75?

Hon STEPHEN DAWSON: Determining the quantity returned is not consistent with current practice and it could be problematic. If the substance has already been prepared for ingestion—for example, mixed with another substance to make it more palatable—then the authorised disposer would not readily be able to determine the quantity of the scheduled substance in the preparation.

Hon NICK GOIRAN: If the authorised disposer is required to record and notify of disposal, is it the case that the minister is indicating that they will be recording and notifying a quantity of which they are unaware? The suggestion is that they are unaware of the quantity of the substance of which they are disposing, which is contrary to the whole idea of recording and notifying. If they are going to record and notify that they are getting rid of something, they should have to identify what it is and how much of it they are getting rid of. It seems counterintuitive to me that we would simply say, “Let the board know that you’ve gotten rid of this thing” when they do not know what it is, let alone how much there is of it. Presumably in order for clause 75 to trigger a requirement on the disposer, they must have some knowledge that part of the thing that they have in their possession includes a voluntary assisted dying substance. If they do not know that, clause 75 is not enlivened. How is the disposer to know that they are required to do anything under clause 75 if they do not know whether the substance is a voluntary assisted dying substance, to say nothing of the quantity?

Hon STEPHEN DAWSON: We are saying that any quantity returned will be disposed of. We are not testing what we are supplying and what is returned. It is our belief that that is overly prescriptive.

Hon NICK GOIRAN: If the board receives an authorised disposal form, it will be the case that the disposer has disposed of a substance that might be entirely a voluntary assisted dying substance or partly a voluntary assisted dying substance and something else. Is that right?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: That is correct. Adding to the earlier comment I made, we will be guided by the voluntary assisted dying substance packaging, but we cannot independently verify the elements that come back to us.

Hon ADELE FARINA: That being the case, where is the harm in recording the volume of whatever it is sent back, because we will know how much powder is provided as part of the voluntary assisted dying substance and the quantity of the syrup that is provided to be mixed with the powder? How big a problem is it to simply record how many millilitres are returned?

Hon NICK GOIRAN: While the minister is thinking about that, this dialogue has been useful for me as I contemplate the amendment standing in my name at 474/75. It is clear that if I move the amendment in its current form, it will not receive the support of the government, for the reasons the minister has indicated, which I respect. I wonder, therefore, whether the solution would be that I delete the word “prescribed”, so that at least the form would indicate the type and quantity of the substance that has been given to the disposer and we will know what they are disposing of.

Hon STEPHEN DAWSON: In relation to Hon Adele Farina’s question, volume is not an effective indicator. A substance may be returned in tablet or powder form, or after it has been mixed in water, etcetera, so it is a very difficult thing to measure. Therefore, I am not sure that it will give the honourable members who have concerns about this issue the comfort that they are seeking to get from it.

Hon NICK GOIRAN: I guess the issue is that clause 75 of the bill mandates that an authorised disposer must complete the form and send it to the board so that there is some regulating around the disposal of the substance. The government, at clause 75(2) of the bill, has determined that it is sufficiently important that the form must also include the name, date of birth and contact details of the patient; the name and contact details of the authorised disposer; the name and contact details of the person who gave the substance to the disposer; the date when the prescribed substance was given to the disposer; the date when the prescribed substance was disposed of by the authorised disposer; and the signature of the authorised disposer and the date when the form was signed. The authorised disposer must do all those things, but they do not have to tell the board what substance, and how much of it, they are getting rid of. I do not quite understand the rationale behind the importance of, for example, setting out the date of birth of the patient when we are disposing of the substance. In many respects, without meaning to in any way sound disrespectful, who cares who the patient is at this particular point in the journey? It is about disposing of a lethal substance in a manner that is safe for the community. I would have thought it would be appropriate that there be some identification of that.

I will explain the mischief that I am concerned about. A rogue disposer may be given a quantity of the substance, but they decide, for improper purposes, to dispose of only some of it. They continue to pretend that they are complying with the law, but they retain a portion of the substance—not the whole lot, but let us say, for the purpose of this example, that they retain half—and they say, “I’m going to dispose of only half of it, and I’m going to keep half and supply it to somebody improperly.” The board would have no idea about that, of course, because the board has simply been told that they have disposed of the substance; it is not told how much.

I query what the objection would be if the board was simply told, “This is the type of substance that I, the disposer, was given, and this is the amount that I have disposed of.” There would then at least be clear tracking of that, rather than a situation in which a form is given to the board, without any particular purpose. The form is giving the board details that it already knows. The only thing the board does not know at this point is in subclause (2)(d) and (e)—the date when the substance was given to the disposer; and the date when the substance was disposed of. The rest of it is not particularly beneficial. A piece of information that would be beneficial is, “What exactly were you given, and how much were you given?” I wonder whether the minister is in a position to provide any further advice on that point.

Hon STEPHEN DAWSON: The substance has a chain of custody from the supplier, agent or contact person to patient, and then it is collected by the contact person. The proposed amendment offers no additional safeguards and my advisers tell me that it may well offer a false sense of security.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, I note that you have not moved this amendment yet. Do you intend to move it?

Hon NICK GOIRAN: I have just decided that I will not. I take the points that have been made by the minister, in particular that there may be some difficulty because the substance has been mixed and so on. However, it still troubles me that we are disposing of something that a person has not fully identified. I might pick this up at a later clause because if we are to concede that it is asking too much of the disposer to identify what it is and how much of it that they are disposing of, at some point in the reporting requirements there should be an obligation to make sure that the board knows how much was provided in the first instance. Let us imagine for a moment that we are talking about practitioner administration. I would want to make sure that the board was aware that the practitioner who was going to administer the substance had to declare or certify what the substance was and how much they received even if they could not identify it at the point of disposal. At this point I will not move the amendment standing in my name at 474/75.

Clause put and passed.

Extracted from finalised Hansard
Clause 76: Disposal of prescribed substance by administering practitioner —

Hon NICK GOIRAN: Will the administering practitioners, including nurse practitioners, be trained and have the facility to dispose of prescribed substances as required by this clause?

Hon STEPHEN DAWSON: They will have the necessary training. In most cases the administering practitioner will be able to dispose of the substance within the facility at which they work. Alternatively, the administering practitioner will be able to arrange for disposal with the local authorised disposer.

Hon NICK GOIRAN: Clauses 76(3) and 76(6) provide that the prescribed poison must be disposed of by the administering practitioner as soon as practicable after the practitioner administration decision is revoked or after the patient’s death. Similarly to the last situation, what is the rationale behind that not being done immediately rather than as soon as practicable?

Hon STEPHEN DAWSON: It is for the same reason I gave before, honourable member.

Hon NICK GOIRAN: Is the administering practitioner required to notify the authorised supplier that they have disposed of the substance in accordance with clause 76?

Hon STEPHEN DAWSON: No, but it will be on the database so the information can be accessed.

Hon NICK GOIRAN: This is my final question under this clause: what requirements of the Medicines and Poisons Act 2014 must the administering practitioner comply with under clause 76(7)?

Hon STEPHEN DAWSON: It is the same answer as I gave last time on this issue, when we dealt with it on a recent clause. I have some further information, though; that is, that the Medicines and Poisons Regulations may be amended to impose additional requirements for disposal of a VAD substance upon the passage of this bill.

Hon NICK GOIRAN: Is the minister indicating that clause 76(7) is to be read in like fashion as clause 74(4)?

Hon STEPHEN DAWSON: The answer, honourable member, is yes.

Clause put and passed.

Clause 77: Administering practitioner to record and notify of disposal —

Hon NICK GOIRAN: Under clause 77(2), there is no requirement for the administering practitioner to record the type of prescribed substance and quantity disposed of. Earlier, the minister gave reasons why that is the case, but he may recall that I indicated I would like to take up this issue, at least with respect to the prescribed substance that was supplied, even if we are not going to deal with the prescribed substance disposed of. I ask the minister to take a look at clause 77(2)(c), which indicates that the practitioner has to report to the board on the date when the prescribed substance was supplied to the administering practitioner. At this point, it would be appropriate for the practitioner to also advise the board the type and quantity of the substance that was supplied to the practitioner at that time; in other words, to give more details of the prescribed substance supplied, rather than merely the date. My question to the minister is: Is that already captured in some other provision? If it is, that would make it unnecessary; but, if it is not, would the government have any objection to the practitioner disclosing to the board more than just the mere date that they were supplied with the substance, but actually the type and quantity?

Hon STEPHEN DAWSON: I am told that the prescription would state the dosage, and the board can access prescription details on the database.

Hon NICK GOIRAN: Does the government object to the administering practitioner providing in the practitioner disposal form the type and quantity of the prescribed substance supplied to the administering practitioner on the date set out in clause 77(2)(c)?

Hon STEPHEN DAWSON: We do not support an amendment. The information is already available to them if they so require it.

Clause put and passed.

Clause 78: Authorised suppliers and authorised disposers —

Hon NICK GOIRAN: Can someone other than a pharmacist be authorised by the CEO to act as an authorised supplier under clause 78?

Hon STEPHEN DAWSON: The clause provides that the CEO can authorise a registered health practitioner, so the answer is yes.

Hon NICK GOIRAN: Is that the intention?

Hon STEPHEN DAWSON: The 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 legislation. The authorised supplier will be limited to registered health practitioners authorised under the WA Medicines and Poisons Act 2014 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 WA Medicines and Poisons Act 2014 to supply schedule 4 and 8 poisons. These
registered health professionals, including pharmacists, are already bound by professional obligations that require
them to act within the scope of practice and area of expertise. The intention at this stage is for pharmacists to
take that role.

Clause put and passed.

Clause 79: Certain directions as to supply or administration prohibited —

Hon NICK GOIRAN: Clause 79(1) refers to an “authorised health professional” under section 3 of the Medicines and
Poisons Act. Can a vet, who is included in the section 3 definition of health professional of the Medicines and Poisons
Act 2014, be given approval by the CEO to act as an authorised supplier under clause 79?

Hon STEPHEN DAWSON: This provision reflects that only a person so authorised by the CEO may supply
a poison for the purposes of voluntary assisted dying. This is an intentional safeguard that cannot be overridden
by a coordinating practitioner or other health professional. This clause excludes the operation of regulations 15 to 17
of the Medicines and Poisons Regulations 2016. The answer to the honourable member’s question is no.

Hon NICK GOIRAN: Nevertheless, this clause as drafted in the definition of “authorised health professional” in
section 3 of the Medicines and Poisons Act is still very broad and captures a broad group of people who can be
authorised by the CEO. In Victoria, these substances can only be prepared by a pharmacist and only one pharmacy
has been approved to supply that substance, as I understand it. Why has the government chosen to draft this clause
so broadly in contrast with the Victorian experience which limits it to one supplier, one pharmacy, and only
pharmacists are able to prepare the substance?

Hon STEPHEN DAWSON: At section 78(1), the CEO may appoint an authorised supplier but they must be
a registered health practitioner. For the purposes of the voluntary assisted dying legislation in WA, this bill makes
it clear that, notwithstanding the authorisation under the Medicines and Poisons Act, a practitioner must be specifically
authorised under the bill to prescribe and supply these medications.

Hon NICK GOIRAN: Where will authorised suppliers obtain these substances from? For example, will they
require importation?

Hon STEPHEN DAWSON: I am told that detail will be determined during the implementation phase, honourable
member.

Hon NICK GOIRAN: Given that you do not know—this is no criticism of you; when I say “you” I mean the
government—or given that the government does not know, how confident can we be that there will even be
a substance available to people? We are saying to people, “Quick, quick, quick, we need to make sure this bill
passes before Christmas,” and any members who want to ask any questions about this are merely described as
wreckers and blockers. Christmas Day, 25 December, is a very important deadline, apparently, according to the
Premier of Western Australia. But as I understand the minister’s answer just now, the government, of which the
Premier is the chief, does not know what substance is going to be provided. That will be dealt with under the
implementation phase, which I understand from an earlier answer the minister gave—not necessarily today, but
on a previous occasion—will be a period of at least 18 months. When I asked the minister whether this substance
might require importation, he indicated that the government does not know whether it will require importation.
The substance might not even be available. While we move at great speed to make sure that the Voluntary Assisted
Dying Bill 2019 is passed before Christmas to meet this artificial deadline, we do not actually know whether the
substance will be available. Why is that? It is because we do not even know what the substance is. I find that quite
remarkable. I will not phrase it in the context of a question; it is more just a comment at this point. My final question
on clause 79 is: why does clause 79(3) include a prohibition against a coordinating practitioner or administering
practitioner directing an authorised health professional to administer a prescribed substance?

Hon STEPHEN DAWSON: The intent of this clause is to override provisions in the Medicines and Poisons Act
that allow other people to administer various schedule 4 or 8 drugs. Regulation 15 of the Medicines and Poisons
Regulations allows a prescriber to give such a direction to an authorised health professional, and clause 79(3) of
this bill operates to override this.

Clause put and passed.

Clause 80: Structured administration and supply arrangement not to be issued for substance —

Hon NICK GOIRAN: In what circumstances might a structured administration and supply arrangement be
documented, and how does the structured administration and supply arrangement operate in those circumstances?

Hon STEPHEN DAWSON: A structured administration and supply arrangement means a document that sets
out the circumstances in which a health professional specified, or of a class specified in the document, may
administer or supply a medicine specified in the document. The intent of this clause is to override any provision
in the Medicines and Poisons Act 2014, particularly regulations 33 to 35 of the Medicines and Poisons Regulations,
that allows for a structured administration and supply arrangement to be made. It would not be prudent to allow
such an arrangement pertaining to the voluntary assisted dying process.

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Hon NICK GOIRAN: Why would it not be prudent? Are there any other drugs, medicines and poisons for which a structured administration and supply arrangement is prohibited from being issued?

Hon STEPHEN DAWSON: I ask the member whether the question is pertinent to his support of this clause. My advisers at the table cannot give me an answer to that question. I am very happy to provide it at a later stage of the consideration of the bill if the member is able to wait and if it is not pertinent to his support of the clause before us.

Hon NICK GOIRAN: I am happy for that question to be answered at a later stage, if the minister could give an indication of the clause under which that information will be provided.

Hon STEPHEN DAWSON: We are seeking advice now. If I can provide it later today, I will. I will provide it as soon as I can.

Hon ADELE FARINA: I am a bit confused about the answer that has been given relating to this provision. The minister has consistently told us that detailed guidelines will be provided to medical practitioners involved in this process about how they are to administer the substance. Maybe I am reading this clause incorrectly, but does a structured administration and supply arrangement not do that?

Hon STEPHEN DAWSON: I am told no, because the only people who can administer the substances are listed in the bill before us.

Clause put and passed.

Clause 81: Notification of death —

Hon CHARLES SMITH: I seek leave to withdraw my amendment 45/81.

Amendment, by leave, withdrawn.

Hon NICK GOIRAN: Mr Chair, I have a number of questions relating to clause 81. Before I ask them, I seek your guidance on amendments 16/81 and 333/81 on the supplementary notice paper. There are a lot of similarities between those amendments, not the least of which is that they both seek to delete the same lines. I notice that Hon Colin Tincknell is away from the chamber on urgent parliamentary business. As I said, I have some general questions relating to clause 81 in any event. The point of clarification that I am seeking at this stage is that if I were minded to move my amendment at 333/81, which is simply to delete lines 6 to 8, I take it that nothing would stop Hon Colin Tincknell, in the event that my amendment was successful, from moving to insert words supplementary to that. I seek clarification on that before I take any precipitous action.

The CHAIR: The consideration of the clause in the first instance requires consideration of the clause in its entirety. From time to time, members may move amendments. At that time, the focus of debate in consideration is then on the amendment in question. In relation to the live situation that Hon Nick Goiran has just described, I will seek to give the call to Hon Colin Tincknell to move his amendment in due course, if he is of a mind to do so. Conversely, if he is not present to move it, and Hon Nick Goiran moved his, which is nearly identical, and then Hon Colin Tincknell were to come in, we could still consider his amendment anyway because they are not in conflict with each other; they seek to delete exactly the same lines in the bill, so we have not moved them on. That is purely hypothetical of course until we come to it. I do not know whether anyone knows where Hon Colin Tincknell is. For all we know, he may be returning to the chamber now. In the short term, the question is that clause 81 do stand as printed.

Hon NICK GOIRAN: Thank you for your helpful advice, Mr Chair.

Under clause 81(5), the medical practitioner who knows or reasonably believes that a person was a patient who self-administered or was administered a voluntary assisted dying substance is required to notify the board of the patient’s death within two business days after becoming aware of that person’s death. How might that medical practitioner become aware of the person’s death?

Hon STEPHEN DAWSON: It is highly likely that the certifying medical practitioner will know that the person has gone ahead with the voluntary assisted dying process because at that stage, the person will have family members, a contact person or an administering practitioner who will already have been engaged in the process. The patient will not be making this decision in isolation, so when everyone is sitting around wondering what went wrong, it will be in the context of the ongoing care that the 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 may simply be a member of the medical community in that town. Even though there has been audiovisual contact between the patient and the coordinating and consulting practitioner, the general practitioner is obviously competent for the certification process.

Hon NICK GOIRAN: I agree that the GP in the scenario the minister painted would be competent to do the task. My question is that clause 81 is triggered only if voluntary assisted dying is in play. How will the general practitioner necessarily know that that is the person before them; in other words, that that person has died as a result of a voluntary assisted dying substance and clause 81 has been triggered? They may be completely unaware of that situation. How will that be addressed?
Hon STEPHEN DAWSON: It is likely that the general practitioner will know if it is voluntary assisted dying, but if not, the contact person certainly will know. We will encourage the patient to tell their GP whether they are self-administering and if it is self-administration, the container will be there.

Hon NICK GOIRAN: We identified earlier in the debate that there may be no contact person at this point because the contact person has been revoked. When the government provides an explanation that, effectively, the contact person is a little bit like a goalkeeper in soccer, it is of no use to the soccer team if there is no goalkeeper. If the goalkeeper is absent from the field, no-one will be able to catch the ball. I am troubled when the explanation is simply that what is likely to happen is that the general practitioner is likely to know. They might not. Again, there might be a falling out between the patient and the general practitioner. The general practitioner may have a conscientious objection to what is happening. The general practitioner might have known the patient for a very long time and be concerned that the person is suffering from demoralisation, so the general practitioner is estranged from the patient. If the government’s safety net is the contact person, that will be of no assistance if no contact person has been appointed following a revocation.

I note that under clause 81, the board will receive some information. What will the board be required to do once it has been notified by the medical practitioner under clause 81(5)?

Hon STEPHEN DAWSON: This is to help the board maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia. I think I made the point before that the information will be provided to the Australian Bureau of Statistics and be available in a de-identified form to Parliament and the community so that it can form a view about how well the legislation is operating. The role of the Voluntary Assisted Dying Board in the collection of accurate statistics and for record keeping will assist to address views espoused in public consultation, led by the ministerial panel, that it was vital that data should be maintained.

Hon NICK GOIRAN: Does clause 81 conflict with the legislative responsibility to report the cause of death under section 44 of the Births, Deaths and Marriages Registration Act?

Hon STEPHEN DAWSON: I am told that it does not conflict and that it is a separate requirement that overrides it.

Hon NICK GOIRAN: Did the government consult with the WA Registrar of Births, Deaths and Marriages in drafting this clause; and, if so, what recommendations were made?

Hon STEPHEN DAWSON: Yes, we did consult with them and the clause as it stands reflects that discussion.

Hon NICK GOIRAN: Does the clause as it stands have the support of the WA Registrar of Births, Deaths and Marriages?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: I do not necessarily need to know who the WA Registrar of Births, Deaths and Marriages is, but when were they appointed?

Hon STEPHEN DAWSON: I do not know when they were appointed and I am not sure whether the appointment date affects the bill before us, but certainly there has been continuity with the person we have been dealing with at the office. I am advised that in relation to this bill, we have been dealing with the second in charge, who has given the okay from the Registry of Births, Deaths and Marriages.

Hon NICK GOIRAN: Earlier, when I asked whether the government had consulted with the Western Australian Registrar of Births, Deaths and Marriages, really the answer should have been no, it has been dealing with somebody else subordinate within the office of that organisation. It is absolutely pertinent, because if the government, through the course of this consultation, has suddenly put in a new Registrar of Births, Deaths and Marriages in recent times, we would want to know that and whether it conflicts with any other advice that has been provided to the government. Perhaps the minister could indicate this to us: did the ministerial expert panel receive any advice from the registrar?

Hon STEPHEN DAWSON: The issue has been covered. I am not being rude; I think the concern has been covered. We consulted with the former registrar and the second-in-command. The registrar left and I am advised that the 2IC has kept the new registrar up to date.

Hon NICK GOIRAN: With that continuity, that office has consistently advised that what is being proposed in clause 81 is acceptable and supported, and no concerns have been raised by the registrar, former or current, about this particular provision.

Hon STEPHEN DAWSON: That is my advice, yes.

Hon COLIN TINCKNELL: I move —

Page 55, lines 6 to 8 — To delete the lines and substitute —

(6) The medical practitioner must state that voluntary assisted dying was the cause of death.

I am going to keep this brief, because we discussed this a lot in clause 1 and there was a reasonably good debate about this issue. I never heard anything that convinced me that we should not be doing any different. I believe that
if the cause of death is assisted dying, it should be on the death certificate. I understand there were discussions about stigma and all that, but I think we are actually adding to the stigma by trying to cover up the actual cause of death. The cause of death in any sort of terms is what actually happened, and what actually happened was that the person decided to take up the option of voluntary assisted dying. Clause 81(6) states —

The medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

I just do not see how that is reflective of what has actually happened. I do not want to be responsible for any mistruths, in my opinion, on the death certificate. If the people of Western Australia and this Parliament decide to bring assisted dying into place, we should indicate quite clearly how that person’s life was ended. The only way we can do that is to say that they took the option of voluntary assisted dying, and that should be reflected on the death certificate.

Hon NICK GOIRAN: I am really troubled by the information that the minister provided earlier. I draw to the minister’s attention the second last paragraph on page 88 of the “Ministerial Expert Panel on Voluntary Assisted Dying: Final Report”, which clearly states —

The Panel received feedback from the Registrar that he would have concerns …

I asked in various forms whether the Registrar of Births, Deaths and Marriages had raised any concerns. I was told, “No, we’ve been dealing with the second in command, and so on and so forth.” Then I read at page 88, in black and white, that the registrar did raise concerns. I find that highly unsatisfactory. In addition, if we look at the final paragraph on that page, we see a very, very interesting comment. I wonder how many people have picked up on this. I would like the government to explain—not least given that it has at its disposal the chair of the ministerial expert panel—the very interesting line that says —

There were a range of views on this topic in the Panel.

In relation to the question about the differences of opinion, I am advised that some panel members were concerned that the death certificate would not disclose voluntary assisted dying as the cause of death. Some had strong views; others had different views. Certainly, where we have landed, can I say, was the view of the majority and all members of the panel reached a consensus that they support where we have landed.

Hon STEPHEN DAWSON: My advice still stands on the conversations and the consultations that the department had with the Registrar of Birth, Deaths and Marriages. The member read comments from page 88 of the ministerial expert panel’s final report. The report states —

… the Panel recommends that in the case of a person whose death is caused by voluntary assisted dying, a separate reporting mechanism for this information be considered. The Panel recommends that the medical practitioner report this information directly to the oversight body, who in turn can report this information to the Registrar of Births Deaths and Marriages.

The Panel received feedback from the Registrar that he would have concerns about such a mechanism …

It is the mechanism that is referred to in his comments. That is what that says. Certainly, my advice from the Department of Health on the drafting of this bill is that conversations and consultations have taken place, and that the office of the registrar is happy with where we have landed. Ultimately, the government accepted the ministerial expert panel’s advice that maintaining a family’s privacy was paramount.

Hon ALISON XAMON: I rise to indicate that I will be supporting this amendment. I have been perplexed about why this provision is included in the bill in the first place. We have other causes of death that are recorded. For example, if someone takes their life, the way that person died is recorded on the death certificate, but so is the fact that the person took their own life. That is already there and it happens regardless of whether people are concerned about stigma or perhaps families do not want to have that revealed. This decision is made independently

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Clause 81: Notification of death —

Committee was interrupted after the amendment moved by Hon Colin Tincknell had been partly considered.

Hon PETER COLLIER: I have a couple of questions because I am a little perplexed about this clause. When a person dies, their cause of death is on their death certificate. If the person suffers a heart attack, the matter is referred to the coroner, whereas a car accident might have resulted in death following a head trauma. If this bill becomes law, we will have voluntary assisted dying. If someone makes a decision to go down the voluntary assisted dying path because they have a terminal disease—say, cancer—first of all, what will appear on their death certificate?

Hon STEPHEN DAWSON: The answer is “cancer”, honourable member.

Hon PETER COLLIER: I have a bit of an issue with that. I have no doubt that cancer would have taken that person’s life, but had that person taken the voluntary assisted dying substance on 1 December, they would have died as a result of taking the substance, not as a result of the cancer.

I do not want to be self-indulgent, but I will for one moment. I mentioned this in a previous contribution. On two occasions, my mother was provided with a diagnosis of terminal cancer—one in 1976 and the other in 1989. She turned 86 years of age two months ago. Had she gone down the voluntary assisted dying path, if it were available at that time—I can guarantee members she would not have—she would not have died from cancer of the uterus or lung cancer; she would have died from voluntary assisted dying. She is alive and very well today. The minister probably does not even need to answer this; it is a comment more than anything: when push comes to shove, most people who sent me correspondence in support of voluntary assisted dying have said, “It’s my body. I want control. I want to be empowered. It is my decision. It’s not for you to make the decision. It’s me who has to make the decision; I want to make that decision.” I respect that a person can decide whether to go down that path, but in 10, 20 or 30 years’ time, when their grandchildren and great-grandchildren reflect, they will know that was their decision to make. As Hon Alison Xamon said, we do not want to stigmatise it. We do not want it to be a dirty, dark secret that a great-grandmother went down the voluntary assisted dying path: “Oh no, she died of cancer.” “Actually such-and-such from school said that she didn’t; she actually died of voluntary assisted dying.”

There is a profound difference. If they make that decision, that is a decision that they made, hand on heart. They wanted to go down that path because they did not want any more pain, agony or despair. They made that conscious decision to say, “I’m going down the voluntary assisted dying path.” Rather than the death certificate stating that their great-grandmother died from cancer, it will state voluntary assisted dying. But do members know what? That was her call; she died with her family around her, just like she wanted. That was the pathway that she decided to take.

At this stage, if we do not have that on the death certificate, quite frankly, I do not think that is an honest, transparent reflection of that person’s death. I honestly do not. By design, as Hon Alison Xamon said, we will create a stigma around voluntary assisted dying. I do not think that people who are supportive of voluntary assisted dying would support that. They want to know that that is their call; it is their decision. It is not a doctor’s decision. It is no-one else’s decision: “It is my decision. I’ve made that decision. In the years to come, my children, my children’s children and their offspring will know how I passed away.” The minister has answered my question. I do not think that that person will have died of cancer; I think that that person would still be alive on 2 December if they had not taken the substance on 1 December. I will be supporting the amendment.

Hon STEPHEN DAWSON: I know that the member was making a statement rather than seeking further comment, but I think it is important that I comment. In Western Australia currently, the disease or condition directly leading to death is entered as the cause of death on the death certificate. Treatment options, such as terminal sedation at the end of life—which occurs when the patient is sedated to manage their symptoms adequately—are not recorded as the cause of death; nor is the decision to turn off a life-support machine or the patient’s decision not to eat or drink.

They are not entered as the cause of death on the death certificate. I do not think that people who are supportive of voluntary assisted dying would support that. They want to know that that is their call; it is their decision. It is not a doctor’s decision. It is no-one else’s decision: “It is my decision. I’ve made that decision. In the years to come, my children, my children’s children and their offspring will know how I passed away.” The minister has answered my question. I do not think that that person will have died of cancer; I think that that person would still be alive on 2 December if they had not taken the substance on 1 December. I will be supporting the amendment.

Hon RICK MAZZA: I also support this amendment. To me, the Births, Deaths and Marriages recordkeeping is an unemotional record of fact. The bottom line is that if somebody has elected to use voluntary assisted dying as a means of ending their life, that is what should be recorded on the death certificate. We have already, in this bill, stated that voluntary assisted dying is not suicide. Now, we do not want to state on the death certificate that someone has accessed voluntary assisted dying. I do not think we should disguise anything here. At the end of the day, this bill becomes an act and law as part of our system, so let us be honest about it. If somebody has elected to

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use voluntary assisted dying as a means of ending their life because of an underlying disease, then let us have that on their death certificate. I am not quite sure how the state records laws operate in putting things on death certificates. I have no problem with an underlying issue such as that the patient accessed voluntary assisted dying due to cancer. I am relaxed about that, but I think that as the actual reason for a person’s death, it is very important that we have a record of fact.

**Hon TJORN SIBMA:** I might add my voice very briefly to the chorus, and then end with a question to the minister. Part of the justification for the entire legal regimen is to provide transparency and greater understanding of issues at the end of life. I cannot fathom how the amendment moved by Hon Colin Tincknell would in any way compromise the operation of the legislation or its accessibility to people who are eligible to utilise it. I seek from the minister some understanding of whether the proposition as put would serve in some way to disincentivise people from accessing this regimen. I would find that difficult to believe, but I am trying to understand the operating motivation underlying the opposition to this amendment. I also reflect that, on the supplementary notice paper, there is a new clause 160A on the establishment of a parliamentary committee to look into these kinds of issues. I do not want to foreshadow too much, but I intend to support that motion because I am keen to see accountability, and I think that this is a necessary measure to ensure that a committee, if it is supported and formed in some way, actually has an external data point to validate what is actually transpiring in the state of Western Australia. Once again, to the minister: what would be the practical impediment or the operational problem with accepting the amendment put by Hon Colin Tincknell?

**Hon STEPHEN DAWSON:** In answering that question and speaking against the amendment moved by Hon Colin Tincknell, the intent of clause 81 of the bill is to prevent circumstances in which the information is released into the community by persons who may see the cause of death on the medical certificate, which is provided by the medical practitioner to a person making funeral arrangements. For cultural and faith-based reasons, it would not be appropriate for information about a patient accessing voluntary assisted dying to become more widely known by several communities. Such knowledge could cause distress or negative interactions between family and/or community members. This sentiment was reflected in the consultation led by the Ministerial Expert Panel on Voluntary Assisted Dying and the Department of Health. The ministerial expert panel recommended that none of the death certificate documents include information pertaining to voluntary assisted dying. Instead, it recommended that a separate reporting mechanism should be used whereby the doctor should notify only the Voluntary Assisted Dying Board. The panel’s concern was that if any of the current death certification documents were leaked or inadvertently shared by a third party such as a funeral director, the knowledge could cause distress or negative interactions between family and/or community members. The role of the Voluntary Assisted Dying Board to collect accurate statistics and of record keeping will assist to address views espoused in public consultation led by the ministerial panel that it was vital that data should be maintained.

In relation to the comment about hiding information, it is not the intention of the provision in the bill to somehow enable the hiding of information about voluntary assisted dying. Rather, clause 81(2) makes it clear that this information is to be collected albeit through a more secure and respectful means.

**Hon Dr STEVE THOMAS:** I know that this is a popular clause. I was happy to wait for a little while until I heard that particular comment. I would like to get something straight. The minister just said that for those people in a religious community for whom suicide is not accepted and is a sin, the intent of this clause is to make sure that those religious organisations do not find out, perhaps in the process of a burial. The government is suggesting that the reason “voluntary assisted dying” cannot be put on a death certificate is that someone might have to tell the truth to a religious community that opposes it. If that is what I just heard, I think that is an immensely bizarre response. I do not understand how keeping the cause of death secret from an organisation for whom it is a tenet of faith actually serves anybody. During my speech in the second reading debate, I said that this bill is not a question of religion. If someone does not believe in voluntary assisted dying, whether we call it suicide or not, they should not go through with it. If they are happy to go forward, it is not a religious issue; it is not a religious question.

The response from the government is that for those who want to have a bet each way, it will hide what they died from. I have sat here and received non-answers to economic questions for weeks, and I am used to not getting answers, but that is the most bizarre answer that I have heard in this entire rather bizarre debate. I am not sure how the government can justify that. It is now on the record as saying its intent is to keep secret from those organisations that hold this as a tenet of faith what has gone on. That is bizarre.

I turn to the substance of the amendment. I was not inclined to support Hon Colin Tincknell’s amendment until I heard the very good comments of Hon Alison Xamon, who convinced me to both support the amendment and make a short address on this. The reason for that is if voluntary assisted dying is such a positive issue in the community and is to be supported as a good thing, why is the government ashamed of it to the point that it will not put it on a death certificate? Why is it so negative that we cannot say that this is what happened and put it on the death certificate, but we think it is a good outcome? Hon Peter Collier raised this when he said it was an issue of pure truth. I think that was a particularly good contribution. It may be the truth that the person’s death was caused by the taking of a substance, but if it is not caused by the taking of that substance this whole bill might as

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well not exist. The death was caused by the taking of a substance. We do not know whether the death might have occurred one week, two weeks or 10 weeks down the track following that, or there might have been a remission or death might not have occurred at all.

Hon Peter Collier: That happened to my mum.

Hon Dr STEVE THOMAS: That is right. The person might, unfortunately, walk out the next day and be run over by a bus and the cause of death would be something completely different. The only thing that is a fact —

Hon Alannah MacTiernan: Currently, there are many people whose doctor provides them with terminal sedation. It is exactly the same.

A member interjected.

Hon Dr STEVE THOMAS: Oi! This is my interjection, thank you!

Hon Alannah MacTiernan: Exactly the same argument could apply. Here we are talking about the underlying disease. It is not recorded on their death certificate that these people had terminal sedation.

Hon Dr STEVE THOMAS: That is right, except, long-term sedation is not terminal. It does not actually cause the death of the patient. If that patient is deliberately overdosed, it could quite accurately be put on the death certificate that this patient died of an overdose of an opiate–sedative combination. I said in my second reading contribution that that is legal right now. If a medical practitioner needs to increase the patient’s dose for pain relief and dissociatives to a point—a combination of the valium–pethidine mix, whatever we want to go to—that may well cause respiratory suppression and death. The medical practitioner can put on the death certificate that these high doses to treat this disease were the cause of death of that patient—absolutely. That happens now. However, the point made that long-term sedation is the same as a deliberate cause of death is not true. At the end of this process, I come back to the fact that, surely, if it is a good thing, this chamber would not object to the truth being written down. If we are too ashamed to have the truth written down, what level of debate are we truly having about the bill before the chamber? I am not here to try to prevent people from engaging in this process, but, surely, if people believe in it, they will say, “This is what I did because this was my belief”, and they would be happy to have the truth written on the death certificate. Every other component of the debate I have heard so far varies from the trite to the bizarre. If people believe this is a good thing, surely they cannot be opposed to having it written down.

Hon AARON STONEHOUSE: I do not think there is much more I can add to this debate because I think it was pretty well canvassed by the last two or three speakers. However, I would like to quickly observe that we are going to quite a great effort to pass a bill to allow for voluntary assisted dying. We are having extended sittings. We will be here all night tomorrow and Thursday to try to get through this bill before Christmas. We are going to such great efforts to allow voluntary assisted dying, but here is a clause that will cover up what actually happens. I find that rather concerning. We should not be trying to suppress the truth through legislation. I think it is undesirable to compel medical practitioners to, effectively, lie on an official record. What makes it worse is that we are compelling medical practitioners to lie on an official record. What makes it worse is that we are compelling medical practitioners to lie on an official record because we are concerned about offending people with certain religious or cultural sensibilities. I think that is a step too far. I think it was well summarised by Hon Dr Steve Thomas a moment ago.

That is, essentially, what we are trying to do. Because certain religious or cultural groups do not approve of voluntary assisted dying, we will compel medical practitioners to lie on an official record. I really do not think that is how we should be going about our business here. The records should be accurate and truthful and their integrity should be maintained. Obviously, it would be inappropriate for anyone to leak information from an official death certificate about how somebody died. But let us not forget that that kind of thing can happen already. People can die in the most violent and horrific means and, currently, that is at least recorded on their death certificate.

I take the point that was raised by way of interjection earlier that if someone dies after having some kind of sedation, sedation may not be listed as the cause of death; the underlying medical condition may be listed as the cause of death. Just because that is the current practice, it does not mean that we should embark on that path with this bill. If it were up to me, all death certificates would reflect accurate and truthful information. Just because incomplete information is being listed currently does not justify us going down that same route when we have an opportunity to correct the record and point medical practitioners in the right direction. I absolutely support this amendment and I look forward to its passage.

Hon ALISON XAMON: I just want to clarify something. Currently, death certificates are accurate. They often have two components. Firstly, they always describe the physiological cause of death—always. Secondly, if there have been additional circumstances around the death, they are recorded, such as whether it was self-inflicted or was the subject of a homicide. That is the way that death certificates currently operate. There will be an initial assessment by the coroner about what has occurred physiologically, and often after further investigation or even an inquest, a codicil will be put on the death certificate. I know; I have seen them. That is the way that death certificates are written. They are done in that way so that we have a clear and accurate record of the circumstances under which someone has died. If someone were to avail themselves of voluntary assisted dying, as should be their right—I remind

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I will go through a couple of personal experiences. On Monday, I got a call to tell me that a good friend of mine had suicided. He hanged himself at work. After the investigation, the way that person passed away will be recorded as truthfully as we can in doing so. Members talked about doctors assisting people to die comfortably. Once again, not an emotional decision. If this legislation were to pass and become law, we must make sure that we have acted 100 per cent right.

Hon Rick Mazza mentioned, the Registry of Births, Deaths and Marriages is about the truth. It is about facts, not an emotional decision. If this legislation were to pass and become law, we must make sure that we have acted as truthfully as we can in doing so. Members talked about doctors assisting people to die comfortably. Once again, we are making a brand-new law that will come into place in the next few years and we have to do our best to get it 100 per cent right.

I also want to pick up on this idea that somehow the record of the facts is being expunged to assuage people’s concerns about stigmatising deaths. We do not do that with suicide, and I have already made it clear why I distinguish between VAD and suicide. We do not do that with suicide and we do not do that with homicide, and we know that they can be highly stigmatising deaths. I do not accept the argument that somehow this is an entirely different category that requires us to make sure that we wipe this from history, even though the entire bill in front of us says that it is okay.

I am simply asking for the records to be accurate. I am also going to flag that I am one of the people who is inclined to flag a future amendment. I think this is a really important issue for us to keep revisiting. The one thing I want is to make sure that the data that is kept by the Registry of Births, Deaths and Marriages is accurate, and I think that we have an obligation to capture that historically at this time.

Hon JACQUI BOYDELL: Obviously, this has been quite a difficult issue for both the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying. During the break, I looked at the consultation process and, obviously, this was a very perplexing issue that was faced by people, particularly during the consultation phase of the ministerial expert panel. I think we can always find arguments for either side.

I find myself not in support of the proposed amendment for a couple of reasons. Ultimately, I think the difference between recording suicide and voluntary assisted dying on a death certificate is that the decision to access voluntary assisted dying is a private decision of the patient in managing their end-of-life care. They will get to the position of considering voluntary assisted dying because of the underlying illness that they have been diagnosed with. If they did not have that illness, they would not face having to make that decision. Just as a patient will make decisions with their medical practitioner, family and contact person in managing other aspects of their illness towards the end of their life, the decision to access voluntary assisted dying will be a private decision determined between the patient, their family, their medical practitioner and whomever they have those discussions with within their support network. For me, that is fundamentally the reason that the patient’s decision about how they seek to manage their end of life should be respected. To me, this is not about hiding information from faith-based organisations—it is not about that at all. It is about protecting the patient, and the patient making the decision to protect their family so that they are not stigmatised by the patient’s decision. The patient may be Catholic or from a different faith denomination, or their culture may not accept access to voluntary assisted dying. This is not about hiding the information that the patient has made that decision; it is about the patient protecting their family so that they are not stigmatised against or used for an organisation’s political or social agenda. It is about making sure that the family members who remain are not used as an object in those agendas. That is where stigma comes in; it is attached not to the patient, but the family members who are left behind. For that reason, I do not support the proposed amendment.

Hon COLIN TINCKNELL: I moved this amendment because of some truths. One of the truths is that the Joint Select Committee on End of Life Choices was unanimous. It was a hard decision, but it was unanimous that voluntary assisted dying should be recorded on the death certificate. Another truth is that the ministerial expert panel was not unanimous in this. The panel debated it, but it was not unanimous in its decision when it was debating this issue. The Law Society of Western Australia has written about this, and it has an issue with it.

As Hon Rick Mazza mentioned, the Registry of Births, Deaths and Marriages is about the truth. It is about facts, not an emotional decision. If this legislation were to pass and become law, we must make sure that we have acted as truthfully as we can in doing so. Members talked about doctors assisting people to die comfortably. Once again, we are making a brand-new law that will come into place in the next few years and we have to do our best to get it 100 per cent right.
Whatever the circumstances of the death, they will be recorded correctly. It is not a nice situation, but that is the way it will be. Going back 17 years, my mother-in-law was given three months to live. If voluntary assisted dying had been around then, she would have taken that option because she believed everything the doctor told her. That is the sort of lady she was. She lived for another 13 years. She was very thankful for that extra 13 years. In the end, she died from cancer. That is how she passed away. If she had been recorded as dying from VAD 17 years ago, it would have been a mistruth. She would have known that, I would have known that and the family would have known that. The death certificate should record the truth. We come into this place, we speak our truth and we vote on that. I ask members who are 100 per cent behind VAD going ahead to consider this amendment because it needs to be added to this bill. It is an important and very, very honest amendment. I put it forward because we need to reflect the truth in this chamber every time we can. Thank you.

Hon NICK GOIRAN: With respect to the member, I rise to put to bed the myth propagated by Hon Jacqui Boydell that this was somehow an issue of contention, or confusion, for the Joint Select Committee on End of Life Choices. Nothing could be further from the truth, honourable members. Members need only look at page 228 of the Sanderson report, which states the committee’s view —

Where an assisted death takes place it must be noted on death certification documents.

That is not the minority report; that is the report of the committee that the member for Morley chaired. Members can support or reject this amendment, but please do not do so based on incorrect information. This was not an issue of contention for the Joint Select Committee on End of Life Choices. The view of that committee is clearly stated at page 228. In contrast, I absolutely support Hon Colin Tincknell indicating and reminding us that the ministerial expert panel had a variety of views on this issue. The honourable member was correct when he stated that the Law Society of Western Australia has written on this issue. It has certainly written to me and I assume other members have also received correspondence from the Law Society in recent days or weeks on this issue.

My last point is that clauses of the government’s bill, which we have passed until this point, support this amendment. I ask members to look at clause 7, which we have agreed to. What does clause 7 say? It says —

(1) The CEO may … approve a Schedule 4 poison or Schedule 8 poison …

What for? Clause 7 continues —

… for use under this Act for the purpose of causing a patient’s death.

How will the person die? It is because the CEO has approved a schedule 4 or 8 poison. Why? The government tells us in this bill, which we have all agreed to at clause 7, that it is —

… for use under this Act for the purpose of causing a patient’s death.

What kind of substance is used? It is a voluntary assisted dying substance, but under no circumstances record that on the death certificate. That makes no sense whatsoever. Clause 26 of the bill requires the coordinating practitioner to inform the patient that the expected outcome of self-administering or being administered the substance is death. We are saying to the coordinating practitioner, “Under the law of Western Australia, you have to tell the patient that if they take this, the expected outcome is death.” But do not put it on the death certificate. 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).

Clause 72 contains labelling requirements for the voluntary assisted dying substance. An authorised supplier must attach a statement in writing to the relevant package or container in which the voluntary assisted dying substance is contained. What has to be on the package? It warns of the purpose of the dose of the substance. Why would we need to warn the person, other than that they are going to die after taking the substance? Paragraph (b) refers to the dangers of administration of the substance. There is a danger that a person will die if they take the substance. That is the point of the labelling requirements. Therefore, everything that we have done so far — clauses 7, 26, 66 and 72 — tells the story that if a person takes this substance, the expected outcome is death. But now we get to clause 81 and we say, “But don’t put it on the death certificate.” Hon Colin Tincknell is absolutely spot-on with this amendment and he has my full support.

Hon SUE ELLERY: I have tried to stay out of the debate because I think that others who are part of the group supporting the bill are better able to articulate the arguments than I am. Two things strike me about this. I can understand people’s judgement, I guess, that this is trying to hide something, but there are two compelling arguments for me. One issue is the point made by Hon Jacqui Boydell about the individual protecting their privacy. One of the words that has been used about this debate is “dignity”, and I think this goes to people’s dignity. The other issue for me is the notion that somehow there is no other way that information about the use of the provisions in this bill will be held to account. The bill does include provisions about information that is provided to the board so that there is a degree of information gathering to determine how and when the provisions will be used, and, I am sure at some point, will be used to provide advice if changes need to be made at some point in the future. Those are the two arguments that, in my mind, led to my decision. I listened to this part of the debate and although I can appreciate
the arguments that have been put by those who are saying that somehow this is inconsistent with the position that we have taken on other elements of the bill, in fact I think it goes to the principle of human dignity. It is completely consistent, in my mind, with how that argument was developed. Therefore, for those reasons, I will not be supporting the amendment. I do not accept the argument that if we do not support the amendment, we are somehow not supporting truth. I do not think that is the case at all; I think that is too simplistic and superficial an argument to put about something that is deeply important to people. I think that misdescribes the debate that is being had. For those reasons, I will not support the amendment.

**Hon DIANE EVERS:** I have only a few points to make. As I said just the other day, the person is dying from their disease or illness; otherwise, they will not be eligible to take up the opportunity to use voluntary assisted dying. The person is dying. They do not know whether it will be in a week, a day, a month or an hour—it is coming. They know it is coming. They know they are in pain. They know that they want to relieve that pain in whatever way they can, and this is the way that they are choosing to do so. That person may have religious beliefs or values that say that they should not give up—that they should not accept this as a way to escape life. It may hurt them that they are even thinking about voluntary assisted dying, but they are thinking about it and they want to relieve their pain permanently. The person who is making this decision should have a right to privacy about that decision. As it is, they could starve themselves or refuse treatment. Refusing treatment does not get listed on a death certificate as the cause of death—the person died from their disease or illness. Why would we make somebody go through the horrors that this notification could bring?

Just last evening, I was talking to someone who said, “Thank you so much for what you’re doing. My father starved himself to death when he wanted to end his life.” Can you imagine just sitting there watching somebody die like that? I cannot. I do not want to ever be in that situation. We need to bring in voluntary assisted dying. If this amendment were to stop even one person from taking the comfort of having this as an option, it would be wrong. It would be wrong for that person and it would be wrong for all people for us to stand here and say, “No, it must be listed that you chose to end your life so that your offspring and your grandchildren can know that you made use of this.” Sure, it would be nice to list on a death certificate that a person was peaceful when they died, but I do not believe that it is a requirement for our death certificates to say how much pain a person was in or was not in at their time of death. I think we need to vote against this amendment to make sure that people are not dissuaded from taking up this option by having to show that they gave up, that they could no longer take it and that they were too weak to last it out until the final breath that they might have been able to take had they taken every treatment available. I will not be supporting this amendment.

**Hon KYLE McGINN:** While I was waiting to get the call, most of what I was going to say was actually said by Hon Sue Ellery and Hon Diane Evers, but I will put on the record that I have found listening to this part of the debate quite interesting. I heard Hon Nick Goiran’s comments about clauses in the bill referring to the substance as being the cause of death of the individual. As Hon Diane Evers said, patients will be in this position because they are terminal—they are dying. There is a cause of death. They are going to die. In my view, that is why they will get access to the substance. It is not because it is going to kill them—they are already dying. If we are looking for accountability, I am pretty confident, from what the minister has said and what I have heard in other briefings, that the board will have details of all reported deaths. There will be a record of people who die from voluntary assisted dying. In my mind, the transparency will be there. I do not think that this amendment is needed. I think that privacy is important. If someone makes the decision to end their life in this way, they are dying anyway. Too many things would be affected if this was put on a death certificate. There is the family side of things and their social life—all that sort of stuff—and the potential to be remembered for something that the person did not want recorded on their death certificate. This was mentioned throughout the report of the Ministerial Expert Panel on Voluntary Assisted Dying. They are the reasons I cannot support the amendment.

**Hon SIMON O’BRIEN:** May I just point out to members what the question before us is about. That is not in any way to disassociate myself or, indeed, suggest that anybody else should be disassociated from the very compassionate comments we have heard just in the last half-hour or hour. The question before us right now is that the two lines should be deleted. The question is not about the manner in which someone will die in the sense of whether they will starve themselves, whether they have cultural inhibitions or whether someone will be upset by what is on a written record—it is about deleting two lines. The reason to delete the two lines is to avoid a situation in which we pass a law that says that, in future, when a responsible medical officer has to certify something, they will certify something false by law. That is what it is about. It would be totally reprehensible to pass such a law. That is what the question is about now. I have been encouraged by the degree to which I have heard members from various parts of the compass recognise that that is what it is really about. We are not going to have a vote on this amendment before we rise for a brief adjournment, so I hope members think about it before we come back and vote on it.

**The DEPUTY CHAIR (Hon Adele Farina):** I draw members’ attention to supplementary notice paper 139, issue 17, which was distributed a little earlier during the course of the debate. Noting the time, I will leave the chair until the ringing of the bells.

*Extracted from finalised Hansard*
Hon MARTIN ALDRIDGE: This is an interesting clause, one that has engaged quite a lot of members and will, perhaps, engage quite a few more after me. I have certainly entered into this debate and exercised my conscience at every opportunity, and I must say that on a few occasions I have found myself challenging the preconceived ideas that I had about particular aspects of this bill. This amendment is one that I thought I would naturally oppose, but having listened to members’ contributions and having reflected on some of them during the break, I am now starting to doubt whether that is the right approach.

I want to identify the challenge that I have in trying to resolve this matter. Several references have been made by members to “My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices”. Fairly limited remarks on this matter were made in that report, but the committee still made its view quite clear in its publication. The report was the precursor to the Ministerial Expert Panel on Voluntary Assisted Dying and the bill before us. I want to very briefly read two relevant paragraphs from that report. I refer to paragraph 7.83 on page 223, which states —

The explicit inclusion of voluntary assisted dying as either the manner of death or a contributing cause of death on a death certificate would provide Western Australians with a means to monitor assisted dying and its effects on mortality trends.

Paragraph 7.85 goes on to state —

A record of voluntary assisted dying is essential for the regulation of the practice, together with accurate reporting of mortality trends and patterns. Accordingly, there must be appropriate amendment to each of the three relevant documents, above, and the provision of clear guidance to doctors.

Those three relevant documents are outlined in paragraph 7.84 and are the medical certificate cause of death, the manual death registration form and the death certificate. Key recommendation 24 establishes the framework that the joint select committee recommended. One aspect of that framework related to death certification. At pages 228 and 229 the framework states, in part —

Where an assisted death takes place it must be noted on death certification documents.

The WA Government should amend the:

   a. Medical Certificate Cause of Death — completed by the doctor certifying cause of death;
   b. Manual Death Registration Form — completed by the funeral director to register a death; and
   c. The Death Certificate — issued by the Registrar of Births Deaths and Marriages,

   to make provision for the inclusion of voluntary assisted dying as a contributing cause of death, and to provide guidance for doctors and others who complete each of the documents.

That was obviously the view expressed in “My Life, My Choice”, the August 2018 report of the Joint Select Committee on End of Life Choices.

Reference has also been made today to the views of the Ministerial Expert Panel on Voluntary Assisted Dying, which were, I must say, limited, although it dedicated probably a couple of pages to them in its “Final Report”, so it was slightly more expansive than the joint select committee. A paragraph on page 88 of that report states —

However, the Panel is mindful of the feedback it has received regarding concerns about third parties (such as funeral directors) who have links to the person’s (and their family’s) community becoming aware that a death has occurred through voluntary assisted dying and exposing the family to negative treatment. This feedback is applicable to the Medical Certificate Cause of Death, because this document is seen by third parties such as funeral directors.

The ministerial expert panel’s comments did not go to the fear that I have heard expressed in the chamber today of the patient not wanting to access voluntary assisted dying because, at some time in the future, that information will become public information. In fact, on my reading of this section of the ministerial expert panel’s report, its concern was about the treatment of patients’ families after the death. The panel did not expand much on that. It is a bit hard for me to perceive the negative treatment that a funeral director might visit upon the family of a person who has died as a result of voluntary assisted dying. Perhaps the minister can enlighten us about the concern that the ministerial expert panel was trying to address in that instance by dealing with clause 81 in the way in which it did.

With regard to members’ concerns about patients potentially not accessing VAD because of the information appearing in some way on their death certificate, that is certainly not a view that I have heard expressed by people in general throughout the course of this debate. People have been very willing to engage in this debate, and perhaps that is because they do not understand the detail; I think that is probably right. They support the concept, but they do not understand the detail. Certainly, I cannot recall a single person coming up to me to express a view or a concern about the medical certificate issue. In fact, the thinking of people who have engaged me on this is that this is a decision that they should have the personal right to exercise at a time of their choosing. That perhaps has led me to believe that they would not have any objection to people knowing that they had accessed voluntary assisted dying, but these are all observations.

Extracted from finalised Hansard
When we commenced debate on this bill, I mistakenly thought that voluntary assisted dying would be listed as either the primary or a contributing cause of death. In fact, I mistakenly thought that the death certificate would state, “The person died from”, and then state the illness or disease they were naturally going to die from were it not for voluntary assisted dying, and then state the administration of voluntary assisted dying as a contributory cause of death. That was my mistake, because that is clearly not what clause 81 sets out, and it certainly takes a different path from the view formed by the joint select committee in its “My Life, My Choice” report.

I have one question on this proposed amendment and that is about a potential practical implication. In earlier parts of the consideration in committee of this bill, there was some talk about insurance. Can the minister provide any advice about whether the issue of insurance played any role in both the ministerial expert panel and the government landing on the position that voluntary assisted dying should not be cited on the death certificate; and, if Hon Colin Tincknell’s amendment were to succeed and voluntary assisted dying was the cause of death, what might be the practical implications for life insurance claims, for example? I ask the minister whether he can respond on that point, and perhaps provide elaboration on the different views taken by the joint select committee and the ministerial expert panel on whether voluntary assisted dying should be listed.

Hon ALANNAH MacTIERNAN: While the minister is gathering his views and advice, I would like to make a couple of comments. Likewise, I find this a very interesting debate. Unfortunately, I will not be able to support Hon Colin Tincknell’s proposed amendment, because that would have the consequence of making the cause of death the treatment that the person sought. Hon Alison Xamon put the argument that if we prevent any reference to voluntary assisted dying, we may stigmatise it. That is worthy of discussion. In all the debate around this amendment, that is the argument that has caused me to have some concerns about the current provision. As I have said, I will not be able to support Hon Colin Tincknell’s proposition, because that would simply require—I think quite misleadingly—the cause of death to be VAD.

Hon Martin Pritchard spoke about the concerns that were raised by the joint select committee. The provisions that Hon Martin Aldridge read out are concerned with ensuring that there is a means of monitoring the dying with dignity legislation and that there is a record. To a very significant extent, that is now addressed by requiring reporting to the board, which will be the repository of that information and will keep those records and provide reports. The fundamental concerns that were raised by the joint select committee centred around ensuring that there was transparency—not transparency about the individual case, but about the rate of access, who was doing this and where it was occurring. That was the fundamental theme of the concerns raised by the joint select committee in this particular area. The question is: should we allow some reference to voluntary assisted dying, and is there any merit in the argument that if we prevent any reference to voluntary assisted dying, we may stigmatise it? That issue is worthy of concern.

However, at the end of the day, I have been persuaded by the arguments all around—Hon Jacqui Boydell argued this very well—that the fundamental issue here is privacy. For some people, this decision is not so difficult; for other people, it is a very difficult and challenging decision, and it might go against the grain of the community from which they come. To me, the person’s privacy should be given primacy. That is a valid concern, given the way in which the death certificate has to be handed around, such as to the funeral director. The issues raised by the joint select committee have absolutely been addressed through the requirement to report to the board, which will have that record-keeping role.

I think that over time, this will cease to be an issue. However, at the moment, there are issues of community sensitivity. After deep reflection about this, I think a solid and substantial argument can be made, on the basis of privacy, that the fact that a person chose voluntary assisted dying should not be recorded on their death certificate. I also note, as I said by way of interjection to Hon Dr Steve Thomas, that people have terminal sedation, which no doubt hastens their death by a week, or sometimes two weeks. That is not recorded. People decide that they will starve themselves to death, and they are legally allowed to that. That is not recorded. People decide that they have had enough of chemotherapy, they are not doing that any more, and their demise comes more quickly than it otherwise would. That is not recorded. Therefore, for us to single out people who choose this way to end their pain and suffering is not the right approach. I appreciate that we have had a good and interesting debate on this. I have been thinking: are there issues here? It has been argued that a community might discriminate against a family because a family member did this. I do not think that is the best argument. The substantial argument is that this is a question of privacy for a person who has made this deeply personal decision. The state will have all the records that it needs to understand how this legislation is unfolding and how the practice of voluntary assisted dying is happening in reality.

The DEPUTY CHAIR (Hon Dr Steve Thomas): My goodness! Who has not spoken yet? Neither of you. I will go to Hon Michael Mischin, and then Hon Alison Xamon and Hon Jim Chown.

Hon MICHAEL MISCHIN: I have listened with interest to the arguments for and against. I will go back to some basics here. This provision in the bill requires whoever completes the death certificate to deliberately exclude relevant information. It is not a question of privacy and sensitivity and dignity. One would have thought that if I were to go to the extreme of suiciding, and leave all the evidence that I had done so because I have personal issues, whether psychological, medical or otherwise, and I want to put myself out of my misery and bare my soul in that fashion, would I have an argument for the coroner to say, “No, this was not a suicide; it was some underlying
issue that created the problem’’? Once upon a time, suicide was disguised because of the stigma attached to it. It was described as a misadventure and the like in order to avoid the very stigma and opinion that might affect families and might show a potential betrayal of one’s religious beliefs and convictions. That is not the case now. We found our society and our knowledge and understanding of what is going on in society on some level of truth. Whether or not a medical practitioner required to report a death includes in the death certificate—sometimes 48 hours after the event, and whether or not they witnessed it—that there was an administration of a substance that led to that death, as well as the underlying cause that initiated that course of action on the part of the deceased, ought to be a matter for them. That is what the case is now. But with this legislation we are proposing to say, “Whatever you know about the circumstances, leave this bit out.” I find that an astonishing proposition.

The two arguments that have been presented are that it is somehow a matter of privacy and dignity. This bill is replete with comments about how voluntary assisted dying is not suicide, so there is no question of stigma there. We are told it is not even euthanasia, so there is no stigma there. We are told that the whole point of this bill is that, by availing themselves of the provisions in it, people could have a dignified death, yet we are somehow saying at the same time, “Leave out an element of the truth about how it happened out of respect for people’s dignity.” We are not talking about palliating people’s sense of upset that they have taken this course. The point of it is that there is some accountability to the rest of the community about how this came about. For my part, whether we simply delete the words and substitute some appropriate formula is by the bye, but we should not instruct and demand that someone completing the certificate ought to leave out a material and relevant fact, which is what substance was administered to this patient, to this deceased, in the lead-up to their demise. That, as a matter of principle, is wrong.

Where do we draw the line with this? Will we next amend the Coroners Act 1996 so that anything that might upset people ought not to be published on a death certificate out of some kind of respect for sensitivities that may or may not be there? Hon Diane Evers suggested that someone might be deterred from taking advantage of voluntary assisted dying if they thought that it would appear on their death certificate. I have to say that I find that a wild proposition, with all due respect. If someone is devoutly Catholic, for example, yet they resort to this extreme course because they are in such pain, and they are suffering so much, the last thing they will be worried about is what is on their death certificate. As for the sensitivities of the families, this bill is about choice for the deceased; it has nothing to do with the families. The primary consideration is what happens to the deceased and the accountability to the state, as representative of the public good.

As I mentioned, there seem to be numerous references in the bill itself to speaking honestly about death. I turn members’ attention, for example, to that very early clause that we debated at length, clause 4(1)(f), which states —

a person should be encouraged to openly discuss death and dying, and the person’s preferences and values regarding their care, treatment and end of life should be encouraged and promoted;

Yet, along with the other tendentious phrases that are used in the second reading speech and elsewhere, we have a disguise of that; we want to conceal it. Now we are going even further. We are demanding that whoever has the responsibility of completing a certificate actually does not include relevant information if that person feels it is relevant and material to understanding the cause of death. As a matter of principle, I find that wrong. Whether we replace the terms that are being deleted, as proposed by Hon Colin Tincknell, with the formula that he has picked or whether we replace them at all is beside the point. Perhaps we should just leave it blank and allow what is currently the case in death certificates—the judgement of those who complete it and the exercise of their good faith that we currently rely upon. But I will oppose the idea that we ought to tell people with that responsibility that they should leave out some reference that is material and that they think is relevant. That is wrong.

Part of this debate may very well be turning on some perhaps misunderstandings or imperfect understandings. For my part, it would be useful if it were on the public record in this chamber and we could understand what goes into a death certificate. How much detail is put into a death certificate? Likewise, what sort of detail needs to be put into that? A form is prescribed that has a variety of detail in it. I am not sure what all that information is required at all.

I have to say that for my part I do not like the clause as it currently stands. It is wrong in principle and it is dishonest of this Parliament. It is dishonest to promote a bill that is supposed to encourage a dignified death but then say that if someone does this, they might be stigmatised for it, so the government will be twee about it and remove some of the information from the public record to disguise what has happened. That is not the case in other circumstances that might be equally, if not more, sensitive, or might be equally, if not more, damaging to a person’s reputation and to the sensitivities of their families. Whether we replace it or not, I do not care, but I do not like it the way that it is. I am not formulating an amendment at this point, but there may be some other reference that can be made rather than leave it blank and leave it wrong.
than simply, blandly “voluntary assisted dying”. Maybe a reference to the substance that has been administered can be made and just leave it at that—“Cancer and” whatever the substance happens to be, which would satisfy a variety of needs. But I leave that for the future. At this stage, I agree with the deletion of the words.

**Hon STEPHEN DAWSON:** I know that other people want to make contributions, but some questions have been asked and I want to try to deal with them as we progress. I thank the Minister for Regional Development for her contribution. I want to reiterate one thing she said, and that was that a refusal to accept some forms of treatment was asked and I want to try to deal with them as we progress. I thank the Minister for Regional Development for her contribution. I want to reiterate one thing she said, and that was that a refusal to accept some forms of treatment was asked and I want to try to deal with them as we progress. I thank the Minister for Regional Development for her contribution.

Leaving a voluntary assisted dying bill silent on life insurance provides agency to all insurers and the public. People can usually access entitlements when terminally ill and expected to die within a certain time frame. Upon diagnosis, the individual would either already have life insurance or not, and they may be unable to take out life insurance after being diagnosed. Many life insurance policies include terminal illness cover, so a person who is diagnosed with a terminal illness and is not expected to live more than 12 months will be entitled to receive their benefits in full prior to their death. Many Australian life insurance policies cover suicide, but only after a specified exclusion period, and I am advised it is usually 13 months. Insurance was not a consideration factor for the clause 81 exclusion. I am told that the clause 81 exclusion was based on the ministerial expert panel’s recommendations.

**Hon Michael Mischin** asked a question about the current process for death certificate documents. When a person dies, their death is certified by a medical practitioner. This medical practitioner, who is responsible for the patient’s medical care immediately before death or who examined the deceased’s body, is required to complete a form known as the “Medical Certificate of Cause of Death”. This is pursuant to section 44 of Western Australia’s Births, Deaths and Marriages Registration Act 1998. This form requires the medical practitioner to define the disease or condition that directly led to the death and other causes or conditions that contributed to the death. These details inform what is on the public death certificate and also data collected at state and national levels. The “Medical Certificate of Cause of Death” is forwarded by the doctor to the funeral director who, in turn, provides it to the Registrar of Births, Deaths and Marriages. The funeral director then completes the manual death registration form and sends it to the Registrar of Births, Deaths and Marriages, along with the “Medical Certificate of Cause of Death”. Following the receipt of those two forms, the Registrar of Births, Deaths and Marriages issues a death certificate to the funeral director or family of the person who has died.

**Hon ALISON XAMON:** I want some clarification about some issues that have been raised, and particularly pick up on a point made by Hon Alannah MacTiernan. The first thing I want to say is that I do not like clause 81(6) as it is currently written. I think that needs to come out of the bill in its entirety. Picking up on Hon Michael Mischin’s comments, I believe that the current process used by the coroner in determining the most appropriate information to go on death certificates should be the same for people who avail themselves of voluntary assisted dying as it is for any other form of death. It leads me to a question about the amendment that is also in front of us at the moment. I see that this potentially can be dealt with in two parts. One is that an amendment could be moved to simply take subclause (6) in its entirety out of the bill. To be perfectly honest, I would be satisfied with that as well. The second question is whether we include the words as put forward by Hon Colin Tincknell; that is —

The medical practitioner must state that voluntary assisted dying was the cause of death.

Hon Alannah MacTiernan put forward to this chamber her understanding that if this subclause were to get up, a death certificate would say “Cause of death—voluntary assisted dying” as opposed to what I want to see, which is “Cause of death—cancer”, with the necessary codicil underneath. That would be further information on the record that voluntary assisted dying was also utilised, in the same way that is done with drug overdose, suicide, murder and a whole range of other forms of death when a further explanation about the circumstances of death is required.

I have an important question to ask the minister. It is not about the substance of whether clause 81(6) should be defended and should stay; I am very clear that I think it should go. Does the minister interpret Hon Colin Tincknell’s proposed amendment would have the effect of describing the cause of death as solely being voluntary assisted dying? If that were the case, I would not be supportive of it. Part of the reason we also need to have the physiological descriptor of death, apart from having an accurate record, is so that people can do things like track their family history. These are good reasons to have these things on the record. Can I please ask the minister whether that is how it is being interpreted, as has been suggested by Hon Alannah MacTiernan?

**Hon STEPHEN DAWSON:** Our reading of it is yes.

**Hon ALISON XAMON:** In that case, I would like to move an amendment—I am not sure how this will be treated by the chamber; I seek your guidance, Mr Deputy Chair—or maybe foreshadow an amendment, that lines 6 to 8 on page 55 be removed.

*Extracted from finalised Hansard*
The DEPUTY CHAIR: Let me check this: are you proposing that no words would be inserted?

Hon Alison Xamon: That is correct.

The DEPUTY CHAIR: The motion currently before the chamber is that the words to be deleted be deleted. If members simply voted against the words to be inserted being inserted, which would be the following question, that would achieve that outcome. The member does not need to move an amendment. If her intent were simply to remove clause 81(6) and not replace it with anything, she would vote aye for the first question and no for the second question. Does everybody understand that?

Hon JIM CHOWN: Initially, I was going to support Hon Colin Tincknell’s amendment but Hon Alison Xamon makes a very good point. As a supporter of this bill, I am a little concerned that we are delving into the depths of hypocrisy in regard to some of the statements being made by members. Obviously, there is no stigma with VAD; otherwise, 80 per cent of people in this state would not be supporting it. If I were in the situation of accessing VAD, I would get all my friends and family around and make it very public. I would get their support about my intentions in regard to taking my own life to alleviate suffering. They would all support me. I believe that privacy is not an issue that we should be concerned about in regard to having VAD or something along the lines that Hon Alison Xamon suggested be on the death certificate.

I have a copy of a death certificate in front of me. One of the questions asked is “Manner of death”. Obviously, the square boxes need to be ticked. One of them is “Intentional self-harm”. I do not know where VAD would fit in that particular part of a death certificate. We may start to get concerned about public notifications. It has already been mentioned by Hon Michael Mischin and researched quite extensively by Hon Donna Faragher; I thank her very much for her work over a brief discussion at tea time. Western Australia has the Cremation Act 1929 and the Cremation Regulations 1954. I am not sure whether the form 7 for cremation is a public document, but it is certainly a document. On page 2, it asks very specific questions under the Cremation Act. One of them is “Direct cause of death”. That must be filled out prior to a body being cremated. In this state, 80 per cent of people who die are cremated. This is a document that states the cause of death. If it did not say anything else, it would be an untruth. Alongside “Clinical observations”, it states —

Do you know, or have reason to suspect, that the deceased’s death was directly or indirectly due to any of the following? (tick or circle if yes)
- violence
- privation or neglect
- drowning
- burns
- poison
- medical procedure
- suffocation

The substance we are talking about is already stated in the act; it is a schedule 4 or schedule 8 poison. It has to be stated what it is on this document. That makes an absolute joke of the death certificate not including this as the cause of death. I would like the minister to answer a couple of questions about this matter. I would certainly support an amendment along the lines proposed by Hon Alison Xamon or one to provide some clear statement on the death certificate about what the person died from; otherwise, it will come out on form 7 under the Cremation Regulations 1954. The death certificate or the cremation form will be dishonest.

Hon COLIN HOLT: Perhaps the mover of the amendment can confirm this: if the chamber supports the amendment, “voluntary assisted dying” will be recorded on the death certificate as the cause of death—is that right?

Hon Colin Tincknell: That is my amendment.

Hon COLIN HOLT: I pick up the point made by Hon Michael Mischin, who said that relevant information would not be recorded on the death certificate. I think the underlying cause of the illness, which is the motivating factor behind voluntary assisted dying, is important information. If we support the amendment moved by Hon Colin Tincknell, that information will not be recorded on the death certificate.

Hon Nick Goiran: That is not true. Ask the minister.

Hon COLIN HOLT: I think that is the interpretation he gave us earlier. Maybe the minister can clear it up. I think that is important information because we want to know the underlying cause of death. People undertake this process because they are dying from some underlying illness. That should absolutely be recorded on the death certificate.

Hon Michael Mischin: I don’t have a problem with that.

Hon COLIN HOLT: I know, but if we pass this amendment, the cause of death is voluntary assisted dying.

Hon Alison Xamon: That is what the minister said.

Hon COLIN HOLT: Yes, that is what the minister said.

Hon DONNA FARAGHER: I have a query. Hon Jim Chown raised an issue. My query relates to the Cremation Act 1929. The minister might be able to assist us. Obviously, the subclause we are referring to at the moment relates to the cause of death certificate under the Births, Deaths and Marriages Registration Act 1998.
I understand that a permit is required and an application must be made for any cremation. That is undertaken through the regulations and by filling out a form. Hon Jim Chown mentioned this. The minister may be able to clarify this for me. Under “Cause of death”, that form states, in part —

*Direct cause of death:
*Antecedent causes of death (if any):
*Conditions contributing to or accelerating death (if any):

I have not seen this in this part of the legislation. I ask the minister: is it intended that the Cremation Act and the relevant regulations and forms will have to be amended if this clause is passed? The way I read it, the certificate of cremation of the medical practitioner would, under the current provisions, have to indicate the acceleration of death. I would appreciate getting some clarification on that.

The DEPUTY CHAIR: I remind members that it is unparliamentary to pass between the Chair and a member on their feet. We have had a couple of examples on both sides of the house this afternoon and this evening. This is a gentle reminder to ensure that you are not passing between the speaker and the Chair.

Hon STEPHEN DAWSON: I am advised that the Cremation Act requirements for certification comes from the cause of death on the medical certificate. Therefore, if the cause of death is not on the medical certificate, it will not be listed as a cause or antecedent. Let me say that again.

Hon DONNA FARAGHER: I am happy to give the minister a copy of the form that I have located—form 7, under the Cremation Act 1929.

Hon Stephen Dawson: Not the medical certificate cause of death?

Hon DONNA FARAGHER: No. This is why I am seeking some clarification. If this provision is to remain, does the government intend to make any relevant changes to the Cremation Act 1929 or the regulations that would form part of the matter we are dealing with?

Hon STEPHEN DAWSON: I am advised that the form does not need to be changed because it states —

(* If a Medical Certificate of Cause of Death is attached, answers are not required to these questions.)

Hon DONNA FARAGHER: The minister is correct; it says yes and then it asks for the name of the doctor who signs the certificate, and then there are these points, including direct cause of death. It is quite clear. I appreciate that there is a little note next to it, which states —

(* If a Medical Certificate of Cause of Death is attached, answers are not required to these questions.)

The point is that they are still on this form. I appreciate that in certain circumstances, the cause of death may not be required. In what cases will it not be required? If that is the case, what is the point of even having it on this form? That is what I want clarified. If the issue is with the certificate, I accept that but why is it still on this form?

Hon STEPHEN DAWSON: This is a form under the Cremation Act 1929. It is not a medical certificate of cause of death. My advice is that the bill before us does not change that form and there is no requirement to change the wording on the form.

Hon DONNA FARAGHER: I apologise. I am not an expert on the Cremation Act.

Hon STEPHEN DAWSON: You and me both, honourable member.

Hon DONNA FARAGHER: We are learning quickly. I understand that in order to apply for a permit to cremate, one of the forms that must be filled out is the one that we are referring to. It must be filled out by a medical practitioner in addition to the certificate that we referred to already. There are requirements, as I understand it, and I am happy to be proven wrong. The way I read it, given my very short reading of it this afternoon, it is required to be filled out.

Hon STEPHEN DAWSON: I am advised that the form needs to be filled out when accessing cremation, but in relation to the cause of death, again the section that refers to the direct cause of death, antecedent causes of death, if any, and conditions contributing to or accelerating death, if any, will not need to be filled out if the medical certificate of cause of death is attached. That is the intention.

Hon DONNA FARAGHER: What happens if the medical certificate is not attached?

Hon STEPHEN DAWSON: I am told that it has to be for a VAD situation.

Hon ROBIN CHAPPLE: Those members who served on the Joint Select Committee on End of Life Choices with me will remember that I had a passionate intensity for the issue of “do not resuscitate”. That is put into advance health directives. It appears on the end of the bed of the patient. The patient is making a decision with or without the family, just with the doctor, and nothing is recorded with the coroner that the person who has passed away has made a deliberate decision to end their lives if they suffer a stroke, a heart attack or whatever else. I am very interested in why we are going down this path when there are elements of advance healthcare directives that allow people to say, “I want to die if I have this situation”, but it will not be recorded. Those people who served
on the committee will know that that is my perennial issue; I think Hon Colin Holt and Hon Nick Goiran will be thinking, “Oh, no, he’s mentioning DNR again.” It is a deliberative decision of the patient to end their life under certain circumstances, and it is not recorded anywhere.

Hon NICK GOIRAN: I fear that the simple is being made complex. I have in front of me a copy of a “Medical Certificate of Cause of Death”, to which the minister has referred several times this evening. Under the heading “Cause of death details” are three boxes. The first two boxes under part I say —

(a) Disease or condition directly leading to death (disease, injury or complication that caused death NOT only the mode of dying e.g. heart failure, respiratory failure)

(b) to (e) Antecedent causes (morbid conditions, if any, giving rise to the abovementioned cause, stating the underlying condition last)

Then at part II, it says —

Other significant conditions contributing to death but not related to the disease or condition causing it

I urge members to fully appreciate that the amendment moved by Hon Colin Tincknell, whether they agree or disagree with it, will require a medical practitioner to state “voluntary assisted dying” somewhere in these boxes, particularly under part I. It will not, despite any assertion by anybody to the contrary, then state that a medical practitioner can do nothing more with the form. That is false. The medical practitioner will have to write “voluntary assisted dying” and then continue to fill out the form, including listing any other antecedent causes and morbid conditions, if any, giving rise to the abovementioned cause, stating the underlying condition last. That is on the form at the moment. If a person’s underlying condition is, for example, cancer, it will be listed last. That will be the case irrespective of whether members agree or disagree with Hon Colin Tincknell. He is not doing anything whatsoever with regard to that. I seek the minister’s confirmation that the information I have just given to members is correct.

Hon Dr STEVE THOMAS: I appreciate the words of Hon Alison Xamon. I think she has delivered a lot of commonsense into the debate today. On the comments of Hon Robin Chapple, there is an enormous difference between “do not resuscitate” and taking an active role to end somebody’s life, so to link the two and say that they are the same thing takes us back into this strange realm that we entered a little earlier today. “Do not resuscitate” means that the disease with which the person has been afflicted is likely to take their life and doctors will not spend an inordinate amount of time trying to reverse it. That is not the same as giving the person a bolus dose of barbiturates to end their life, and we should not consider them anything alike.

Hon MARTIN PRITCHARD: I was going to ask how we will deal with this particular provision. I have always been concerned with subclause (6). The previous Deputy Chair gave me an option to deal with it in a way that I think is appropriate. I certainly support the first part of the member’s amendment to delete the words, but, unfortunately, I will not support the second part to substitute words.

Hon COLIN TINCKNELL: I have a question for the minister. I just want to make sure that I heard him correctly. Is the minister prepared to agree to the amendment that Hon Alison Xamon mentioned?

The DEPUTY CHAIR (Hon Robin Chapple): Member, no amendment has been moved. Currently, we are dealing with the words to be deleted.

Hon COLIN TINCKNELL: I am asking whether the minister could please repeat his answer to Hon Alison Xamon’s question, because I missed it; I did not hear it.

Hon STEPHEN DAWSON: I indicate first of all that the suggestion by Hon Alison Xamon is already on the supplementary notice paper under the name of Hon Nick Goiran. Hon Alison Xamon will not get the opportunity to move it, given that it is already on the supplementary notice paper under the name of Hon Nick Goiran. We are not supportive of the amendment standing in the name of Hon Nick Goiran, nor are we supportive of the amendment that stands in the name of Hon Colin Tincknell on this issue. In answer to Hon Nick Goiran’s last question, we do not believe that “voluntary assisted dying” should be listed anywhere on the medical certificate as the cause of death for privacy reasons.

Hon Jim Chown: Who is “we”?

Hon STEPHEN DAWSON: The government does not believe it should be listed.

Hon Jim Chown: I thought it was a conscience vote.

Hon STEPHEN DAWSON: I am not sure where the honourable member has been for the last goodness knows how many hundreds of hours, but my job in this place as we have progressed has been to give the government’s view on the amendments.

Hon Jim Chown: It sounds like you’re talking about the whole chamber.

Hon STEPHEN DAWSON: Honourable member, for goodness sake! What I have been advising the chamber as we progress —

Several members interjected.
The DEPUTY CHAIR: Honourable members!

Hon STEPHEN DAWSON: Let me just remind honourable members in this place that my job has been to give the government’s view on the various amendments before us. That has been my job the whole time and it will continue to be my job for the foreseeable future.

Hon Jim Chown: I understand that, but you used the word “we”.

Hon STEPHEN DAWSON: I just remind the member that when I say “we” in that —

Several members interjected.

The DEPUTY CHAIR: Members!

Hon STEPHEN DAWSON: We—the government—do not support Hon Colin Tincknell’s amendment or, indeed, Hon Nick Goiran’s amendment.

Hon MARTIN PRITCHARD: The minister indicated that we may have an opportunity to vote on amendment 333/81. I do not think that is the case. If this amendment is defeated, will we get an opportunity to vote on Hon Nick Goiran’s amendment?

The DEPUTY CHAIR: Member, you would not, because it would fall away. It is the same question.

Hon MARTIN PRITCHARD: Can I ask for clarification? At the moment, we are dealing with the amendment moved by Hon Colin Tincknell. I understand that we can vote in favour of the deletion of the lines and then oppose the proposed substitution. I understand that the outcome of that will be the same as the outcome of amendment 333/81. If both amendments were defeated, would we have an opportunity to vote on that one?

The DEPUTY CHAIR: No, we would not.

Hon MARTIN PRITCHARD: So the only option for me to get the outcome that has been suggested is to vote in favour of the words to be deleted and then oppose the substitution, which is what I indicated before.

The DEPUTY CHAIR: Yes, that is correct.

Hon ALISON XAMON: I just want to make sure that we are really clear, because I feel that we are getting to the point of wrapping up this debate. If members think that “voluntary assisted dying” should never, ever be mentioned on any death certificate and should never become part of the record, they should not support deleting the words and including the provision moved by Hon Colin Tincknell. If members believe that the status quo should be maintained—that is, that the coroner or medical practitioner should have the discretion to deal with the various components on the death certificate—they should vote to delete the lines, and that would effectively take out subclause (6). If members also believe that it is important that voluntary assisted dying be proactively put on the death certificate as a requirement, they should support the inclusion of the words put forward by Hon Colin Tincknell. They are the three choices.

The only concern that I again flag is that I have heard two conflicting views about the provision put forward by Hon Colin Tincknell, one of which is that it will be part of the record. That was certainly the position put forward by Hon Nick Goiran and it was the position that I always understood. The other view is the position put forward by the minister that the wording as articulated by Hon Colin Tincknell would effectively preclude the capacity to have all the other circumstances around somebody’s death incorporated into a death certificate, and the cause of death would simply be voluntary assisted dying, which I obviously would not support. I think this is the last piece of the puzzle that we need clarified in this chamber: whether the words to be inserted by Hon Colin Tincknell’s amendment would have the effect of limiting further the provisions available on a death certificate, which would run counter to my concerns, because that is precisely my concern with subclause (6) as it currently stands.

Hon NICK GOIRAN: I ask the minister to clarify that. As the honourable member said, I put forward a position and I want confirmation. The government does not need to tell me that it does not want voluntary assisted dying put on the death certificate. I already understand that. That is not the question. The question is: if we support the insertion of the words as put by Hon Colin Tincknell, would it be the case that (a) they are the only words that can appear on the death certificate or (b) they are some of the words that will appear on the death certificate but not limit the medical practitioner in listing as many other things under “cause” as they wish to?

Hon Stephen Dawson: Can Hon Nick Goiran ask his question again?

Hon NICK GOIRAN: If the words to be inserted by Hon Colin Tincknell’s amendment are supported, will it (a) result in “voluntary assisted dying” being the only words that can be inserted as cause of death or (b) require those words to be put on the death certificate but not limit the medical practitioner in listing as many other things under “cause” as they wish to?

Hon STEPHEN DAWSON: The answer is (b).

Hon ADELE FARINA: I will be very brief because my position on this issue is already on the public record. I covered it in my contribution to the second reading debate. I do not agree with subclause (6). I support the amendment moved by Hon Colin Tincknell. I think it is really important from a statistical and accuracy point of

Extracted from finalised Hansard
view that official documents are properly completed, and we should leave that to the medical practitioners who have been doing it for decades—centuries. They know what they are doing. This amendment simply requires that voluntary assisted dying is included in the description of the cause of death. It does not eliminate anything being mentioned. I support the amendment.

**Division**

Amendment put and a division taken, the Deputy Chair (Hon Robin Chapple) casting his vote with the noes, with the following result —

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<th>Ayes (17)</th>
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<td>Hon Colin Tincknell</td>
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Amendment thus negatived.

**Hon NICK GOIRAN:** What would be the effect of opposing clause 81?

**Hon STEPHEN DAWSON:** If this clause were defeated, we would not have the data that we seek to collect as a result of this clause. By including this clause, the board will be able to maintain complete and accurate statistics on participation in voluntary assisted dying in Western Australia. This information will be provided to the Australian Bureau of Statistics and available in a de-identified form to the Parliament and the community so that they can form a view on how well the legislation is operating. That is one thing we would not have if it were deleted.

**Hon NICK GOIRAN:** As a result of clause 81, the Voluntary Assisted Dying Board will be told that a person has died as a result of ingesting or being provided with a voluntary assisted dying substance. That will be part of the statistics that are kept and made available, to which the public will have access, maybe in a redacted form. The clause also provides that voluntary assisted dying will not appear on the death certificate. Is that the sum total of clause 81?

**Hon STEPHEN DAWSON:** Yes, you are correct, honourable member.

**Hon MICHAEL MISCHIN:** Clause 81 is focused entirely on what information is to be provided to the board, but, unless I am wrong, it does not negate the obligation of any relevant person, such as a medical practitioner, to comply with the requirements of the Coroners Act and notify the coroner of relevant material regarding the death. Would that be correct?

**Hon STEPHEN DAWSON:** It does not negate the obligation when the practitioner forms the view that it is not a death in accordance with the voluntary assisted dying legislation. Clause 166 is a consequential amendment to the Coroners Act that provides that a voluntary assisted dying death is not an automatically reportable death, other than for a person held in care. In relation to reporting to the coroner, if the certifying medical practitioner is of the opinion or suspects that the patient’s death has not occurred in accordance with the bill, they do not have to fill out the death certificate, but must refer the matter to the coroner. This is because, in these circumstances, only a death that has occurred in accordance with the VAD legislation will not be a reportable death.

**Hon MICHAEL MISCHIN:** To take that a little further, if clause 81 were to be deleted from the bill, there would still be a requirement, pursuant to the Coroners Act, to report the death to the coroner unless it falls within the provisions of the intended amendment to the Coroners Act prescribing that VAD deaths are not reportable, and there would still be an obligation under section 44 of the Births, Deaths and Marriages Registration Act 1998 to report the death to the registrar. Would that be right?

**Hon STEPHEN DAWSON:** The honourable member is correct on both fronts.

**Hon MICHAEL MISCHIN:** So the only purpose of clause 81 is to legislatively require whoever is completing the certificate to not reveal the truth about the circumstances of the death in all the detail that they might think relevant, and to prescribe for a certain reporting condition to the board. Those are the only things that it does. Would that be right?

**Hon STEPHEN DAWSON:** Honourable member, I disagree with your premise that it is about not revealing the truth. We have had a debate on that.

**Hon Michael Mischin:** All the relevant facts.

*Extracted from finalised Hansard*
Hon STEPHEN DAWSON: We have had a debate. In relation to the facts, Hon Michael Mischin could be correct. In fact, I am told that he is incorrect, because I am told that a voluntary assisted dying death will be a lawful death.

Hon MICHAEL MISCHIN: Whether or not it is lawful is not the point, minister. It is a relevant fact. Anyway, that has been dealt with. However, those are the only two consequences of clause 81, so if it happened to be deleted, there would still be an ability on the part of the board to get the relevant information by some other means. It could do that with reference to death certificates and by accessing any records of the coroner from time to time. Would that be correct?

Hon STEPHEN DAWSON: It is possible that there are other ways of getting the information to the board. For the information of the chamber, it is the government’s view that clause 81 as it stands should be included in the bill, and I hope honourable members will vote to include it.

Hon DONNA FARAGHER: I have one very quick question. I apologise if this question was asked while I was out of the chamber on urgent parliamentary business. I refer to subclause (6) and not including any reference to voluntary assisted dying in the death certificate. Is a penalty attached if they do choose to include that or is it simply the fact that a family member or other caregiver could make a complaint to the relevant medical board or complaints office? I am just wanting some clarification of how the process will go if they do that, because that is not clear from the bill.

Hon STEPHEN DAWSON: I am advised that under clause 10 it would be a contravention of the legislation by the registered health practitioner. There is no penalty attached under the legislation, but it could be unprofessional conduct. There are offence provisions in the legislation prohibiting people leaking personal information about voluntary assisted dying. As such, a doctor or funeral director who informs family or community members that someone has died due to voluntary assisted dying is in breach of the legislation under clause 105.

Division

Clause put and a division taken, the Deputy Chair (Hon Robin Chapple) casting his vote with the ayes, with the following result —

Ayes (19)

Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Tim Clifford
Hon Alanna Clohesy
Hon Nick Goiran
Hon Jacqui Lambie
Hon Michael Mischin
Hon Adele Farina
Hon Laura Fraser
Hon Don Farrell
Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Laurie Graham
Hon Colin Holt
Hon Alannah MacTiernan
Hon Kyle McGinn
Hon Samantha Rowe
Hon Robin Scott
Hon Dr Sally Talbot
Hon Darren West
Hon Pierre Yang

Noes (14)

Hon Jim Chown
Hon Nick Mazza
Hon Donna Faragher
Hon Michael Michelin
Hon Adele Farina
Hon Simon O’Brien
Hon Martin Pritchard
Hon Charles Smith
Hon Aaron Stonehouse
Hon Colin Tincknell
Hon Alison Xamon
Hon Ken Baston

Clause thus passed.

Clause 82: Terms used —

Hon NICK GOIRAN: Clause 82(b) provides that an agent of a patient is an eligible applicant. What will be the procedure to determine whether the person making an application to the State Administrative Tribunal is, in fact, an agent of the patient? While the minister is considering that, perhaps he can also advise whether a contact person would qualify under clause 82(b).

Hon STEPHEN DAWSON: The patient would have to confirm to the State Administrative Tribunal that an agent had been appointed. With regard to whether a contact person could be appointed as an agent, the answer is that the contact person could be appointed as an agent if the person chooses them.

Hon NICK GOIRAN: When we use the term “agent” at clause 82, I take it that we are not necessarily restricting the use of that term to the use of “agent” as used elsewhere in the bill; it has a broader interpretation?

Hon STEPHEN DAWSON: We are talking about a broader use of the word “agent”, and I am told that it is a commonly used term across health to denote a person chosen by the patient to act on their behalf.

Hon NICK GOIRAN: Clause 82(c) allows someone with a special interest to be an eligible applicant. Can the minister explain who someone with a special interest might be and how this would be determined by the tribunal?

Hon STEPHEN DAWSON: A person who has a special interest in the medical treatment and care of the patient may also apply to the tribunal for a review. This highlights that only persons directly involved with a particular voluntary assisted dying case are able to seek a review of decisions via the tribunal. The requirement of “special interest” excludes people who simply oppose voluntary assisted dying; they cannot interfere with the autonomous decision of a patient to access voluntary assisted dying. A primary caregiver, such as a relative or carer, or the patient’s lawyer, may be determined by the tribunal to have a special interest. Merely being a member of the patient’s family

Extracted from finalised Hansard
is not alone intended to be sufficient to constitute having a special interest for the purposes of this clause. 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. A person may make an application to the tribunal; however, it is then ultimately up to the tribunal to decide whether it will hear the case that has been put before it. This will be determined on a case-by-case basis by the tribunal in its independent function as a deliberative body.

Clause put and passed.

Clause 83: Application for review of certain decisions by Tribunal —

Hon NICK GOIRAN: Section 18 of the Victorian Voluntary Assisted Dying Act 2017, which is equivalent to clause 83, does not allow for a review of practitioner decisions around the patient’s voluntariness, and whether the patient is acting without coercion. Why does the government deem it necessary to include in the bill clauses 83(1)(a)(iii), (b)(iii) and (c)(ii)?

Hon STEPHEN DAWSON: I am advised that upon consultation with the President of the State Administrative Tribunal, it was raised. It was confirmed that it is appropriate for SAT in its ordinary jurisdiction to consider whether a person is acting voluntarily and without coercion. This occurs routinely in the human rights stream of SAT.

Hon NICK GOIRAN: Why is the opportunity for tribunal review otherwise limited to decisions by the coordinating or consulting practitioner about the patient’s residency, decision-making capacity, and the voluntariness of the patient’s request? What if an error is made by the coordinating or consulting practitioner about the patient’s diagnosis or prognosis, the practitioner’s assessment of which is required under clause 15(c)? How can this decision be reviewed?

Hon STEPHEN DAWSON: The matters that may be the subject of review by the tribunal are limited and do not extend to each of the eligibility criteria. Most of the criteria involve clinical decisions and are not subject to review by the tribunal. A person could seek judicial review of a decision made by a coordinating or consulting practitioner that is not reviewable by the tribunal. They may also refer a complaint to the Health and Disability Services Complaints Office and the CEO of Health, or refer concerns to the WA Police Force.

Hon NICK GOIRAN: Would that judicial review be to the Supreme Court?

Hon STEPHEN DAWSON: I am advised that, yes, it would be.

Clause put and passed.

Clause 84: Notice of decision and right to have it reviewed —

Hon NICK GOIRAN: Why does the government deem it necessary to modify the operation of section 20 of the State Administrative Tribunal Act?

Hon STEPHEN DAWSON: The decision-maker may not know who the agent is, but the patient can inform the agent. Further, the decision-maker will not know that persons are within paragraph (c) of the definition of eligible applicant, because the tribunal must determine who such a person is. I am further advised that this was raised by the President of the State Administrative Tribunal to be included in the bill.

Hon NICK GOIRAN: How will an eligible applicant who is not the patient be made aware of a tribunal decision referred to in clause 83(1)?

Hon STEPHEN DAWSON: I am advised that it is only if they become an applicant that they will receive advice about the notice of the decision.

Hon NICK GOIRAN: Does an eligible applicant who is not the patient, for example an agent or someone with a special interest, have a right to have a tribunal decision under clause 83(1) reviewed; and, if so, how will they be made aware of this right of review?

Hon STEPHEN DAWSON: Can the honourable member ask his question in a different way, please, to clarify exactly what he is asking for, so we can be clear about what answer he is looking for?

Hon NICK GOIRAN: Clause 84 refers to —

… person who has to be given notice under that section in relation to a decision referred to in section 83(1) …

I am asking: of the various people who can be given notice, is one of those people an applicant? Earlier, particularly under clause 82, we established that an applicant might not be a patient. If the applicant is not a patient, for example an agent or someone with a special interest, do they have a right to have a tribunal decision under that clause reviewed? If they do, how will they be made aware of this right of review?

Hon STEPHEN DAWSON: I am advised that the CEO of Health will make general information available, but a person seeking a review would seek legal advice. A person must be a party to proceedings to be given notice of the decision and information by SAT about appeal rights. I am further advised that there is no right of further review. There is a right of appeal, but that is only available to a party to proceedings in SAT.

Extracted from finalised Hansard
Hon ADELE FARINA: Can I just check, is there some tension between clause 84 and clause 93(1), which states that any decision or order of the tribunal on an application in relation to a patient needs to be provided to the coordinating practitioner, the consulting practitioner, the administering practitioner, the CEO and the board?

Hon STEPHEN DAWSON: I am advised there is no tension. Clause 84 relates to the decision-maker and clause 93 relates to the tribunal.

Clause put and passed.

Clause 85: Consequences of review application —

Hon NICK GOIRAN: Clause 85(1) provides —

This section applies if a review application is made in relation to a patient.

Other than the patient, who else may be the subject of a review application?

Hon STEPHEN DAWSON: I am told no-one. Others can be parties to a review application, but the subject of a review application is always the patient.

Hon NICK GOIRAN: Clause 85 assumes that the review application will be made either before the request and assessment process has been completed—that can be seen at clause 85(2)—or, indeed, after the request and assessment process is completed but before the prescription, supply or administration of a voluntary assisted dying substance. If the step of prescription, supply or administration has already been taken, is there any avenue for tribunal review?

Hon STEPHEN DAWSON: I am constantly amazed that even with the four of us sitting at this table, when the honourable member asks a question, we hear different things. I hope we have an answer to what the honourable member asked. Clause 85(3) contemplates stopping the process even after the substance has been supplied but before it has been administered. The State Administrative Tribunal could make an interim injunction.

Hon NICK GOIRAN: The explanatory memorandum states —

This clause modifies the operation of section 25 of the State Administrative Tribunal Act 2004 …

What is provided for in that section and why does the government deem the modification of that act necessary?

Hon STEPHEN DAWSON: Section 25 of the SAT act has a general provision for all SAT proceedings on review. Clause 85 has specific provisions for VAD tailored to the processes under the VAD bill. In particular, there is an automatic stay under clause 85, whereas under section 25(2) of the SAT act, the tribunal may make an order staying the operation of a decision.

Clause put and passed.

Clause 86: Review application taken to be withdrawn if patient dies —

Hon NICK GOIRAN: Even if the patient has died, is it not in the interests of justice and community safety that a review decision be made by the tribunal if it is alleged that a coordinating and/or consulting practitioner has made an error in the request and assessment process?

Hon STEPHEN DAWSON: Once the patient dies, the tribunal’s role stops. There would be no need to seek a change of the review decision because it would have no effect, given that the patient is dead. There would be no dispute to review. Courts and tribunals do not rule on hypotheticals. Regarding the role of the 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 obviously cannot proceed with the voluntary assisted dying process so the tribunal would have no decision to make. The tribunal’s decision ultimately would not be required because it would have no effect. It would not, for example, 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.

Hon NICK GOIRAN: If there is a dispute over a contentious issue and maybe a matter of interpretation, would it not assist the facilitation of the process moving forward if a tribunal actually made a decision, irrespective of whether the patient has died, so that other medical practitioners, the CEO, the board and everybody else could understand how the tribunal would interpret these matters from time to time?

Hon STEPHEN DAWSON: I am advised that the decision is of no force and has no effect on the patient because the patient is dead. The tribunal may have other opportunities to make decisions to assist practitioners under the act. There are other opportunities. If there are concerns about the process, people can report their concerns to the CEO of Health, for example, or to the WA Police Force. The Voluntary Assisted Dying Board and tribunal could report to the appropriate authority if they suspected any criminal behaviour. The CEO of Health, the Health and Disability Services Complaints Office, the Western Australian Police Force and the Australian Health Practitioner Regulation Agency all hold a range of powers of investigation into these things.

Hon NICK GOIRAN: Is there any other avenue of review for an eligible applicant to follow if that applicant believes an error has been made by the coordinating or consulting practitioner in the request and assessment process, regardless of whether the patient has died?
Hon STEPHEN DAWSON: If they have a complaint, they could take it to the CEO. Does that give the member the answer?

Hon Nick Goiran: It is more about if somebody is concerned about an error that has been made rather than a complaint, so they want it to be reviewed. Is the only avenue the tribunal and the Supreme Court? Is there any other place they can go for review?

Hon STEPHEN DAWSON: I think the CEO of Health is another option.

Clause put and passed.

Clause 87: Decision of Tribunal —

Hon NICK GOIRAN: How will the tribunal decide whether a patient has decision-making capacity in relation to voluntary assisted dying?

Hon STEPHEN DAWSON: I am told that it will review the evidence so it can seek reports. SAT can have specialists on the tribunal. It can consider whether the person has been properly assessed under clause 6. I am advised that SAT is already well versed in this.

Hon NICK GOIRAN: Would a former treating medical practitioner for the patient be permitted to give evidence about the patient’s medical record without the consent of the patient?

Hon STEPHEN DAWSON: I am advised that that would be a decision for the State Administrative Tribunal.

Clause put and passed.

Clause 88: Effect of decision under s. 87(a), (c) or (e) —

Hon NICK GOIRAN: Minister, there is no equivalent clause in our bill to clause 88 in the Victorian legislation. Why has the government deemed this clause necessary for inclusion in the Western Australian bill?

Hon STEPHEN DAWSON: I am advised that it is because we wanted to make it clear exactly what the effect of a SAT decision will be on whomever.

Clause put and passed.

Clause 89: Effect of decision under s. 87(b), (d) or (f) —

Hon NICK GOIRAN: Does the patient have a right to appeal a decision of the tribunal under clause 87(b), (d) or (f), which effectively renders them ineligible to access voluntary assisted dying?

Hon STEPHEN DAWSON: I am advised that under section 105 of the State Administrative Tribunal Act, they can appeal the tribunal decision only on a question of law, but they need leave to appeal.

Clause put and passed.

Clause 90: Coordinating practitioner may refuse to continue in role —

Hon NICK GOIRAN: Clause 90(2) provides that a coordinating practitioner must transfer their role to the consulting practitioner in accordance with clause 155 if they refuse to continue to perform the role of coordinating practitioner. What if the consulting practitioner refuses to accept the transferred role of coordinating practitioner?

Hon STEPHEN DAWSON: If the consulting practitioner refuses the transfer of the role, the original practitioner may refer the patient to another medical practitioner for a further consulting assessment and transfer the role of coordinating practitioner to that medical practitioner, if the practitioner accepts the referral for a further consulting assessment and assesses the patient as eligible for access to voluntary assisted dying and accepts the transfer of the role.

Hon NICK GOIRAN: In the interim, is the coordinating practitioner required or effectively forced to continue in the role of coordinating practitioner until a suitable person can be identified who is willing to be transferred this particular role?

Hon STEPHEN DAWSON: They need only find another person; they are obliged to transfer, but they do not need to advance the voluntary assisted dying process.

Hon NICK GOIRAN: Clause 90 also provides that only the coordinating practitioner may refuse to continue in the role. I note that section 73 of the Victorian legislation, which is the equivalent of clause 90, provides that the consulting practitioner, as well as the coordinating practitioner, may refuse to continue in their role. Why is provision not made in clause 90 or, from what I can gather, anywhere else in the bill, for the consulting or, indeed, the administering practitioner to refuse to continue in their role?

Hon STEPHEN DAWSON: If the request and assessment process is complete, there is no further role for the consulting practitioner. The coordinating practitioner is a continuing role. The consulting practitioner has a fixed role of consulting assessment.

Hon NICK GOIRAN: Yes, but what about the administering practitioner?
Hon STEPHEN DAWSON: I am advised that the administering practitioner can transfer the role under clause 62(1)(c).

Hon NICK GOIRAN: If clause 90 did not appear in the bill, would it not be the case that the coordinating practitioner would already have the right to transfer the role, as the administering practitioner does, and that, in effect, clause 90 is unnecessary, albeit that the government may well say that it desires to have the provision in the legislation?

Hon STEPHEN DAWSON: Clause 90 highlights the continuing role of the coordinating practitioner in the voluntary assisted dying process. In answer to the honourable member’s question: if the clause were not there, it would probably be of little effect. It is in the legislation out of an abundance of caution and an acknowledgement of the continuing role that they play in the process.

Clause put and passed.

Clause 91: Constitution and membership of Tribunal —

Hon NICK GOIRAN: Clause 91(2)(a) modifies the operation of section 11 of the State Administrative Tribunal Act. What is contained in that section and why does the government deem it necessary to modify the operation of the section? While the minister is contemplating that, my second question relates to section 115(5) of the State Administrative Tribunal Act, which is modified by subclause (2)(b). Why are sections 11 and 115(5) of the State Administrative Tribunal Act being modified under this clause?

Hon STEPHEN DAWSON: Clause 91(2)(a) under part 5 provides —

the Tribunal, when exercising its review jurisdiction, must be constituted by, or so as to include, a judicial member;

The President of the State Administrative Tribunal recommended the insertion of this provision into the bill. The intent of this subclause is to enable an appeal from a decision of the tribunal to be heard by the Court of Appeal in accordance with section 105 of the Western Australian State Administrative Tribunal Act 2004. Section 105 provides for an appeal to be made to the Court of Appeal if the decision was made by the tribunal constituted by members who include a judicial member. It should be noted that the president of the tribunal is a Supreme Court judge and the two deputy presidents are District Court judges. Their role is to ensure the effective functioning and independence of SAT and to resolve difficult questions of fact and law.

Subclause 91(2)(b) enables a public sector employee to be appointed to be a non-judicial member in respect of matters in the tribunal’s review jurisdiction. This amendment was recommended by the president of SAT for insertion into the bill. Non-judicial members may be experienced in law or may be experienced in or have special knowledge of relevant professions, occupations and fields in which SAT makes decisions. Members may be full-time or sessional and may be appointed for up to five years. This subclause modifies the operation of section 117(5) of the State Administrative Tribunal Act 2004 to enable psychiatrists, psychologists and other persons with relevant skills and training—for example, a police officer—who are public sector employees to be appointed as sessional members to sit on a panel on a review under part 5.

Clause put and passed.

Clause 92: Hearings of Tribunal to be held in private —

Hon NICK GOIRAN: Clause 92 appears to modify the operation of section 61 of the State Administrative Tribunal Act. What is provided for in that section, and why has the government deemed it necessary to modify the operation of the section? It seems that the President of the State Administrative Tribunal has asked for quite a number of modifications, and this is the latest one.

Hon STEPHEN DAWSON: Section 61 of the SAT act provides for hearings to be public unless otherwise ordered. Hearings in relation to voluntary assisted dying matters should not be made public. This is to ensure that the patient is protected and supported as they go through the voluntary assisted dying process. It also offers protection from public intrusion to practitioners who participate in the process. This modification was supported by the president of the tribunal.

Hon NICK GOIRAN: Will family members of the patient be able to be present at tribunal hearings?

Hon STEPHEN DAWSON: I am told that it will depend on the tribunal. It will be a decision of the tribunal.

Hon NICK GOIRAN: Presumably, that would be the case only when a family member is not an applicant.

Hon STEPHEN DAWSON: Generally, yes.

Hon NICK GOIRAN: In what circumstances would a family member who is an applicant not be able to be present at the tribunal hearing?

Hon STEPHEN DAWSON: It would generally be because the patient and the family member may be appearing before the tribunal in the same case, but there may well be extreme animus between them so they would be in two different rooms.

Clause put and passed.
Clause 93: Notice requirements —
Hon NICK GOIRAN: The explanatory memorandum states that under clause 93 notice is required to be given to the coordinating practitioner, the consulting practitioner, the administering practitioner—if that person is not, of course, the coordinating practitioner—the CEO and the board. This is said to be necessary to—
... ensure that persons and bodies who are not parties to the proceedings, but who have an interest in the proceedings, receive appropriate notice of applications and decisions or orders of the Tribunal.

Should a former coordinating, consulting or administering practitioner also be included?
Hon STEPHEN DAWSON: Those former practitioners play no ongoing role in the patient’s care, but it is at the tribunal’s discretion as to whether it may include them.

Clause put and passed.

Clause 94: Coordinating practitioner to give Tribunal relevant material —
Hon NICK GOIRAN: This clause modifies the operation of sections 24 and 35 of the State Administrative Tribunal Act. What do those sections provide for that the government has deemed is appropriate for modification?

Hon STEPHEN DAWSON: Section 24 of the SAT act relates to decision-makers giving the tribunal reasons for decisions being reviewed, and section 35 of the SAT act is about obtaining information from third parties. I am advised that we need specific provisions that are tailored to voluntary assisted dying–related decisions. The coordinating practitioner may not always be the decision-maker whose decision is being reviewed.

Clause put and passed.

Clause 95: Tribunal to give written reasons for decision —
Hon NICK GOIRAN: This clause modifies the operation of four sections of the State Administrative Tribunal Act—sections 75, 77, 78 and 79. What is provided for in those sections that the government has deemed appropriate for modification?

Hon STEPHEN DAWSON: I am not sure whether the honourable member needs me to identify what each of those sections is.

Hon Nick Goiran: If it is quick.

Hon STEPHEN DAWSON: I can say generally what each of them is for. They are about individual decisions made by the tribunal. Section 75 of the State Administrative Tribunal Act 2004 of WA is headed “To whom copy of written decision has to be given”, section 77 is “Reasons for final decision”, section 78 is “Written reasons may be requested” and section 79 is “Written decision or reasons using transcript”. I am advised that we need to tailor these provisions specifically to the voluntary assisted dying process, because the SAT act is more generalist and the Voluntary Assisted Dying Bill is much more specific. Section 18 of the SAT act allows for modification of the SAT act. This will occur when specific provisions are better suited than the general provisions of the SAT act.

Clause put and passed.

Clause 96: Published decisions or reasons to exclude personal information —
Hon NICK GOIRAN: Before I move the amendment standing in my name at 475/96, I will provide a brief explanation for the benefit of members. In effect, this was an oversight in the bill that was picked up, in that the privacy protections in clause 96(1) do not extend to practitioners who may have held the role of coordinating practitioner at one point but have since transferred out of that role. Likewise, the current drafting of clause 96(1) provides protection only to the current consulting practitioner and not to other practitioners who have previously been involved in consulting assessments for the patient. For those brief reasons, I move—

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;

Hon STEPHEN DAWSON: I indicate that we—for Hon Jim Chown’s purposes, “we” means the government—are supportive of the amendment moved by Hon Nick Goiran at 475/96. We are also supportive of amendment 476/96. We accept these amendments. Certainly in relation to 475/96, the intent was to cover former practitioners in the bill, but there is no harm in being clear with the proposed amendment.

Amendment put and passed.

Hon NICK GOIRAN: I move—

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.

The reasons for this amendment have just been provided.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: Again, we support this amendment. It does not detract from the bill. It is a drafting amendment that says the same thing that is already in the bill, but we are supportive of it.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 97: Interim orders —

Hon NICK GOIRAN: In what circumstances might the tribunal see fit to make an interim order?

Hon STEPHEN DAWSON: I am told an example of this may be that a person may require a temporary decision from the tribunal and will need to file an interim application form in addition to the standard application form.

Clause put and passed.

Clause 98: Unauthorised administration of prescribed substance —

Hon MICHAEL MISCHIN: I have a few questions regarding part 6 generally, but we will start off with clause 98. Clause 98 provides that a person commits a crime if they administer a prescribed substance to another and they are not authorised to administer that prescribed substance to the other person. The clause prescribes a penalty of imprisonment for life. Why is it imprisonment for life? Is it regarded as being akin to attempted murder?

Hon STEPHEN DAWSON: As Hon Michael Mischin pointed out, the penalty under this clause is life imprisonment. This reflects the seriousness of anyone administering a voluntary assisted dying substance outside the process allowed under the legislation. I am advised that this is consistent with similar provisions under the Criminal Code—sections 279, 280 and 283.

Hon MICHAEL MISCHIN: In which court would those offences under the Criminal Code be tried?

Hon STEPHEN DAWSON: The Supreme Court, honourable member.

Hon MICHAEL MISCHIN: Is that the case for an offence contrary to clause 98?

Hon STEPHEN DAWSON: Yes.

Hon MICHAEL MISCHIN: I ask that because last week I received a copy of a document of some eight pages, signed by the president of the Law Society of Western Australia, Mr Greg McIntyre, SC, entitled “Submission to the Voluntary Assisted Dying Bill 2019 (VAD Bill)”, and dated 27 November 2019. I understand I received a copy of the same document that had been sent to the Premier, the Minister for Health and the Attorney General. Some observations are made in the submission regarding the offence provisions in part 6 of the bill. Has the minister been given access to that document and any advice from either his instructing minister or the Attorney General regarding the content of that document and the matters it raises?

Hon STEPHEN DAWSON: I have not seen it. Can I ask the member to table the document?

Hon Michael Mischin: Not a problem at all, but I confess some surprise that —

The DEPUTY CHAIR (Hon Martin Aldridge): Member, only one member can have the call.

Hon STEPHEN DAWSON: It has been received by the government, but I ask the member to table it so that I can have a copy in front of me. If the member is referring to particular parts of the document, I can answer questions about them. If the member does not want to table it but wants to facilitate getting me a copy, that will do the same thing.

Hon MICHAEL MISCHIN: I am happy to table a copy of it. I confess some surprise that the government has not favoured the minister with a copy of it and some advice as to the matters raised therein. I seek leave to table a copy of the document that I have just described.

Leave granted. [See paper 3474.]

Hon MICHAEL MISCHIN: Hon Nick Goiran has in the interim provided me with a further copy of the document, which I can perhaps pass to the minister while we are waiting for other copies to be distributed.

I draw the minister’s attention to the base of page 7 of that document. I will read it out for the record. It comes under the heading “4. Criminal Law” and the subheading “4.1 Offences”. Paragraph 4.1.1 states —

The Society wishes to point out that, following recent amendments to the jurisdiction of the District Court, allowing it jurisdiction to deal with offences attracting a penalty of life imprisonment, the offences of unauthorised administration of a prescribed substance (clause 98) and inducing self-administration of a prescribed substance (clause 100) would be dealt with in the District Court, not the Supreme Court. This contrasts with the offences of wilful murder, murder and manslaughter, which are not within the jurisdiction of the District Court and must be determined in the Supreme Court.

The minister has told us that that is not going to be the case. The Law Society has come to a different view. I am wondering whether the minister might be able to assist us.

Extracted from finalised Hansard
Hon STEPHEN DAWSON: The honourable member is correct; I have to give an apology. Recent amendments have been made to the law to permit the District Court to consider certain offences. Section 42 of the District Court of Western Australia Act 1969 gives the District Court jurisdiction unless the offence is prescribed. However, the jurisdiction does not limit or diminish the jurisdiction of the Supreme Court. The District Court would have jurisdiction unless the exclusion of the offences was prescribed in the District Court of Western Australia regulations, but this does not limit the jurisdiction of the Supreme Court. I am advised that the Law Society of Western Australia’s view would be taken into consideration, but the Department of Health would seek further views on this matter from the Attorney General, the Solicitor-General, the Director of Public Prosecutions, the Supreme Court and the courts and tribunals.

Hon MICHAEL MISCHIN: I thank the minister, and I am not blaming the minister for the error in this. However, I am surprised, as I indicated, that the Premier, the minister’s instructing minister and the Attorney General did not provide the minister with a copy of this document and brief him on the issues that are raised in it, in particular the issues that I am about to cover about the criminal enforcement of the provisions of the Voluntary Assisted Dying Bill. As the minister said, section 42 of the District Court of Western Australia Act provides essentially that the District Court has all the jurisdiction and powers of the Supreme Court in respect of any indictable offence, and, because this is defined as a crime, that makes it, by definition, an indictable offence by reason of the Interpretation Act 1984. Section 42(2) provides that the court does not have jurisdiction to try an accused person charged with an indictable offence that is a crime under sections 279, 280, 283, 288 or 290 of the Criminal Code—all of which are homicide-type offences—nor does it have jurisdiction to try a person charged with an indictable offence that is an offence, or offence of a class, prescribed in the regulations. Can the minister assist us as to whether any offences have been prescribed in the regulations to date?

Hon STEPHEN DAWSON: Sorry, but the member will have to ask that question again—just that last bit.

Hon MICHAEL MISCHIN: Can the minister tell us whether to date any offence, or a class of offences, has been prescribed in regulations under the District Court of Western Australia Act that require trial by the Supreme Court, in addition to the ones that are stated; and, secondly, whether the government plans to pass a regulation that requires a charge under proposed section 98 of the Voluntary Assisted Dying Bill to be tried by the Supreme Court?

Hon STEPHEN DAWSON: To my knowledge, no regulations have been made thus far. In relation to whether the regulations will be amended, that will be decided in consultation with the DPP, the Attorney General and the courts during the implementation phase, so upon the passage of the bill and the amendment.

Hon MICHAEL MISCHIN: One would hope that although contraventions of proposed section 98 would be rare, they would be tried by the Supreme Court alone, given that they would carry a term of life imprisonment and would be akin to at least negligent homicide, if not attempted murder. I will leave that one there.

Hon STEPHEN DAWSON: The honourable member’s views are noted, as are the views that were expressed by the Law Society. I will certainly ensure that they are fed into the process.

Hon Michael Mischin: Is the minister able to —

The DEPUTY CHAIR (Hon Matthew Swinbourn): Hon Michael Mischin, I have not given you the call. I was about to give the call to Hon Adele Farina, who had sought the call, but I think she has been gracious enough to let you continue.

Hon MICHAEL MISCHIN: Thank you; I appreciate that. I have only one further question.

Is the minister able to seek advice from the responsible ministers and, when we reconvene tomorrow, provide us with some indication of whether the government has in mind that an offence against clause 98 will have the same gravity as homicide offences in the Supreme Court, and whether it proposes to regulate, in due course, that these will be dealt with by only the Supreme Court? Maybe the government has not formed a position on it, but in light of the Law Society having provided this information last week, I would have thought that someone would have turned their mind to it in the meantime and come to a view on how these sorts of offences ought to be dealt with.

Hon STEPHEN DAWSON: I can tell the honourable member that the matter is under consideration but it will not be decided until after the Director of Public Prosecutions, the courts and the Attorney General have been consulted. That will be dealt with during the implementation phase.

Hon ADELE FARINA: Could the minister explain to the chamber what constitutes “administers”? Would that include mixing the voluntary assisted dying substance with a sweet drink? Would it include holding the glass for the patient while the patient drinks? Would it include giving the VAD substance and the sugary substance to the patient, so the patient can mix them? Would all those constitute “administering”?

Hon STEPHEN DAWSON: I ask the honourable member to repeat the third example.
Hon ADELE FARINA: I would be happy to, minister. The third example was providing the VAD substance and the sugary drink to the patient so the patient could mix them up themselves. My question is: does any one of those or all three of those constitute administering?

Hon STEPHEN DAWSON: “Administers” is to be distinguished from “supply” and “prepare”. Only the patient or administering practitioner can prepare a voluntary assisted dying substance. Mixing is preparation. Regarding providing the substance to the patient, I have indicated that only the patient or the administering practitioner can prepare a voluntary assisted dying substance. In relation to holding the glass, that is possibly administering. If the person is actually pouring the substance down the patient’s throat, my advice is that that would be administering.

Hon ADELE FARINA: What about if the patient drinks it through a straw and the carer just holds the glass?

Hon STEPHEN DAWSON: I am advised that that is not administering. The patient would actively be sucking through the straw. It is not administering.

Hon ADELE FARINA: If the patient needs to have it administered through a feeding tube, would connecting the substance to the feeding tube constitute administering?

The DEPUTY CHAIR: Before I give the call to the minister, I just note that another supplementary notice paper has been circulated. It is supplementary notice paper 139, issue 18, for members to note.

Hon STEPHEN DAWSON: The answer to that one is yes, it is administering.

Hon NICK GOIRAN: Regarding the enforceability of clause 98, how will sufficient evidence be found when unauthorised administration of the prescribed substance is alleged, particularly in light of the evidence provided to the Joint Select Committee on End of Life Choices by the Director of Public Prosecutions —

… there is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem for us.

The director made this statement about the prosecution of cases in which it is alleged that the doctor has wrongly hastened the death of a patient. The Director of Public Prosecutions went on to state —

… at the end of the day it is one person’s say-so and that is the person administering the treatment. The patient, of course, is deceased.

In light of that, what confidence can we have that the new offence in clause 98, included to provide protection for vulnerable individuals against wrongful death, can be effectively investigated and prosecuted?

Hon STEPHEN DAWSON: I am advised that evidence will be masked in the usual way, as per an investigation into a murder or other serious crime. A witness, including a concerned family member or carer, may raise concerns with police.

Hon MICHAEL MISCHIN: Is the minister able to tell us what advice or consultation took place in the crafting of the offence contained in proposed section 98? The minister said that the Director of Public Prosecutions is yet to be consulted regarding which jurisdiction this offence will be tried in, but did the DPP give advice about the formulation of the offence and its elements?

Hon STEPHEN DAWSON: I am told that the Department of Justice, the Solicitor-General, the Director of Public Prosecutions and the Western Australia Police Force have been consulted on the offence provisions and penalties, and are agreeable to the provisions. The Office of the Director of Public Prosecutions was consulted and was provided with a consultation draft of the bill.

Hon MICHAEL MISCHIN: How did it respond to the consultation draft of the bill? Did it have any specific comment about the provability of what is planned in clause 98?

Hon STEPHEN DAWSON: I am advised that the DPP, the Attorney General’s office and the Solicitor-General met, and the settled positions are in the bill before us.

Hon MICHAEL MISCHIN: The reason for my concern is that although the offences in the Criminal Code are fairly simple, I observe there are many elements to this particular planned offence. Bear in mind that each of these elements would need to be proven by the prosecution beyond reasonable doubt and possibly in the absence of a key witness, because death does not have to be one of the outcomes in order to establish the offence. In order to prove this offence, it would have to be established beyond reasonable doubt that the accused administered something; that that “something” was a prescribed substance within the meaning of the act; that it was administered to another person; and that the person doing the administering was not authorised to do so by section 58(5). The following matters at section 58(5) would need to be proven beyond reasonable doubt: if an administering practitioner were not satisfied at the time of administration that the patient had decision-making capacity in relation to voluntary assisted dying; and/or the patient is acting voluntarily and without coercion; and/or the patient’s request for access to voluntary assisted dying was enduring. A lot of things would potentially have to be proven beyond reasonable doubt and we are looking at a circumstance that may have little incentive on the part of other witnesses to come

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forward and say anything about. But if that is what we are looking at as an offence in the legislation, so be it. I wonder why it is that simply prescribing a simpler offence, a failure to comply with the provisions of the act, does not establish an offence of a similar import to that of attempted murder or assisting a suicide. Nevertheless, I have no other comments to make about this particular clause.

Hon ADELE FARINA: In response to my earlier question about the examples, the minister indicated that there was a difference between administration and preparation so that if a carer or family member mixed the substance together with the sugary drink, that was preparation and did not fall under the provisions of this offence. Is it the case that a family member or carer can prepare the voluntary assisted dying substance for the patient?

Hon STEPHEN DAWSON: No. Only the patient or the administering practitioner can prepare a voluntary assisted dying substance, in the case of self-administration. Sorry, the patient in the case of self-administration, and the practitioner in the case of practitioner-administered voluntary assisted dying.

Hon ADELE FARINA: Where is the offence if someone other than the patient prepares the substance in the case of self-administration, or someone other than the administering practitioner prepares the substance in the case of administration by a medical practitioner?

Hon STEPHEN DAWSON: I am told that, depending on the substance, it could be an offence that is captured under either the Misuse of Drugs Act 1981 or the Medicines and Poisons Act 2014.

Hon ADELE FARINA: Why was an offence not included in this legislation? If it is an offence, under the legislation, to administer a prescribed substance, why is it not also an offence to prepare a substance if no-one other than the patient in the case of self-administration and the medical practitioner in the case of being administered by a medical practitioner can prepare the substance to safeguard that?

Hon STEPHEN DAWSON: I am advised that we will be making consequential amendments to the Medicines and Poisons Act and the Misuse of Drugs Act on this issue.

Hon ADELE FARINA: Are the consequential amendments that the government is proposing to the other acts included in the bill?

The DEPUTY CHAIR: Member, I am struggling to see how this fits with the question that clause 98 stand as printed. You were talking about offences that might be or should be included rather than one that is before us. I will let the minister answer your question.

Hon STEPHEN DAWSON: Those amendments are in part 11 of the bill.

Clause put and passed.

Clause 99: Inducing another person to request or access voluntary assisted dying —

Hon NICK GOIRAN: Clause 99(2) states —

A person commits a crime if the person, by dishonesty, undue influence or coercion, induces another —

(a) to make a request for access to voluntary assisted dying; or
(b) to access voluntary assisted dying.

The penalty can be imprisonment for seven years. What happens if the person dies as a result of that dishonesty, undue influence or coercion—that is, the inducement leads to the death of the person? Surely a penalty of seven years is woefully inadequate in those circumstances. Is there another offence in this bill or elsewhere that would capture that situation?

Hon STEPHEN DAWSON: Clause 100 is the avenue for self-administration.

Hon NICK GOIRAN: We are not just talking about self-administration in this bill; we are also talking about practitioner administration. I want to know how the provisions of clause 99(2) work if the inducement leads to the death of the patient. A person may be induced by way of dishonesty, undue influence or coercion. As the minister quite rightly pointed out, that occurs in the context of self-administration, and clause 100 kicks in. What happens if self-administration is not the preferred method?

Hon STEPHEN DAWSON: A person being induced to attend practitioner administration is not the same as a person being induced to self-administer. The coordinating practitioner is the buffer. In the case of practitioner administration, the practitioner has to be satisfied of several things at the time of administration. As the member pointed out, the maximum penalty for the offence in clause 99 is seven years’ imprisonment. Provision is also made for a summary conviction penalty of three years’ imprisonment and a fine of $36,000. The drafting team met with the Department of Justice to discuss the appropriate penalties. In landing upon this penalty, the drafting team took the advice from the Department of Justice, the WA Police Force, the Solicitor-General and the Director of Public Prosecutions. It is consistent with sections 301 and 304 of the Criminal Code where there is a similar penalty regime.

Progress reported and leave granted to sit again, pursuant to standing orders.
VOLUNTARY ASSISTED DYING BILL 2019

Clause 99: Inducing another person to request or access voluntary assisted dying —

Progress was reported after the clause had been partly considered.

**Hon Nick Goiran**: When we concluded yesterday evening, we were looking at clause 99(2) that indicates that a person commits a crime if the person, by dishonesty, undue influence or coercion, induces another person to, amongst other things, request access to voluntary assisted dying or access it. My concern was: what would happen if the person who had been induced died as a result of the inducement? As I understand the minister’s explanation yesterday evening, the minister seemed to indicate that that would be captured by clause 100. Does clause 100 therefore capture all circumstances of voluntary assisted dying in the event of an inducement?

**Hon Stephen Dawson**: For self-administration, yes, it does.

**Hon Nick Goiran**: If it is not self-administration, and a person has been induced, what offence will apply to the inducer other than clause 99(2), particularly if the person dies as a result of the inducement.

**Hon Stephen Dawson**: I am advised that it is potentially captured by section 288 of the Criminal Code, which refers to a person being guilty of a crime if they procure, counsel and thereby induce, or aid another person in killing themselves. The penalty is life imprisonment.

**Hon Michael Mischin**: I appreciate that observation, minister, because I was going to ask about the relationship between clause 99(2) and section 288 of the Criminal Code. The minister assured us that in the event that there has been some dishonesty, undue influence or coercion and a person is induced to access voluntary assisted dying, then notwithstanding that all the other necessities under the bill have been satisfied, the person who did the inducement would nevertheless be guilty of procuring a suicide within the meaning of section 288 of the code. Perhaps I should be a bit more specific. If it is of any assistance, I can pass over my copy of the Criminal Code so that the minister can take advice on it. Section 288 provides —

(1) Procures another to kill himself; or
(2) Counsels another to kill himself and thereby induces him to do so; or
(3) Aids another in killing himself;

is guilty of a crime, and is liable to imprisonment for life.

That covers the field so far as it goes, but I want to make sure that there is no hiatus here and that if those circumstances are satisfied, notwithstanding that the bill provides that if someone follows all the procedures it is not a suicide, and notwithstanding that there is particular provision, it would nevertheless leave a person who induces by the means set out in clause 99(2) liable to conviction and punishment for an offence against section 288.

**Hon Stephen Dawson**: The short answer, honourable member, is, yes; it would be a breach of section 288 of the Criminal Code.

**Hon Michael Mischin**: Thank you. I take it that clause 99(2) is aimed more at inducement that does not lead necessarily to a death. Would that be correct?

**Hon Stephen Dawson**: The member is correct.

**Hon Michael Mischin**: Given that procuring a suicide or inducing someone to suicide carries life imprisonment—I may be a little rusty on the law—and an attempt to do so that does not succeed in causing that person’s death would result in 14 years’ imprisonment, why is this set at only seven years’ imprisonment as a maximum punishment? Ought it not be something at least comparable to an inducement to get someone to kill themselves that is not successful?

**Hon Stephen Dawson**: Honourable member, I answered this last night. It was the last comment I made before I broke last night.

**Hon Michael Mischin**: Sorry.
Hon STEPHEN DAWSON: That is all right. I will point it out briefly. I will not go into it in great detail because it is on the uncorrected Hansard from last night.

Hon Michael Mischin: My apologies.

Hon STEPHEN DAWSON: That is okay. The drafting team met with the Department of Justice to discuss the appropriate penalties. The drafting team took advice from the Department of Justice, the Western Australia Police Force, the Solicitor-General and the Director of Public Prosecutions in landing upon this penalty. I am advised it is consistent with sections 301 and 304 of the Criminal Code — so, offences causing someone to take poison or other noxious things. 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.

Hon MICHAEL MISCHIN: It is comparable to the maximum penalty for simple stealing, fraud — actually, I think with fraud, it is 10 years if it is someone over the age of 60 years — forging and uttering and those sort of offences. Nevertheless, the government has selected that. My only other question is: what is meant by induces another person to access; can the minister give an indication as to what that involves because it seems to be very broad and vague?

The CHAIR: President—I mean minister.

Hon STEPHEN DAWSON: Mr Chair, you are giving me status above my paygrade.

The CHAIR: Well above, yes.

Hon STEPHEN DAWSON: To access is to progress beyond the request and assessment process. It includes prescription and supply, to final administration.

Hon NICK GOIRAN: Earlier when the minister provided an explanation for clause 99(2), he indicated that if the elements set out in clause 99(2) are made out, but an additional element is present — that is, the person died as a result of the inducement — section 288 of the Criminal Code would capture that circumstance. If that is true, why do we need clause 100?

Hon STEPHEN DAWSON: I am advised that it is because we want a discrete offence in the bill similar to that in the Victorian legislation.

Hon NICK GOIRAN: If we want a discrete offence in the bill, why do we not have one similar to that sitting on the supplementary notice paper at 491/99?

The CHAIR: Member, are you proposing to move the amendment in your name on the supplementary notice paper at this point? If the member is going to canvass it, it really needs to be on the business in front of us.

Hon NICK GOIRAN: I am waiting for the minister’s response before I decide whether to move the amendment.

The CHAIR: I will indicate to the chamber that we are not going to get into a debate on a mooted amendment, but I will allow a brief inquiry of the nature that the member has proposed.

Hon STEPHEN DAWSON: The reason is that this is the way that the drafters have drafted the bill and a decision has been made to include clause 100.

Hon NICK GOIRAN: I move —

Page 66, after line 24 — To insert —

(3) A person commits a crime if —

(a) the person, by dishonesty, undue influence or coercion, induces another person —

(i) to make a request for access to voluntary assisted dying; or

(ii) to access voluntary assisted dying;

and

(b) as a consequence, the other person accesses voluntary assisted dying and dies.

Penalty for this subsection: imprisonment for life.

The purpose of this amendment is to mirror what is currently found in the bill at clause 99(2). The same language applies; the only difference is that if someone induces a person by way of undue influence, coercion and the like to access voluntary assisted dying — in other words, they have been put under pressure to access it — and they die as a result, there will be a maximum penalty of life imprisonment. Members will see that precisely the same penalty applies at clauses 98 and 100. We agree that under clause 100, if a person uses dishonesty, undue influence or coercion to influence a person to self-administer the substance, they are up for a penalty of potentially life imprisonment. This issue was canvassed in the other place by the member for Hillarys in a dialogue with the Premier, who was filling in at the time for the Minister for Health. Interestingly, the response provided by the Premier to the same questions effectively asked by the shadow Attorney General and me were different. The Premier referred the member for Hillarys to section 273 of the Criminal Code, yet today we are told it is section 288. I do not think we

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can have confidence that all the offences have been adequately covered when the Premier of Western Australia
tells members in the other place that section 273 of the Criminal Code will capture things and today we are told
that it is section 288.

**Hon Michael Mischin:** Section 273 is not an offence anyway.

**Hon Nick Goiran:** This was the advice of the very learned Premier of Western Australia to the member for
Hillarys. Perhaps it was given at an inappropriate time of the day or morning; I do not know. In any event, the point
is that if members intend to support clause 100 of the bill, there should be no problem supporting the amendment
that currently stands in my name. It ensures that there is no gap. If somebody is put under pressure to access voluntary assisted dying—not just to self-administer, but in any circumstance—the person applying that pressure should be up for life imprisonment. This amendment would achieve that. In conclusion, I draw to members’
attention the submission provided by the Law Society of Western Australia. I know that the minister now has
a copy of it because it was kindly tabled by the shadow Attorney General yesterday. The Law Society states at 4.1.5
on page 8 of the submission —

> Arguably, the maximum sentence for clause 99(2)(b), which is substantially the same offence as clause 100,
> except that it may be committed in cases not involving self-administration, is inadequate, and should be
> the same as for clause 100.

For those reasons, I seek the support of all members.

**Hon Stephen Dawson:** The government does not support this amendment to clause 99. I am advised that
clause 100 adequately deals with inducement for self-administration. Clause 99 has a broader application, which
also includes when practitioner administration is chosen. The offence in clause 99 of the bill is not substantially
the same as at clause 100. Clause 99 deals with request for access and when an administration decision is made.
Clause 100 specifically relates to self-administration when there is no intermediary. Practitioner administration
has an intermediary—the practitioner—so it would not have the same penalty. I am advised that in relation to
proposed clause 99(3)(b) that is unclear because a person could access voluntary assisted dying but die from
natural causes rather than from the administration of the prescribed substance. I want to make the point that, as
stated previously, the government formulated clause 99 in consultation with relevant agencies and the penalty
reflects the penalties at sections 301 and 304 of the Criminal Code.

**Hon Nick Goiran:** Whatever agencies the government decided to consult with, it did not consult with the
Law Society of Western Australia, because we just received its submission this week, which I understand the
minister received yesterday. The other point that needs to be made is that the government’s view seems to be that it
is okay because there is an intermediary. If there is an intermediary—a consulting practitioner and an administering
practitioner—who knows nothing about the inducement whatsoever, they can proceed along their merry way and
inject the patient, having complied entirely with the act. What will happen if, unbeknownst to this intermediary
that the minister referred to, the patient is under pressure? What does the minister propose should be the penalty if
the patient is told by a family member, “If you don’t go ahead with this, I’m going to kill one of the other family
members”? What will happen if that kind of pressure is exerted on the person and the patient does not report it to
anybody out of fear for the safety of their loved one and does not tell the intermediary, as the minister now likes
to refer to him? The inducement is shocking and disgraceful, and imprisonment for life should apply. If the patient
under all of those circumstances and pressure decides that they will not self-administer because they cannot
cope with what is going on and they want practitioner administration, we are suddenly saying that clause 100 will not
apply to them because they chose self-administration. There is nothing in the amendment before the chamber
that is going to undermine anything in the bill. It is consistent with the advice of the Law Society and I seek the
support of members.

**Hon Michael Mischin:** I have sympathy for what is being proposed, because I see a hiatus. Under clause 100
we are looking at a crime being committed if I were, through dishonesty, undue influence or coercion to induce, say,
Hon Nick Goiran, to self-administer. That carries life. It does not matter whether it results in his death; that is not
an element of that offence. He may self-administer but not die, or he may stop short of the actual self-administration
because he has second thoughts. There is no comparable provision as simple as that in clause 99. The closest it
comes to that is at clause 99(2), yet that carries a penalty of a measly seven years’ imprisonment. Again, death does
not have to be an outcome under clause 99(2), but otherwise it seems to be aimed at the same mischief. Yet, the
penalty is a fraction of what might be the case under clause 100. That is one of the points that the Law Society made
in its submission tabled yesterday and circulated to the government last week. It says that arguably the maximum
sentence for clause 99(2)(b), leaving aside Hon Nick Goiran’s amendment, which is substantially the same offence
as clause 100 except that it may be committed in cases not involving self-administration, is inadequate and should
be the same as for clause 100. I wholeheartedly support that. If the government is not going to increase the penalty
in clause 99(2) from seven years, I think it is proper that there be a provision that covers the field in proposed
clause 99(3).

If the minister is concerned about the potential of proposed subclause (3)(b) capturing people when the deceased
has died of natural causes rather than the administration of a substance, it can be cured by a small addition—with

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the words “and dies as a result thereof”. I would have thought that that solves that problem of causation and it complements, at least insofar as there is a consequence to the inducement that has led to a fatal result, a sensible penalty, without having to resort, if necessary, to section 288 of the Criminal Code. Frankly, there is a very good argument for saying that the penalty of seven years should simply be increased and it would solve the problem, but if we are concerned about that and want to reserve the penalty of life imprisonment for something for which there is an actual consequence, I think we should support what Hon Nick Goiran proposes. My only caveat is that to solve the problem that the minister has raised, the words “assisted dying and dies” in proposed subclause (3)(b) ought to continue to provide “as a result thereof”. Therefore, I move —

Paragraph (b) — To insert after “assisted dying and dies” —

as a result thereof

Amendment put and a division called for.

Bells rung.

The CHAIR: Members, this is a unique situation —

A member interjected.

The CHAIR: Order. The member knows not to address the Chair when he is not in his place.

The voices that were sufficient to declare a no vote have apparently evaporated, and, for the record, I note that every member has moved to the right of the Chair. The situation now is that standing order 80 cannot be employed; therefore, this division will proceed. I do not know how we are going to do it without a teller for the noes. Given the unique circumstances, I am going to rule that the ayes have it. Will all members please resume their places.

Amendment on the amendment put and passed.

Point of Order

Hon Dr SALLY TALBOT: A small point of order, just while we are proceeding—I received several comments last night about the fact that the various speakers are leaving their microphones on while the minister is talking to advisers and while the Chair is talking to the clerks, and several conversations were picked up that were quite extraneous to the debate. I wonder whether it would be appropriate for you, Mr Chair, to remind people that, perhaps if they are talking privately they should switch their microphones off.

The CHAIR: There is no point of order, and you have all been told. Thank you, Hon Dr Sally Talbot. It is something to look out for, and I dare say it happens more often than we realise, so thank you for that point.

Committee Resumed

Hon RICK MAZZA: I rise to say that I am inclined to support this amendment. The way that I have considered this is that clause 100 refers only to someone who self-administers, and then obviously dies as a result. Clauses 99(1), (2) and 100 do not really cover a case of an administrating practitioner who has administered a substance to end a person’s life but later evidence shows that the deceased was unduly influenced or coerced into voluntary assisted dying. In my mind, clause 100 is deficient because it deals only with self-administration, and clause 99(2) refers only to coercion, but not coercion resulting in death. On that basis, I am inclined to support Hon Nick Goiran’s amendment to insert proposed subclause (3).

Hon ALISON XAMON: I rise to indicate that I have some sympathy for this amendment, but I am still listening to the debate as it unfolds. We need to remember that we are attempting with this legislation to enshrine the principle of individual choice, which we should cherish, and ensure that people are genuinely consenting to voluntary assisted dying. We have gone to a great amount of pain to do this and reinforce how important it is for people to have that personal choice. In the course of my second reading contribution I expressed my concerns about the way that coercion could occur, partly around elder abuse, but also for people with disability, who had expressed deep concern to me about the way coercive factors can work in their lives, and how important it is for them that we ensure that we have appropriate safeguards. We have incorporated a number of processes in this bill to ensure some oversight by practitioners to make sure that coercion does not occur, and we have debated those at length. But it strikes me that we need to look at the penalties that will apply when those safeguards are bypassed and problems emerge. It is important that, as much as possible, this legislation provides disincentives for anyone attempting to abuse its provisions. I remind people who have been lobbying for a very long time for these provisions that it will take only one person to effectively be murdered through these provisions to potentially bring this entire regime tumbling down. I would think that anyone who is advocating for voluntary assisted dying would want to make sure that these provisions are being protected and that every measure is taken to avoid abuse.

We have strong penalties for what we call the “murder offences”, and it is very important that we do not differentiate too much between the penalties that various murder offences attract. It is problematic to talk about murder as

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defined in the Criminal Code when attracting a life sentence, but then murder in another circumstance, such as the one potentially foreseen here, being of somehow lesser status. I have stood in this place on multiple occasions and talked about industrial manslaughter and said that, as far as I am concerned, manslaughter, in this instance, whether it occurs at work or in other settings, should not be differentiated. Ultimately, if someone dies and someone could have or should have prevented that, there needs to be commensurate penalties. The same applies here. I have always argued that the same penalty should apply to industrial manslaughter as that which applies to regular manslaughter; therefore, I say that murder as it is effectively articulated here, needs to be replicated with our regular murder provision. Indeed, I see this as an important safeguard to maintain the entire regime of voluntary assisted dying, because it is a very, very strong deterrent. The sorts of situations I can foresee in which this might occur are when someone who might potentially be the recipient of a large amount of money puts undue pressure on someone to avail themselves of this. They may be very careful and scrupulous about keeping themselves out of the formal process of voluntary assisted dying so that they never come to the attention of the people who in good faith administer this process; nevertheless, evidence may come to light later that the person who died did not really wish to die but felt that they had no choice. I think in that situation, it is murder and we need commensurate penalties. I am very sympathetic to the principle behind this. I see it as an important protective factor of the regime as a whole, but it is also critical that we do everything possible to make sure that people do not access voluntary assisted dying if they really do not want to.

Hon CHARLES SMITH: I fully urge members to agree with the amended amendment before us. I fully agree that this offence and clause 99 should be regarded as a serious offence. In the current format, there is an option for a summary conviction, and that means that in the real world in a court process, for example, with early pleadings of guilty, a demonstration of remorse for the offence committed, or perhaps it is a first offence, there is a very real possibility that an offender could walk away with a minimal punishment or a fine for trying to get someone to take their own life. I think that is wholly unacceptable. I urge members to consider the amended amendment to make this a serious offence with life in prison.

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

**Ayes (16)**

Hon Martin Aldridge  
Hon Adele Farina  
Hon Simon O’Brien  
Hon Aaron Stonehouse  
Hon Jim Chown  
Hon Nick Goiran  
Hon Martin Pritchard  
Hon Colin Tincknell  
Hon Peter Collier  
Hon Rick Mazza  
Hon Tjom Sibma  
Hon Alison Xamon  
Hon Donna Faragher  
Hon Michael Mischin  
Hon Charles Smith  
Hon Ken Baston (Teller)

**Noes (18)**

Hon Jacqui Boydell  
Hon Colin de Grussa  
Hon Alannah MacTiernan  
Hon Dr Sally Talbot  
Hon Robin Chapple  
Hon Sue Ellery  
Hon Kyle McGinn  
Hon Darren West  
Hon Tim Clifford  
Hon Diane Evers  
Hon Samantha Rowe  
Hon Pierre Yang (Teller)  
Hon Alanna Clohesy  
Hon Laurie Graham  
Hon Robin Scott  
Hon Matthew Swinbourn

Amendment, as amended, thus negatived.

Clause put and passed.

**Clause 100: Inducing self-administration of prescribed substance —**

Hon ADELE FARINA: Can the minister explain whether this offence will cover the situation in which a person prepares the substance for the patient to take?

Hon STEPHEN DAWSON: No, clause 100 does not cover the preparation.

Hon ADELE FARINA: Last night, when I asked the minister this question about clause 98, he told me that, depending on what the substance is, the issue of preparation might be covered under the Misuse of Drugs Act or the Medicines and Poisons Act. I have reviewed both of those acts and neither of them deal with the preparation of the substance. I just want to get some clarification. Is it the case that it is not an offence to prepare voluntary assisted dying substance on behalf of a patient?

Hon STEPHEN DAWSON: I am advised that to prepare, one must have possession of the substance. If a person is not authorised to prepare, they are not authorised to possess. Possession is criminalised by the Medicines and Poisons Act and the Misuse of Drugs Act by way of consequential amendments. Furthermore, I am advised that section 288 of the Criminal Code may also apply.

Hon NICK GOIRAN: Will the prosecution have more or fewer elements to prove if a charge is preferred under clause 100 of this legislation or section 288 of the Criminal Code?
Hon STEPHEN DAWSON: I am told there is no real difference to what has to be proved—so in either case the inducing has to be proved.

Hon NICK GOIRAN: The minister will see here that, as in the previous clause, we introduced this concept of undue influence. The minister will recall that earlier in our debate on the bill, on several occasions, including under the principles, I suggested that it might be appropriate that we use that terminology. The government resisted that; as I understood it, the explanation was that the language was too legalistic. I notice that the principles as originally proposed by the government say that there is a need to protect persons who may be subject to abuse, and thanks to a very good amendment by Hon Martin Pritchard, that now says that there is a need to protect persons who may be subject to abuse or coercion. In this provision, we talk about both undue influence and coercion. What is the difference between the two?

Hon STEPHEN DAWSON: Honourable member, coercion may be threats. Undue influence is more subtle, so it could be persuasion by someone in a position of influence—for example, a guardian or parent. My advisers tell me that it is appropriate to include undue influence in an offence provision in the bill. What I said previously was that “undue influence” is legalistic terminology that is reflected in the offence provisions of this bill. It denotes when a person uses improper influence that deprives another of freedom of choice or substitutes another’s choice or desire for the former person’s own. It is a legal term that is understood by the learned profession; however, it is less familiar to the general community.

Hon NICK GOIRAN: The minister indicated earlier that one of the reasons that the government does not believe it is necessary in clause 100 to go beyond self-administration is that a very important intermediary will be involved. I understood that the minister indicated a practitioner would be involved as an intermediary. Given that that will be the only thing standing in the way of what would otherwise be a crime under clause 100, will it be very important for the intermediary to understand where undue influence or coercion might be present so that they might be able to report such action to the police?

Hon STEPHEN DAWSON: The answer is yes, and there will be training on this as part of the implementation phase.

Hon NICK GOIRAN: I just want to alert the minister now that he has said yes to that answer. We will pick up this conversation again when we get to clause 158. I look forward to the minister’s support at proposed amendment 74/158, but we will deal with that at that time.

Hon MICHAEL MISCHIN: I just want the minister to confirm, in light of what has happened with clause 99, that although under clause 100 it is a crime punishable by life imprisonment for a person through dishonesty, undue influence or coercion to induce another to self-administer a prescribed substance, there is no comparable offence if a person by dishonesty, undue influence or coercion induces another person to be administered a prescribed substance.

Hon STEPHEN DAWSON: I am advised that that would be a breach of section 288 of the Criminal Code.

Hon MICHAEL MISCHIN: Why is it not thought fit to have a like offence to clause 100 in this bill—a person inducing another person to be administered a prescribed substance—carrying a penalty of life imprisonment?

Hon STEPHEN DAWSON: Honourable member, that was discussed in some detail at clause 99, so I do not think it is appropriate to answer that again.

Clause put and passed.

Clause 101: False or misleading information —

Hon NICK GOIRAN: Who are the persons captured by clause 101? For example, could a nurse practitioner be captured; and, if so, what are the forms, declarations or other documents that nurse practitioners are connected with under this bill?

Hon STEPHEN DAWSON: The Voluntary Assisted Dying Board will rely on the information provided in the various forms, records and statements, made under the bill, to carry out a number of functions. Thus, the information provided must be accurate. Furthermore, to maintain the integrity of the VAD process, it is vital that accurate information is provided between the patient and the practitioner. The forms are any and all required to be completed under the bill. For a nurse practitioner, these will be the practitioner administration form, the practitioner disposal form and, in some cases, it could be the administering practitioner transfer form.

Hon NICK GOIRAN: If a medical practitioner injects a person with a prescribed substance, in compliance with the requirements of this bill, and it results in the death of that person, would it be misleading in a material particular—as the phrase is put in clause 101—for the medical practitioner to report that death as a natural death?

Hon STEPHEN DAWSON: If a practitioner reports such a death as from natural causes to the Voluntary Assisted Dying Board, that would be misleading. It is only misleading if the practitioner provides false information, not information as required to be provided lawfully.

Clause put and passed.

Extracted from finalised Hansard
New clause 101A —

Hon CHARLES SMITH: I move —

Page 67, after line 18 — To insert —

101A. Medical practitioner or other person not to be advantaged or disadvantaged in relation to voluntary assisted dying

(1) A person commits a crime if the person gives or promises any reward or advantage (other than reasonable payment for the provision of health services or other relevant services), or causes or threatens any disadvantage, to a medical practitioner or other person —

(a) because the medical practitioner or other person has done anything referred to in subsection (2); or

(b) for the purpose of inducing the medical practitioner or other person to do anything referred to in subsection (2).

Penalty for this subsection: imprisonment for 7 years.

(2) Subsection (1) applies to the following —

(a) participating, or refusing to participate, in the request and assessment process;

(b) prescribing, supplying or administering a voluntary assisted dying substance;

(c) refusing to prescribe, supply or administer a voluntary assisted dying substance.

(3) A person to whom a reward or advantage is given or promised as referred to in subsection (1) is not entitled to retain or receive the reward or to exercise the advantage, whether or not the person knew of the intention to give the reward or advantage, or the promise, at the time that the person did the thing referred to in subsection (2).

Despite the size of this proposed new clause, it is a very short and straightforward amendment and new offence that I believe will plug a hole in this legislation by introducing another safeguard and criminal offence. Coincidentally, last night I received an email from a constituent who reminded me of my stance on crime, and law and order issues. She sent me a snippet of a speech I gave some years ago. I will read out a couple of sentences from that speech —

Our communities want to see more robust sentencing from magistrates and judges …

I am still firmly of that opinion. I concluded that short speech by saying —

I believe individuals should be held fully responsible for their actions. Committing crime is fundamentally a matter of rational choice.

I still firmly believe in what I said some years ago. The new clause I propose aims to prohibit people from seeking to influence the actions of a medical practitioner or other person in relation to participating, or indeed refusing to participate, in the request and assessment process; or prescribing or supplying or administering a voluntary assisted dying substance; and also refusing to refuse to prescribe, supply or administer a voluntary assisted dying substance. I believe this amendment will plug a hole in the legislation that leaves it open to being abused. Experience shows that people take advantage of holes or gaps in legislation. I urge members to consider this particular gap and how this amendment will fill that and provide yet another safeguard.

Hon STEPHEN DAWSON: The government is not supportive of this proposed new clause. The provision melds together a suite of offences that are better left independent of each other. Furthermore, these actions are already covered by existing legislation and, as my advisers tell me, with more appropriately targeted penalties.

Hon NICK GOIRAN: I listened to Hon Charles Smith and when I read the amendment I did not find anything objectionable in it. My question to the minister is: is it already covered somewhere else in the bill? Can the minister indicate to what extent the amendment is duplicated in the bill?

Hon STEPHEN DAWSON: I did say other “legislation”; essentially it is covered by the Criminal Code. I will give some examples. If a practitioner is being bribed to administer the substance to a patient, the briber could be caught under section 273 of the Criminal Code for a lot longer than seven years. Section 273 of the code might apply if the medical practitioner did something as a result of being offered a reward or advantage, which hastened the death of the patient. The medical practitioner and the briber could be charged with unlawful killing and a penalty of life imprisonment could apply. In the case of the briber, he or she may have arguably procured the commission of an offence pursuant to section 7 of the Criminal Code. The threat aspect of the proposed offence is adequately covered by sections 338, 338A and 338B of the Criminal Code, which specifically deal with threats. If a coordinating, consulting or administering practitioner or an authorised supplier or disposer was bribed to participate or refused to participate in the process, section 82 of the Criminal Code would apply. Section 82 provides that any public officer who obtains or who seeks or agrees to receive a bribe, and any person who gives or offers or promises to give

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a bribe to a public officer is guilty of a crime and is liable to imprisonment for seven years. Corruption provisions also apply under section 83 of the Criminal Code with regard to the public officer. In some cases the conduct may constitute fraud under section 409 of the Criminal Code; for example, when there is an intent to defraud and the offender uses deceit for fraudulent means to cause a detriment.

**Hon AARON STONEHOUSE:** I think I see what the amendment intends to address. I wonder whether there is a possible unintended consequence. Proposed new clause 101A(1) states “or causes or threatens any disadvantage”. I wonder how broadly “disadvantage” could be applied. Proposed new subclause (2)(a) states — participating, or refusing to participate, in the request and assessment process;

Might that conflict somehow with conscientious objectors—for example, a medical practitioner who refuses to provide assessment, but then their employer puts them in a situation by saying, “At this clinic, we provide that. That is the policy of this organisation. If you do not want to provide VAD as a medical practitioner, you should find employment elsewhere.” Alternatively, that situation could be reversed and have a medical practitioner who wants to provide VAD, but their employer says that it is a religious-based hospital and if they want to provide VAD, they must go elsewhere; they will not be employed there. I wonder whether the reference to “disadvantage” in this instance might fall foul of that. I do not think it would, because I do not think it meets the threshold of a threat, but I wonder whether any consideration has been given to that and whether the mover of the motion or the minister, through the advice he gets, has anything to say about any potential unintended consequences. If the criticism is merely that these offences would already be captured in existing criminal law or other aspects of the bill, I do not see any problem with passing this new clause. It is seems to merely spell out a little more clearly what we are trying to prevent. If my concern about unintended consequences can be answered by either the mover or the minister, that would be helpful to me.

**Hon STEPHEN DAWSON:** My advisers tell me that the member is right. It would not have to be a threat. If it causes a disadvantage, it would be captured.

**Hon NICK GOIRAN:** When we looked at clause 99, as I understood it, it was about somebody inducing a person, who I will refer to as a patient, to proceed with voluntary assisted dying. As I understand it, this amendment seems to be looking not at the patient, but the practitioner. Earlier, the minister listed a number of provisions of the Criminal Code that he said already capture this. I want to go back to the theme we were looking at earlier—that is, when the outcome of the inducement is the death of a patient. If a person induces a medical practitioner to participate in VAD in the terms that Hon Charles Smith has put before us, or in the terms that the minister has referred to in other sections of the Criminal Code, and it would lead to the death of the person, does one of the sections in the Criminal Code the minister referred to deal with the situation in which death ensues?

**Hon STEPHEN DAWSON:** Can the honourable member clarify his question and ask it again for us, if he does not mind?

**Hon NICK GOIRAN:** I was far ahead of the minister and on to another clause. We were looking at the amendment of Hon Charles Smith. My understanding is that it looks at circumstances in which a person, a doctor or practitioner, is induced. I made the point that clause 99, which we dealt with earlier, looked at inducements of what I have described as a patient. This one looks at the inducement of a practitioner. I am keen to know whether any of the sections in the Criminal Code the minister referred to earlier would capture a situation in which there is not just an inducement of the practitioner to participate in this, but that it leads to the death of the patient. Given that the doctor is one of the safeguards and has to assess whether the person has a terminal illness and will die within six months, is not being coerced, and has decision-making capacity—they have to go through all those things—we do not want the practitioner to do that under duress. We do not want them to be unduly influenced. We do not want them to do it because they have been given some inappropriate incentive or threat of disadvantage—all those kinds of things. I think we all agree that we do not want those things to happen. We especially do not want a wrongful death as a result of it. If we have a practitioner who says, “I’m just going to say that this person has only six months to live”, I want to make sure that the provisions the minister quoted earlier capture the scenario in which death ensues.

**Hon STEPHEN DAWSON:** I am advised that in the example the member has provided, murder or manslaughter could apply. That relates to section 273 of the Criminal Code. If it hastens death, it could be murder or manslaughter.

**Hon NICK GOIRAN:** I am talking about the person who has induced the practitioner to perform the act. Would that still be captured?

**Hon STEPHEN DAWSON:** Is the honourable member suggesting that somebody might be inducing a practitioner to participate in a lawful voluntary assisted dying process?

**Hon Nick Goiran:** Possibly.

**Hon STEPHEN DAWSON:** If so, that would not be an offence. If they were persuading someone to participate lawfully under the bill, that would not be an offence.
Hon NICK GOIRAN: I am not sure that can be right. For example, we talked about conscientious objection earlier in the bill. Let us use that as the hypothetical. If the practitioner has a conscientious objection, but someone started to exert pressure on that person and says, “Listen, sunshine, you put your conscientious objection to one side, thank you very much. I’ve got a patient here who I want to refer to you and you are going to participate in this thing and help this person. You can forget about your conscientious objection. If you don’t do it, I am going to release these photographs that I have of you”, or some other kind of inducement of that sort.

Hon Stephen Dawson: That’s a threat, and it’s probably blackmail.

Hon NICK GOIRAN: We are starting to make progress here. What I am asking is that if, as a result of that, it leads to the death of the person, is that captured by one of the sections that the minister quoted earlier?

Hon STEPHEN DAWSON: If the patient dies after lawful access to voluntary assisted dying, the person who persuaded the practitioner to participate is not guilty of murder. That person may be guilty of the offence of making unlawful threats, which is captured by the examples I gave earlier of section 338(a) and (b) of the Criminal Code.

Hon NICK GOIRAN: I guess it all turns then on whether the patient died lawfully, as the minister described it. I would say that if the practitioner has made an assessment that the person had a terminal illness when they did not have a terminal illness, that is unlawful and there should be major repercussions. Of course, the practitioner has done something unlawful and there should be a penalty for them—no question. But should there not also be an equally severe penalty for the person who induced the practitioner in the first place? That is the mischief that I want to make sure is captured, whether it be by Hon Charles Smith’s amendment or some other amendment, or one of the clauses that the minister referred to earlier. The scenario that I want to make sure we properly capture is the initial inducer—the person who induced the practitioner to do the wrong thing that led to the death of a person.

Hon STEPHEN DAWSON: What the honourable member described in his earlier example is a crime that would be captured by clause 98 of the bill, which states, “A person commits a crime if”, and there is a penalty associated with that.

Hon NICK GOIRAN: Yes; but, minister, correct me if I am wrong, clause 98 applies only to the practitioner, the person who administered the prescribed substance. I concede that that person needs to be prosecuted and be shown the full force of the law, but I want to make sure that we capture the person who induced the person to do wrong under clause 98. What clause in the bill will capture the inducer in the event that the patient ultimately dies as a result of those actions?

Hon STEPHEN DAWSON: If the practitioner is induced to make a false assessment, the inducer would be guilty of a crime, because that is the counselling or procuring of an offence, and that issue is captured by chapter II, section 7, of the Criminal Code.

Hon NICK GOIRAN: So to be clear, that provision of the Criminal Code, when read in conjunction with clause 98, would capture that particular individual?

Hon STEPHEN DAWSON: I am told that it can be read in conjunction with or in separation.

Hon NICK GOIRAN: We can see from this exercise how torturous it is to identify the relevant offence under which the police or the DPP will prosecute. The solution provided by Hon Charles Smith is far simpler because it will all be in the same bill and we will not have to go through this torturous exercise to decide whether a person should be prosecuted. For those reasons, I support Hon Charles Smith’s amendment, albeit I think it could go further.

Division

New clause put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the noes, with the following result —

Ayes (7)
Hon Nick Goiran Hon Simon O’Brien Hon Aaron Stonehouse Hon Ken Baston (Teller)
Hon Rick Mazza Hon Charles Smith Hon Colin Tincknell

Noes (28)
Hon Martin Aldridge Hon Stephen Dawson Hon Colin Holt Hon Tjorn Sibma
Hon Jacqui Boydell Hon Colin de Grussa Hon Alannah MacTiernan Hon Matthew Swinbourn
Hon Robin Chapple Hon Sue Ellery Hon Kyle McGinn Hon Dr Sally Talbot
Hon Jim Chown Hon Diane Evers Hon Michael Mischin Hon Dr Steve Thomas
Hon Tim Clifford Hon Donna Faragher Hon Martin Pritchard Hon Darren West
Hon Alanna Clohesy Hon Adele Farina Hon Samantha Rowe Hon Alison Xamon
Hon Peter Collier Hon Laurie Graham Hon Robin Scott Hon Pierre Yang (Teller)

New clause thus negatived.

Extracted from finalised Hansard
Clause 102: Advertising Schedule 4 or 8 poison as voluntary assisted dying substance —

Hon NICK GOIRAN: Clause 102 uses the word “advertises”; is that intended to include publish?

Hon STEPHEN DAWSON: I am advised that it does include publication.

Hon NICK GOIRAN: If it includes publication, how is a doctor to be told what the schedule 4 and schedule 8 voluntary assisted dying substance is that has been approved by the CEO? The moment the CEO publishes that information he is liable to imprisonment for three years or a fine of $36,000.

Hon STEPHEN DAWSON: It has to be the publication of an advertisement, not a pamphlet handed out by the CEO, for example. It is the publication of an advertisement.

Hon NICK GOIRAN: My first question was: does “advertises” include publishing; therefore, the answer is no, not yes.

Hon Stephen Dawson: It includes the publication of an advertisement.

Hon NICK GOIRAN: I did ask about publishing. Let us make sure that we are on the same page here. A person cannot advertise or put out a publication. How will the CEO communicate to practitioners about a voluntary assisted dying substance without contravening clause 102?

Hon STEPHEN DAWSON: The offence is directed at advertising, not the communication of information. The word “advertises” has a commercial flavour attached to it. The CEO could provide the information to practitioners by writing a letter or sending information to them about the available substance. This is not advertising if it conveys information.

Hon MICHAEL MISCHIN: What is the mischief at which this is aimed? Is it the advertising of a schedule 4 or schedule 8 poison that has not been approved as a voluntary assisted dying substance, or just advertising these as substances that can be used for voluntary assisted dying? What is it aimed at? It may be that the offence needs to be refined somewhat. If it is talking about a substance that has not been approved pursuant to clause 7 as a voluntary assisted dying substance, then I can understand what this provision is driving at. If it has been approved pursuant to clause 7, what is the harm in saying in a pamphlet, “We produce this particular substance, which is an approved voluntary assisted dying substance”, signed off under the banner of the chemical or pharmaceutical company producing it? What are we aiming at here?

Hon STEPHEN DAWSON: The reason for the clause is that schedule 4 and 8 substances are currently supplied to persons pursuant to the WA Medicines and Poisons Act 2014. It would not be prudent to allow the public to know which of these poisons or substances may be used for voluntary assisted dying as it may encourage persons to stockpile their supply for the purpose of suicide or assisted suicide outside the protections of the Voluntary Assisted Dying Act. Furthermore, evidence from overseas has shown that once the medication becomes known as a voluntary assisted dying substance, manufacturers of that substance significantly mark up the price.

Hon MICHAEL MISCHIN: Just on that point then, if I were to find out—inevitably people will find out—which particular schedule 4 or schedule 8 poison is being used for voluntary assisted dying and I were to go on Facebook and say, “Look, this is the stuff they use”, would that be advertising contrary to this clause? Just to take that further, if I were simply to write an email to someone and say, “I have found what they use for this process; this is it”, would that be advertising it?

Hon STEPHEN DAWSON: This clause is aimed at those seeking to profit, so it relates to commercial advertising. If someone is telling a mate, it would not be captured by this. I think that is probably how I would answer it.

Hon NICK GOIRAN: If the person decides as a measure of generosity to the community to charge nothing, not to profit from the advertisement in any way, would it be okay? Would the clause apply only if they were to make a profit? Is that what triggers clause 102? I do not think that can be the case, surely.

Hon STEPHEN DAWSON: If the person was promoting its use, that could be captured. I talked about someone telling a mate about something and saying, “I know what this is”, but if they are promoting the use of it, that could be captured, and the decision about whether charges are laid would be a matter of prosecutorial discretion.

Hon NICK GOIRAN: Would the clause read better as, “A person commits a crime if the person advertises, promotes or in any other way represents a schedule 4 or schedule 8 poison as a voluntary assisted dying substance”?

Hon STEPHEN DAWSON: We are happy with how the clause reads at the moment. Advertising could include promotion, so we do not support an amendment.

Hon ADELE FARINA: I apologise; would the minister mind repeating that?

Hon STEPHEN DAWSON: I indicated that we do not support an amendment to this clause. We believe it should stand as it is. I said that advertising would include promotion. We think the clause reads well as it is and we do not support an amendment.

Hon ADELE FARINA: I am now very confused about the intention behind this clause; I was not when I first read it, but I am now. Does the minister realise that details and information about all of the substances used for voluntary assisted dying, suicide, are extensively available if someone does a Google search? Does that constitute advertising?
Hon STEPHEN DAWSON: I have answered this already; perhaps the member did not hear. The issue is advertising the substance as a voluntary assisted dying substance. 

Hon Adele Farina interjected.

Hon STEPHEN DAWSON: No, they are schedule 4 and schedule 8 poisons that are potentially commonly available at the moment, but this clause captures advertising them as voluntary assisted dying substances. That is what I have said multiple times now. As I have indicated, I support the clause as it stands. Regulations 91 and 100 of the Medicines and Poisons Regulations 2016 currently impose restrictions on the advertising of schedule 4 and schedule 8 poisons.

Clause put and passed.

Clause 103: Cancellation of document presented as prescription —

Hon NICK GOIRAN: I move —

Page 68, line 7 — To insert before “cancel” —

Immediately

Hon STEPHEN DAWSON: We are not supportive of this amendment. The government does not want to say “immediately”, but we would expect cancellation to be in a timely manner, so if not immediately, then as soon as practicable. There is a significant penalty for failure to do so.

Amendment put and negatived.

Hon MICHAEL MISCHIN: My question regarding clause 103 focuses on subclause (2) and the purported creation of an offence. Clause 103(1) provides the circumstances in which the proposed section will apply. The clause then continues, in subclause (2), to provide that an authorised supplier must cancel a document in a particular way and inform the CEO administering the act that the document has been cancelled and the reasons for cancelling it. It then goes on to state —

Penalty for this subsection: imprisonment for 12 months.

The Interpretation Act 1984 provides that when, in an act, a penalty is specified at the foot of a subsection of a section, unless the contrary is expressly provided, a contravention of the section or subsection, as the case may be, is an offence, and the penalty on conviction is the penalty prescribed. I am a little unclear about what the contravention is in this case. Subclause (2) prescribes an obligation to do something, and then says that the penalty for it is imprisonment for 12 months. I infer that what is meant is that a failure to comply with that clause, or failure to do something under one of those obligations, gives rise to an offence by operation of section 72 of the Interpretation Act, but that is by no means plain in the manner in which that clause is framed. By way of assistance, I think there is a similar issue with clause 104(1) and (2). I wonder if the minister can turn his mind to that and, if there is an issue with it, it may be something that the government will need to correct.

Hon STEPHEN DAWSON: I am told that there is no need to amend, because a contravention of subclause 103(2) gives rise to the penalty, and that is based on section 72(1) of the Interpretation Act 1984.

Hon MICHAEL MISCHIN: I am not going to argue with the minister about the matter. I once again draw his attention to the view of the Law Society in its submission, at paragraph 4.1.7, which tends to reinforce the position that I have expressed. It states —

The Society notes that sub-clauses 103(2), 104(1) and 104(2) of the Bill create obligations and then declare a penalty. They do not provide that a crime or offence is committed if a person acts in a particular way, as clauses 98, 99(2), 100 and 102 do. On the face of sub-clauses 103(2), 104(1) and 104(2) they prescribe a penalty for complying with the obligations stated in those sub-clauses. The Society assumes that it was probably intended that those provisions make it an offence to not comply with those obligations. If so, those provisions are required to be amended accordingly.

If the advice that the minister has received, and with which the government is comfortable, is that there is no ambiguity or uncertainty about what is meant there and that there will be no problem down the track, I am not going to argue the toss with him, but I simply draw to his attention that perhaps some clarity would be useful.

Hon STEPHEN DAWSON: I am told it is a drafting convention, and similar to regulation 26 of the Medicines and Poisons Regulations 2016. We have taken advice from the Parliamentary Counsel’s Office and the State Solicitor’s Office, and they agree with the position in the bill.

Hon NICK GOIRAN: I move —

Page 68, line 9 — to delete “inform the CEO” and substitute —

within 2 business days after cancelling the document, inform the CEO and the Board

Hon STEPHEN DAWSON: The government does not support this amendment. The board will be notified via the database that we have spoken about previously. The CEO will be informed in a timely manner. I note that the cancellation of the prescription means that the voluntary assisted dying substance is not supplied to the patient or the agent.
Hon NICK GOIRAN: By way of explanation of this amendment, clause 103 outlines what must be done when an authorised supplier is given a document that is presented as a prescription for a voluntary assisted dying substance and the authorised supplier is satisfied that the document does certain things as set out in subclause (1)(b), which states —

the authorised supplier is satisfied that the document —

(i) does not comply with section 69; or

(ii) is not issued by the coordinating practitioner for the patient to whom it relates; or

(iii) is false in a material particular.

Clause 103(2) provides that the authorised supplier must cancel the document by marking the word “cancelled” across it and inform the CEO that the document has been cancelled and give the reasons for cancelling. The penalty for failure to cancel the document and informing the CEO of the document cancellation is imprisonment for 12 months. The amendment I have moved will do two things: firstly, it will insert a time frame within which notification by the authorised supplier to the CEO must occur—that is, within two business days after cancelling the document. Secondly, it will require the authorised supplier to notify not only the CEO of the cancellation but also the Voluntary Assisted Dying Board. I note that other important notifications within this bill are required to take place within two business days of a form being completed, yet in this instance, when the document is a false or noncompliant prescription and the authorised supplier has to cancel the document, there is no requirement for that notification to the CEO to occur within a set time frame. This deficiency was identified by the Law Society in the submission it circulated to us over the last week. I quote from its submission dated 27 September 2019, particularly the paragraph on page 8, where the Law Society states —

Clause 103 of the VAD Bill provides for the cancellation of documents presented as a prescription by an authorised person but there is no timeframe for compliance.

If we are going to ask the person to inform the CEO—if they do not do it, they are liable to go to jail for 12 months—we should at least let that person know how long they have before they are prosecuted and potentially go to jail. I do not think it is asking too much. I do not really mind whether the period is two days or some other period, but it is the complete absence of a period in this provision that concerns me. As I say, the Law Society itself has raised it with members. The Law Society’s solution was that we could deal with this by way of a prescription by regulation. I understand from previous discussions, particularly under clause 1, that the government is not intending to move any regulations. I would rather we insert it now while we have the opportunity before us, given the constraints with otherwise trying to handle this matter. The second part of the amendment deals with the information being provided not merely to the CEO, as is currently set out in clause 103, but also to the board. This was picked up by the member for Hillarys in debate in the other place on 18 September. I note that this is the only clause that I can identify in the bill that requires a person to provide notification to the CEO only. Clause 93 requires the CEO, amongst a list of persons, including the board, to be notified by the tribunal that a review application has been made. Clause 95 requires the CEO, amongst a list of persons, including the board, to be given the written reasons for a tribunal decision, and clause 109 requires a court to notify the CEO of a conviction for an offence under this act. I cannot see why clause 103 is the exception within this act when the CEO and only the CEO is required to be notified of something by an individual who holds responsibilities under this act in the request assessment and administration process.

I ask for members’ support, emphasising that this is an issue identified by the Law Society in its submission to us dated 27 November this year; and, secondly, if we do not do this, according to clause 103 as it currently stands, an authorised supplier can go to jail for up to 12 months for not providing information to the CEO but we will not tell them how long they have to do so. If it continues to be the position of the government that it does not want to support the amendment in either its current or an alternative form, I ask the minister to, at the very least, clarify how long the authorised supplier will have to inform the CEO that the document has been cancelled before prosecution proceedings commence?

Hon STEPHEN DAWSON: I am told that this provision is consistent with the requirement to inform the CEO in regulation 26 of the Medicines and Poisons Regulations 2016. It was inserted specifically to mirror the MPA in relation to schedule 4 and schedule 8. The penalty is higher to reflect that it is a voluntary assisted dying substance. The board can access the information on the database and the CEO has the discretion to initiate prosecution of this simple offence. It may well be that the practitioner is reminded that they need to do this before any prosecution is initiated. Certainly, the view is that it be done as soon as practicable.

Hon NICK GOIRAN: How much time will the authorised supplier have to inform the CEO before being in jeopardy of a charge? Is it 24 hours, one week, one month or one year? If the government is not going to put in a period when everywhere else in the bill it says two business days, we have a responsibility to make sure we make it clear to the authorised supplier that they have to do that within a certain period because if they do not, they could go to jail for 12 months. What amount of time will be taken before deciding whether the CEO will proceed or not?

Hon STEPHEN DAWSON: It will be at the CEO’s discretion, but the likelihood is that the length of time will be decided upon as part of the guidelines during the implementation phase.

Hon NICK GOIRAN: What makes the provision of this document different from every other document that needs to be provided? Why do all the other documents have to be provided within two days but not this one?
Hon STEPHEN DAWSON: The cancellation of the prescription means that the voluntary assisted dying substance will not be supplied to the patient or the agent, so there is less of a degree of urgency than in other parts of the bill. The board will know whether a prescription has been issued, so if it does not get notification of supply, it can check the reasons.

Amendment put and negatived.

Clause put and passed.

Clause 104: Contact person to give unused or remaining substance to authorised disposer —

Hon NICK GOIRAN: I understand from Hon Rick Mazza that he is not moving any further amendments. On that assumption, I want to ask a few questions on clause 104. What mechanism will be in place to ensure a contact person is notified within 14 days of the date on which the patient made the revocation decision?

Hon STEPHEN DAWSON: The board is required under clause 148 to send the contact person certain information about their obligations and the support services available to them. The board will follow up with the contact person to remind them to return the substance in time or to request information as required.

Hon NICK GOIRAN: What part of the support services or information that will be provided to the contact person will assist them to ensure that they have been notified within 14 days of the date on which the patient made the revocation decision?

Hon STEPHEN DAWSON: The patient must inform the contact person of the revocation.

Hon NICK GOIRAN: If they do not do that, how will the contact person comply with the 14-day time frame?

Hon STEPHEN DAWSON: The coordinating practitioner and the board will remind the contact person to keep in contact with the patient so they know what is going on.

Hon NICK GOIRAN: That sounds like an excellent way to coerce the patient. Will it be a defence to a prosecution under clause 104(1) for the contact person to say that they did not know the day on which the decision was revoked?

Hon STEPHEN DAWSON: As I previously stated, the contact person is expected and likely to be a person who remains in close contact with the patient. The patient will know to tell the contact person. But in answer to the member’s last question, there is no such defence in the bill.

Hon NICK GOIRAN: How will the contact person, appointed by the patient, gain entry to the premises to collect any unused or remaining poison in order to provide that poison to the authorised disposer for disposal?

Hon STEPHEN DAWSON: They would make an arrangement with the patient prior to the event. As part of the role, they will need to make an effective plan with the patient so they know what is going on.

Hon NICK GOIRAN: Clause 104 refers only to the return of a prescribed substance for disposal when a self-administration decision is revoked or the patient has died. What about the circumstance in which the patient loses decision-making capacity but remains in possession of the prescribed substance? How will that be dealt with and provided for in this bill?

Hon STEPHEN DAWSON: In that case, the contact person can contact the coordinating practitioner or the board, and the CEO can work out how to retrieve the substance.

Hon NICK GOIRAN: Is there some sort of power of seizure that would enable the CEO to direct somebody to go to the premises and seize the substance on the grounds that the person has lost decision-making capacity?

Hon STEPHEN DAWSON: Section 103 of the Medicines and Poisons Act 2014 allows for it to be seized.

Clause put and passed.

Clause 105: Recording, use or disclosure of information —

Hon NICK GOIRAN: Clause 105(2) sets out an exhaustive list of occasions when recording, using or disclosing information will be lawful. What are the unlawful occasions that will be captured by clause 105(1) that are not allowed for by virtue of clause 105(2)?

Hon STEPHEN DAWSON: An example of that is that an officer employed by the board cannot disclose confidential information that is received by the board and accessed in his role.

Hon NICK GOIRAN: The minister will see that clause 105(2)(f)(ii) empowers an administrator of the estate to authorise the disclosure of information. Would that person need to have obtained letters of administration before being able to make use of the power; and, if so, are there any circumstances in which that person would need to disclose such information to obtain the letters of administration in the first place?

Hon STEPHEN DAWSON: I am advised that yes, letters of administration would need to be obtained, but there would be no need to disclose such information.

Clause put and passed.

Extracted from finalised Hansard
Clause 106: Publication of personal information concerning proceeding before Tribunal —

Hon NICK GOIRAN: In response to some answers yesterday, the minister indicated that it was apparent that there had been quite a bit of consultation between the government and the president of the State Administrative Tribunal, so I take it that the tribunal has been consulted about clause 106. Be that as it may, if the tribunal uncovers some mischief during a proceeding under part 5, how will it report or deal with that information if clause 106 remains in its current form?

Hon STEPHEN DAWSON: Under clause 95(2)(f) the board gets a copy of the reasons for the decision and, further, under clause 96(2), it can disclose that personal information in those reasons.

Hon NICK GOIRAN: I move —

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;

Hon STEPHEN DAWSON: The government accepts this amendment for reasons that were given in the discussion on amendment 475/96.

Amendment put and passed.

Hon NICK GOIRAN: I move —

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.

Hon STEPHEN DAWSON: Again, the government supports this amendment. Reasons were given when a similar amendment was moved at 476/96. For the very same reasons, we support it.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 107: Failure to give form to Board —

Hon NICK GOIRAN: What defences would be available to a person charged with a clause 107 offence?

Hon STEPHEN DAWSON: The normal Criminal Code defences in chapter V would apply; for example, incapacity. I am further advised that clause 113(2) of this bill may also provide protection from criminal liability under the act. I was not clear that the amendments at 47/107, 48/107 and 452/107 were not being moved. I have an amendment at 406/107. This amendment will mean that there will not be a $10 000 penalty for a medical practitioner who fails to report a first request to the board. This amendment follows from medical practitioners that doctors who were otherwise ineligible to participate, or inexperienced doctors, such as junior doctors, could inadvertently fail to lodge a first request form; however, the practitioner can still be held accountable via clause 10 of the bill. Contravention of the act is capable of constituting professional misconduct and unprofessional conduct. The government considers this to be a good amendment and obviously I support it. I move —

Page 70, after line 27, the table, the first row, the first column — To delete —
s. 21(1)

Hon NICK GOIRAN: I support this amendment—the fiftieth that will be agreed to by this chamber on this bill that we were told required no further consideration; no amendments needed. That is not the only reason I support it. Members may recall that when we were first considering this alleged perfect bill I indicated that it was totally over the top. I put on the Hansard record several times during the consideration of that particular clause that it was totally over the top to ask a medical practitioner to have to supply a form to a board about a first request and then say to them, “By the way, if you do not do that within two days, you will be fined $10 000”, including when the bill states that the person is not available. I am grateful that commonsense has prevailed, and this amendment has my full support.

Hon STEPHEN DAWSON: I want to make it clear, because Hon Nick Goiran has reminded us of amendments having passed this place thus far, that I have always made it clear in this place that I would give consideration to proposed amendments. We have listened to all members in this place and, indeed, stakeholders like the Australian Medical Association. The government has engaged with them about their genuine concerns. I have no problem moving amendments if I believe they are beneficial to the bill. As I said, that is consistent with my point during this lengthy consideration of the bill.

Hon NICK GOIRAN: I take no issue whatsoever with the conduct of this minister, who has been exemplary in the handling of a difficult and lengthy debate. However, I put on the record that that type of approach has not been shared by the Premier who said that anyone who wants to suggest amendments will be wrecking the bill. “Wrecking” has been used repeatedly in the public domain by that individual who has been intemperate in his remarks. I simply make the point that this will be the fiftieth—five-zero—amendment that has been passed by the chamber.

Amendment put and passed.

Clause, as amended, put and passed.

Extracted from finalised Hansard
Clause 108: Application of *Medicines and Poisons Act 2014* Part 7 —

Hon NICK GOIRAN: Clause 108 is complex for even the most experienced of legislators. Clause 108(6) states that section 101 of the Medicines and Poisons Act “is to be read as if section 101(1)(a) and (2) were deleted”. I note that, in effect, the government is asking us to agree to obliterate the majority of the provisions in section 101 of the Medicines and Poisons Act. At the moment, section 101 of the Medicines and Poisons Act states —

(1) An investigation may be carried out for either or both of the following purposes —

(a) monitoring whether this Act is being complied with;

We are taking that out —

(b) investigating a suspected contravention of this Act.

(2) The regulations may make provision relating to the procedures to be followed by investigators when carrying out functions under this Act.

In those circumstances, why will investigations be unable to be carried out for the purpose of monitoring whether the voluntary assisted dying act is being complied with?

Hon STEPHEN DAWSON: I am told that it highlights the delineation of the role of the Voluntary Assisted Dying Board and that of the CEO of the Department of Health. The latter will have the investigative role and the board will have the monitoring role for this bill.

Committee interrupted, pursuant to standing orders.

[page 9805]

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Martin Aldridge) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 108: Application of *Medicines and Poisons Act 2014* Part 7 —

Committee was interrupted after the clause had been partly considered.

Hon NICK GOIRAN: Clause 108 sets out quite a raft of modifications to the Medicines and Poisons Act 2014, particularly part 7. Can the minister table some form of schedule or document that sets out exactly what we are agreeing to at clause 108? As I say, the way it is drafted may well be concise but it is incredibly unhelpful for the reader. As the minister will appreciate, for example, clause 108(6), states that section 101 of the Medicines and Poisons Act is to be read as if section 101(1)(a) and subsection (2) were deleted. One has to go on an excursion—a little like a needle in a haystack—to find out exactly what all the provisions state, what has been deleted, what is to be read in and what is to be replaced. Surely somebody in government must have a schedule that sets out exactly what we are agreeing to in clause 108. Does such a schedule or document exist and, if it does, can it be tabled?

Hon STEPHEN DAWSON: Such a schedule or table does not exist, but I am advised that a table will be provided during the implementation phase to help those who need to navigate this clause.

Hon NICK GOIRAN: I think it is reasonable to assume that someone in Parliamentary Counsel’s Office had something at their disposal on this during the drafting process. For instance, subclause (5) states —

Section 95(1) is to be read as if section 95(1)(c) were deleted.

When somebody was doing the drafting, they must have uplifted part 7 of the Medicines and Poisons Act and would have prepared some form of document and got some instructions on it. In fact, if that was not the case, it means that no-one has turned their mind to clause 108. I doubt very much that everyone in cabinet, everyone in caucus or everyone in the other place have spent time looking through clause 108 and reconciled it with the Medicines and Poisons Act. I acknowledge that the minister said a document would be prepared during the implementation phase. Would it be possible for it to be tabled by the end of this week?

Hon STEPHEN DAWSON: I am told, honourable member, that one does not exist. Drafting instructions were given to Parliamentary Counsel’s Office and this was drafted as a result of those instructions, but no table, schedule or list was provided. I have asked the question, but I do not believe it can be provided by the end of the week.

Hon NICK GOIRAN: I will conclude on this point, minister: it troubles me that clause 108 is in the form it is in. It would be useful at the very least, if nothing else happens from this exercise, that some instruction, direction or advice could be given to parliamentary counsel to say that in future, yes, by all means, if it is the drafting convention to draft a clause like this, so be it, but it should be accompanied with something superior, whether it be in the explanatory memorandum or some other document that can be made available to members. I very much have my doubts that 95 legislators in Western Australia have reconciled all the provisions in clause 108. In the absence of doing that, we are, effectively, agreeing to a new part of the law blind. That is not acceptable lawmaking. I recognise that if no document is available, so be it. If it is not possible to table it by the end of the week, could it be tabled by the first sitting day on the resumption in 2020?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: I am advised the work is not scheduled to be done until the implementation phase of the bill. I have some sympathy with the view the honourable member has expressed and I will certainly take his suggestion forward and bring it to the attention of the Attorney General, who is the most appropriate person. A few views have been brought to my attention about the drafting during the consideration of the bill and they will also be passed on.

Clause put and passed.

Clause 109: Court to notify CEO of conviction of offence under Act —

Hon NICK GOIRAN: Minister, what is the CEO expected to do when in receipt of notification of a conviction and a penalty imposed?

Hon STEPHEN DAWSON: It is important for the CEO 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.

Clause put and passed.

Clause 110: Who may commence proceedings for simple offence —

Hon NICK GOIRAN: Why can a prosecution for a simple offence under this act be commenced only by the CEO or a person authorised by the CEO to do so?

Hon STEPHEN DAWSON: This is consistent with the Medicines and Poisons Act under which the CEO or delegate is primarily the decision-maker for prosecutions. The Medicines and Poisons Regulations Branch conducts the investigative work and then makes a prosecution recommendation to the CEO or delegate in accordance with section 122 of the Medicines and Poisons Act.

Hon NICK GOIRAN: Would anything in this clause therefore prohibit the WA Police Force from commencing a prosecution?

Hon STEPHEN DAWSON: The CEO of Health may authorise the WA Police Force to commence a prosecution for a simple offence.

Hon NICK GOIRAN: Would the WA Police Force be able to initiate a prosecution on its own initiative?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: I find that unacceptable because we are talking here about something very serious and very significant. The minister has repeatedly said so himself over the course of this debate. Now we are saying that the WA Police Force is prohibited from commencing a prosecution. Prosecutions on a serious matter to do with voluntary assisted dying should not be at the whim of just the CEO of the Department of Health. If the Commissioner of Police in Western Australia, whose primary duty it is to enforce the laws of our state, considers that an offence has occurred, he should be able to commence a prosecution. I note that the minister indicated that this is consistent with, I think, the Medicines and Poisons Act or some other provision. Under the other act that the minister referred to, is it the case that the WA Police Force is not able to commence a prosecution unless the CEO authorises it to do so, and is this the first time that that would be the case?

Hon STEPHEN DAWSON: I am told that the WA Police Force is currently authorised by the CEO for the purposes of the Medicines and Poisons Act 2014. Authorisation is required only for the prosecution of simple offences.

Hon NICK GOIRAN: Does that mean that the WA Police Force will be able to commence proceedings for a simple offence under this act by virtue of that existing authorisation, or will a new authorisation need to be provided?

Hon STEPHEN DAWSON: The CEO would need to issue a new authorisation.

Hon NICK GOIRAN: Is it the intention of government to ensure that the CEO provides such an authorisation?

Hon STEPHEN DAWSON: I am advised that it will be discussed between the CEO and the WA Police Force during the implementation phase.

Hon NICK GOIRAN: I reiterate that I find that unacceptable. The CEO had better authorise the WA Police Force to do so, because otherwise I can imagine we will be spending plenty of time investigating this matter as a Parliament moving forward. I do not even agree with voluntary assisted dying in the first place, let alone to the CEO of health deciding who is or is not to be prosecuted. That is the trouble with the WA Police Force. If the CEO referred to in clause 110 was a reference to the Commissioner of Police, I would have no issue with this but it is the CEO from the Department of Health—no disrespect to the current incumbent whatsoever, who is a fine upstanding public servant—and that is not his primary role, responsibility or duty. I trust that this matter will be addressed in the implementation phase. If it is not, as I say, I will certainly take this matter up in the coming year. I also note the provision under clause 162 to review the act. If by that stage we still find ourselves in the untenable situation that WA police is not able to commence prosecutions for simple offences, I trust whoever is responsible for conducting that review under clause 162 will have sufficient pride in their own professional work to make sure that they address this issue.

Clause put and passed.
Clause 111: Time limit for prosecution of simple offence —

Hon NICK GOIRAN: Why is a time limit deemed necessary for the prosecution of a simple offence under this legislation?

Hon STEPHEN DAWSON: I am advised that this time limit is consistent with the Western Australian Medicines and Poisons Act 2014.

Hon NICK GOIRAN: Why is it not necessary for the prosecution notice to contain particulars of the day on which the offence is alleged to have been committed under clause 111(2)(b)?

Hon STEPHEN DAWSON: Again, this is consistent with section 123 of the Medicines and Poisons Act.

Clause put and passed.

Clause 112: Protection for persons assisting access to voluntary assisted dying or present when substance administered —

Hon NICK GOIRAN: The eighth of the fundamental legislative scrutiny principles routinely used by the Standing Committee on Legislation when considering bills asks whether a bill confers immunity from proceeding or prosecution without adequate justification. In light of that, why is this clause deemed necessary for inclusion?

Hon STEPHEN DAWSON: These provisions are consistent with the protections in the Victorian Voluntary Assisted Dying Act and section 133 of the Western Australian Medicines and Poisons Act 2014, and the protection provided to persons providing surgical or medical treatment including palliative care under section 259 of the WA Criminal Code. It was felt important to have a clear statement in the act that people are protected.

Hon NICK GOIRAN: The explanatory memorandum states that without this clause, a person might commit a criminal offence by assisting a person or being present when a person self-administers or is administered a prescribed substance. What criminal offence might a person commit by being present when a person self-administers or is administered a prescribed substance?

Hon STEPHEN DAWSON: The offence that might be committed is assisting a person to kill themselves, which is at section 288 of the Criminal Code.

Hon NICK GOIRAN: It is interesting that the only thing that would change whether a person is assisting a person to kill themselves is clause 112. If I understand it correctly, without clause 112, a person would be assisting a person to kill themselves. Have I understood that correctly?

Hon STEPHEN DAWSON: People may fear that they might be prosecuted and this is to give them some comfort that they will not be.

Hon NICK GOIRAN: How does one establish whether the assistance was provided in good faith in order for the person to be availed of these protections from criminal liability?

Hon STEPHEN DAWSON: What will be required for something to be done or omitted in good faith may vary from one case to the next, so it will be for a court to determine whether something was done in good faith.

Hon ADELE FARINA: In the example that I gave earlier today and yesterday about a family member or carer assisting the patient to prepare the substance, would this provide a defence to the carer or the family member?

Hon STEPHEN DAWSON: If the person is authorised to prepare the substance, this would protect them; if they are not, it would not protect them.

Clause put and passed.

Clause 113: Protection for persons acting in accordance with Act —

Hon NICK GOIRAN: Does this clause provide that as long as the coordinating practitioner or consulting practitioner acts in good faith, they will be protected from all civil and criminal liability for their actions and omissions, even if those acts or omissions result in the wrongful death of their patient?

Hon STEPHEN DAWSON: It will provide protection from criminal liability under the Voluntary Assisted Dying Act, and protection from civil liability under all legislation. It is important to note that the criminal liability protection will apply in relation to an offence under only the Voluntary Assisted Dying Act and not other legislation such as the Criminal Code.

Hon NICK GOIRAN: That was not my question. My question was: does this clause as it currently stands provide that as long as the practitioner acts in good faith—that is the only phrase that is in there at the moment; I note that the minister has an amendment standing in his name, but we have not got to that yet—they will be protected from all civil and criminal liability for their acts and omissions, even if those acts and omissions result in the wrongful death of their patient?

Hon STEPHEN DAWSON: The answer is no.

Hon NICK GOIRAN: In which case why does the minister need his amendment?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: I am going to speak to my proposed amendment at 407/113 on the supplementary notice paper, and perhaps I will move it at the same time. I move —

Page 74, line 12 — To delete “faith,” and substitute —

faith and with reasonable care and skill,

This proposed amendment specifically addresses 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 provides that negligent conduct will not be protected, but the amendment will make it explicit in the bill. This amendment has been included following consultation with the Australian Medical Association, and the government considers it to be a good amendment. 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 exempts a person from criminal liability if they do something with reasonable care and skill. As such, the proposed amendment reflects the language used in WA legislation.

Amendment put and passed.

Hon NICK GOIRAN: Minister, thank you for that amendment. It satisfies the concern that I had; that is, in effect, the practitioner just simply had to say, “I’ve acted in good faith and I’ve done certain thing in accordance with the act. I believe, on reasonable grounds, that I’ve done those things in accordance with the act and I’m shielded from any prosecution, whether civil or criminal or, indeed, professional misconduct and the like.” It is appropriate that we have now added the extra element that it is not good enough to simply say that a person is acting in good faith; they also have to demonstrate that they have reasonable care and skill. We cannot have unskilled, inept practitioners running around, providing voluntary assisted dying in Western Australia, with them saying that they are protected because they did all this in good faith. I congratulate the AMA for its advocacy on that amendment. Interestingly, clause 113, “Protection for persons acting in accordance with Act” is actually listed as safeguard 80 in the list of 102 alleged safeguards contained in the bill. Can the minister explain to us how the protections provided in clause 113 can be considered a safeguard against wrongful deaths under the bill?

Hon STEPHEN DAWSON: This provision provides protection only to persons—for example, doctors—who act in good faith with reasonable care and skill. It is an incentive to doctors who take reasonable care and skill.

Hon NICK GOIRAN: Just for the record, we know now that there are not 102 safeguards in the bill. When the government has prosecuted this fake narrative—not the minister, but others, particularly outside the chamber—that this bill has 102 safeguards, it is laughable when one of the safeguards is this one, clause 113, which has absolutely nothing to do with protecting the patient, but has to do with providing a shield for practitioners. As I always suspected, there are really only two safeguards in this bill, which are the two practitioners who have to sign-off on this.

Hon STEPHEN DAWSON: We will have to agree to disagree on that. We believe it is a safeguard and that list of 102 safeguards are about the bill.

Hon Nick Goiran: Not to the patient.

Hon STEPHEN DAWSON: I do not think anyone said necessarily that they are to the patient.

Clause, as amended, put and passed.

Clause 114: Protection for certain persons who do not administer lifesaving treatment —

Hon NICK GOIRAN: The explanatory memorandum assumes that in these circumstances the person will have made a voluntary, informed and enduring decision to die and the protected persons should not prevent this from occurring. The fact that someone will have administered, or have self-administered, a poison that causes their death, does not make it clear to the health practitioner, ambulance officer or other person with a duty to administer lifesaving treatment that this administration has taken place in accordance with this legislation. How is the health practitioner or ambulance officer or other person with a duty to administer lifesaving treatment supposed to know that the administration occurred in accordance with the act?

Hon STEPHEN DAWSON: Clause 114(2)(b) states “the protected person believes on reasonable grounds that the other person” et cetera. Therefore, if they believe on reasonable grounds, that is a protection.

Hon NICK GOIRAN: What should the health practitioner, ambulance officer or other person with a duty to administer lifesaving treatment do if they hold the belief on reasonable grounds that the other person did not have decision-making capacity to self-administer or capacity to consent to practitioner administration at the time the substance was administered?

Hon STEPHEN DAWSON: If they believe that to be the case, there is a duty to administer lifesaving care. This clause makes it clear that the ordinary obligations to provide life-sustaining treatment or clinically indicated medical treatments do not apply when the patient accesses voluntary assisted dying. The ordinary obligations do not override the process of self-administration of the substance authorised by the voluntary assisted dying scheme. If an ambulance officer or health practitioner believes the person lacked capacity, they cannot believe on reasonable grounds that the patient administration was in accordance with the act.
Hon NICK GOIRAN: What would happen if the administration had been in accordance with the act but the patient was experiencing complications? What would the person do in that situation?

Hon STEPHEN DAWSON: In that case, they could provide care and support to the patient.

Clause put and passed.

Clause 115: Board established —

Hon NICK GOIRAN: Have any other jurisdictions established a board to oversee the functions of their schemes?

Hon STEPHEN DAWSON: Victoria has a board under part 9 of its act. Some other jurisdictions have committees, but not boards.

Clause put and passed.

Clause 116: Status —

Hon NICK GOIRAN: What status, immunities and privileges of the Crown will be held by the board?

Hon STEPHEN DAWSON: I am looking for information for the honourable member, but while we seek it, I make the point that all boards that are established by statute have this provision. I will get information about what status, immunities and privileges it refers to.

I do not have an exhaustive list. I wonder whether I can give the member an example now and keep moving, if it is not pertinent to the member’s support of this clause. Perhaps I can provide the member with a list later in the evening. I can give the member the example of protection from civil liability or public interest immunity. I will leave it there and seek to provide a list to the member after dinner or later in the evening.

Clause put and passed.

Clause 117: Functions of Board —

Hon NICK GOIRAN: In Victoria, the website for the review board describes its review role as —

… reviews all assessments and forms submitted for voluntary assisted dying retrospectively.

Regarding the submission of forms to the board, in a number of places the explanatory memorandum states —

The intent of this provision is to ensure that the Board is notified progressively of the person’s participation in the voluntary assisted dying process, including the outcome of each assessment, to monitor that the correct process is being followed in each case of voluntary assisted dying …

That quote is from the explanatory memorandum on clause 60. Do I take it that the government means that each request and assessment process will be scrutinised before the death and that investigations will be triggered to prevent breaches of the act within the nine days or even shorter periods in some cases?

Sitting suspended from 6.00 to 7.00 pm

Hon SUE ELLERY: First, can I just provide some information to Hon Nick Goiran about the discussion that was going on during the previous clause, if the chamber will grant me that. The range of privileges and immunities at common law that would apply under clause 116 are immunity from being sued, immunity from coercive orders, immunity from execution, the right to withhold documents on the grounds of public interest immunity and priority of crown debts.

I now respond to the issues that were raised about the clause before us. The monitoring function of the VAD board has already been canvassed at several points during the debate in clauses 1, 8, 28, 32, 40, 45, 49, 50, 59 and 73, but essentially the board, supported by the secretariat, will monitor that the correct process is being followed. It is not the role of the board to contemporaneously clinically review each case, but to determine that the processes are being duly followed.

Hon NICK GOIRAN: Minister, is it the case then that the board will have the capacity, with those investigations, to intervene to prevent breaches of the legislation within the nine days in which some of these cases will be handled?

Hon SUE ELLERY: The board’s main functions will be advisory and monitoring in the areas of research and analysis, and collecting and maintaining statistical data, for example. It also has the power to refer. The board will not be an investigative body. It will not have an investigatory, a determinative or a punitive role. It will refer any issue related to voluntary assisted dying that it identifies as relevant to the function of a referral body. Those referral bodies are, for example, the Commissioner of Police, the Registrar of Births, Deaths and Marriages, the CEO of Health, the State Coroner, the Australian Health Practitioner Regulation Agency, the CEO of the prisons portfolio, and the director of the Health and Disability Services Complaints Office. The intent is to enable the board to refer any suspected contraventions of the legislation or other matters to the appropriate body.

Hon NICK GOIRAN: The Victorian legislation has additional section 93(1)(b), which states that the review board is —

to review the exercise of any function or power under this Act;

Why is this function not included for the WA board under clause 117?

Extracted from finalised Hansard
Hon SUE ELLERY: The honourable member is right to identify a difference between the legislation before us and the Victorian legislation. We have made a deliberate policy decision to have the board conduct the roles that I have already described—that is, monitoring and oversight of the functions. It will deliberately refer any investigations or reviews to other investigatory bodies. The member is right; there is a difference between the Western Australian model and what is in place in Victoria, but the policy decision made here was that the role of the board was best placed to be a monitoring, advisory and referral one, and if issues need to be further investigated or reviewed, they will be done so by the appropriate external bodies.

Hon NICK GOIRAN: We dealt with the distinction of the investigatory power on the earlier question. This question is about a specific section of the Victorian legislation, section 93(1)(b), which states—

to review the exercise of any function or power under this Act;

It has nothing to do with investigations, referrals or other elements. It is curious that that particular element of the Victorian legislation has not been included. If it is a deliberate decision of the government not to allow the board to review the exercise of any function or power under this legislation, who will do that task?

Hon SUE ELLERY: I will note a couple of things. Clause 117 states that the functions of the Voluntary Assisted Dying Board are—

(a) to monitor the operation of this Act;

(b) to provide to the Minister ... advice, information and reports on matters relating to the operation of this Act …

In doing that, it is anticipated that the board will provide advice to the minister on what it has found as a result of monitoring the operation of the act. Then, more generally, clause 162 outlines how the minister will review the act, which may well encompass a range of matters. The functions of the board include the monitoring of the operation of the act. If that is read in conjunction with clause 117(b), the board also provides advice. We believe that that encapsulates how the board will advise the government on how the act is operating.

Hon NICK GOIRAN: In what circumstances might the board see fit under clause 117(c)(ii) to refer a matter to the Registrar of Births, Deaths and Marriages, and what is the registrar expected to do once they receive that referral?

Hon SUE ELLERY: The chamber has already had a fairly extensive debate about the certification of death and what might or might not be recorded on the certificate. Births, deaths and marriages is included as a possible referral body because if the board is of the view that something needs to be brought to the attention of births, deaths and marriage, it would respond according to its own legislation, which is separate to what we are dealing with tonight.

Hon NICK GOIRAN: What is that type of thing that the board would refer? Obviously someone thought that it was sufficiently important to specify the Registrar of Births, Deaths and Marriages at paragraph (c)(ii). What is it anticipated that the board would need to refer to the registrar?

Hon SUE ELLERY: The relationship is around the certification of death. It would not be particularly helpful or appropriate for us to second-guess what might happen, but the relationship between the board and the registrar relates to certification. If the board thinks that something related to the certification needs to be brought to the attention of the Registrar of Births, Deaths and Marriages, this is the head of power that gives it that capacity. With the greatest respect, member, I do not know that it is helpful to second-guess what that might be. We know that the legal connection between the Registrar of Births, Deaths and Marriages and this legislation is based around certification.

Hon NICK GOIRAN: At one of the stakeholder round table consultations, the principal registrar from the Coroner’s Court identified a number of reasons why a death caused by voluntary assisted dying should be reported directly to the coroner. One of the reasons for that was the coroner already has in place the systems to ensure that an investigation could take place and that steps could be taken quickly to ensure that any post-mortem investigations were undertaken promptly. Why has the government chosen to ignore the advice of the coroner and opted instead for an optional board referral to the coroner?

Hon SUE ELLERY: In order to have the full context of this discussion, I need to refer to a provision in the bill to insert at clause 166 a consequential amendment to the Coroners Act. This is required to exempt deaths brought about by voluntary assisted dying, otherwise these deaths would fall within the definition of a reportable death and result in automatic involvement of the coroner. Deaths associated with voluntary assisted dying are, by their very nature, planned deaths as opposed to—

Hon Nick Goiran: Unexpected.

Hon SUE ELLERY: — unexpected deaths—thank you—that are automatically referred to the coroner. Referral to the coroner would occur if there was reason to believe that something had gone awry and it needed to be investigated. New clause 166, which we will get to eventually, provides that a death that occurs in accordance with the Voluntary Assisted Dying Act will not automatically be a reportable death under the Coroners Act 1997. The reference here to whom they can refer is related to that.

Extracted from finalised Hansard
Hon NICK GOIRAN: What mechanisms will be put in place to ensure that that referral that takes place under clause 117(c)(iii) takes place in sufficient time before the burial or cremation of the person’s body?

Hon SUE ELLERY: I am advised that there is not a locked-in, if you like, period of time within which it is anticipated the coroner will need to be advised that a decision has been made to refer; however, there have been discussions with the coroner already, and it is anticipated in the process of implementation that Health will work closely with the coroner to establish the correct protocols, the agreed protocols. That is how it panned out in Victoria. I am advised it was not a precise provision of the bill that things would happen within a specified period of time, but it was worked out as part of the implementation process. I am just getting notes furiously written, so bear with me. In the implementation phase there will certainly be stakeholder consultation and work between the board and the Coroner’s Court about the appropriate protocols and whether a time will be attached to that.

Hon NICK GOIRAN: In what circumstances might the board see fit to refer a matter to the CEO of the department of the public service principally assisting in the administration of the Prisons Act 1981, under clause 117(c)(v)?

Hon SUE ELLERY: This applies if the person who is exercising the choice for voluntary assisted dying is a prisoner and in the custody of the CEO of the prisons.

Hon NICK GOIRAN: In those circumstances why would the board need to refer anything to that CEO?

Hon SUE ELLERY: The honourable member will recall that a little bit earlier I said that we needed to consider this in conjunction with the changes we propose to make at clause 166. I have given the member an explanation about a discretionary referral, if you like, to the coroner; however, the note about clause 166 says that a death generally does not have to be reported to the coroner as a matter of course other than if the person was held in care immediately before their death. That means that the death of someone held in the care of the state will be automatically referred to the coroner. The cause the member referred to in clause 117(c)(v) relates to a person held in care in the prison—who is in the custody of the prison. To complete the information for the member, that is an automatic referral to the coroner, and the provisions in clause 166, which we will get to in due course, give effect to that.

Hon NICK GOIRAN: I notice that one thing that has not been listed in clause 117 is the function of the board to provide a notice of no objection to the coordinating practitioner with regard to the administration decision. What is the basis for the government’s decision to not give the board the role of providing a notice of no objection?

Hon SUE ELLERY: The no-objection provision is in effect a permit system, and the board must give the coordinating practitioner notice that it does or does not object. I am advised it was canvassed by some members in the debate on clause 1 on 22 November. We have taken the view that it is an extra bureaucratic layer that does not provide additional protection. We do not believe it will add any further safety, but it will cause delays to access for people. Express authorisations are built into the bill that further negate the need for a permit system or a no-objection system like that in Victoria. Those authorisations enable the various identified players to variously—these things have been canvassed broadly in the debate—receive, possess, prepare, supply, dispose or administer, for example, and the bill already enables the board to raise any concerns and refer matters for investigation, if it has concerns about the processes not being followed, as I outlined when we started this clause debate.

Clause put and passed.

Clause 118: Powers of Board —

Hon NICK GOIRAN: Does the board have the power to contact parties to the process, including the patient and the practitioners involved, to seek clarification about matters pertaining to the board’s monitoring of the operation of the act?

Hon SUE ELLERY: I draw the member’s attention to clause 149, which we are not at yet. That clause goes to requesting information, and reads —

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 any of its functions.

2. A person may comply with a request … despite any enactment that prohibits or restricts the disclosure of the information.

Clause put and passed.

Clause 119: Delegation by Board —

Hon NICK GOIRAN: In what circumstances does the government anticipate that board powers or duties may be referred to a member or committee?

Hon SUE ELLERY: This clause enables the board to delegate its power or duties to a member or a committee established under the bill. A delegated power is not further delegable. The delegation function is important to enable the continuity of service. The member asked for examples. For example, the board may simply delegate its function to notify a person from whom the board received a form that the form has been received, or the board may delegate its function to record and retain statistical information to a particular member or committee who specialises in statistics.

Clause put and passed.

Extracted from finalised Hansard
Clause 120: Staff and services —

Hon NICK GOIRAN: What “staff, services and facilities and other resources and support” does the government propose to provide the Voluntary Assisted Dying Board to perform its functions?

Hon SUE ELLERY: This is a standard clause for a number of boards under the Department of Health, and it ensures that the board will be able to access the administrative and other resources that it requires to properly execute its functions under the act. I am sure that resources will be allocated in the usual fashion. For example, there will need to be a secretariat that is resourced—that sort of thing.

Clause put and passed.

Clause 121: Assistance —

Hon NICK GOIRAN: Clause 121 indicates that the board can do something with the approval of the minister. Do any other board decisions require the approval of the minister?

Hon SUE ELLERY: I am advised that the answer is no. The member will notice that further on, clause 125 provides for the minister to designate one member of the board as the chair and another as the deputy chair. That is standard operating procedure; it is not really seeking approval for something.

Clause put and passed.

Clause 122: Minister may give directions —

Hon NICK GOIRAN: Clause 122 deals with circumstances in which the minister may give directions. Why is a direction about the performance of a function in relation to a particular person or matter prohibited from being given?

Hon SUE ELLERY: That is to ensure that there cannot be, if you like, political interference in a particular case, and that the role of the minister in issuing directions is around the broad functions and administration, but not about being able to intervene in a particular case.

Hon NICK GOIRAN: We heard earlier that the board did not have the capacity to intervene in a particular case, so it follows that the minister would not be able to either. Is there any other explanation of why clause 122(2) is needed?

Hon SUE ELLERY: I am advised that the purpose is to make it absolutely explicit.

Clause put and passed.

Clause 123: Minister to have access to information —

Hon NICK GOIRAN: Clause 123(3) states —

… the Minister is not entitled to have personal information about a person unless the person has consented to disclosure of the information.

Will this restriction remain post death?

Hon SUE ELLERY: I am advised that, if the person has died and thus cannot give consent, consent may be obtained by an executor or administrator of their estate, under clause 105(2)(f).

Hon NICK GOIRAN: Minister, if consent is not granted in those circumstances, including by way of an executor or administrator, can the document still be provided to the minister subject to any redactions?

Hon SUE ELLERY: The minister cannot be provided with individual information without consent. However, there might be a circumstance in which the board wants to provide to the minister information that shows perhaps a trend or some particular examples of something that went very right or something that went very wrong, so redacted information might be provided to the minister. The minister would not know whom it was from. It might include information about somebody, because statistical information or analytical research information was being provided to the minister, but the minister would not know whom that information was about. The only way the minister can get personal information that identifies the person and links that person with particular information is with the consent of the person before they pass away or as a result of consent from the executor or the administrator.

Hon NICK GOIRAN: Would the board have that personal information but the minister would not?

Hon SUE ELLERY: That is correct.

Hon NICK GOIRAN: The other point on clause 123 is that the member for Scarborough raised an issue at page 79, line 9. I will get the minister to take a look at page 79, line 9. The view of the member for Scarborough in debate in the other place was that the use of the word “person” should read “patient”. As we know, the attitude of government in the other place was very different from that of government in this place. No amendments were supported in the other place and we have passed 51 amendments in this place. What is the view of government regarding the use of the word “person” at page 79, line 9 instead of “patient”?

Extracted from finalised Hansard
Hon SUE ELLERY: A person in the context of clause 123(3) is any person, not just a person who may also be a patient exercising their choice around voluntary assisted dying. This might be any of the other people in the chain of the process.

Hon Nick Goiran: Like the doctor?

Hon SUE ELLERY: It could be a doctor; it could be a contact person; or it could be any other person whom the board would have information about. It is not necessarily about just a patient.

Clause put and passed.

Clause 124: Membership of Board —

Hon NICK GOIRAN: What knowledge and skills will be required and considered by the minister to make the appointment of the board members?

Hon SUE ELLERY: WA 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. There is no reason to apply a different approach to voluntary assisted dying. The minister will receive advice from the Department of Health about those whom the department considers competent to carry out those tasks, making sure that the board has the appropriate mix of skills and experience. Currently, the mechanism for people to put their name forward is a government portal called OnBoardWA. All appointments and reappointments that are established by statutes and that specify that appointments are to be made by the minister must be brought to cabinet. In Victoria, an ex-Chief Justice of the Supreme Court has been appointed as chair of its Voluntary Assisted Dying Review Board. That is the sort of status and insight we expect of the people who will serve on the board.

Clause put and passed.

Clause 125: Chairperson and deputy chairperson —

Hon NICK GOIRAN: What act or omission is contemplated by clause 125(3)?

Hon SUE ELLERY: I am advised that this is a provision that applies in other acts around the governance of boards. It essentially cements, if you like, the authority of the person acting as chair. Their authority to make decisions or to omit to do something cannot be challenged on the basis that they were not really the chairperson at the time. It seems to me to be a clumsy way of expressing it, but when I asked, I was advised that it is a standard form of words that appears elsewhere for governance arrangements for boards.

Clause put and passed.

Clause 126: Term of office —

Hon NICK GOIRAN: Is a board member eligible for indefinite appointments under clause 126(2)?

Hon SUE ELLERY: I am advised that nothing prevents that. That reappointment will be determined by the Minister for Health based on the performance of the board member and the needs of the board. Consideration will be given during the implementation stage to the staggering of board appointments. The member will appreciate that a board might appoint somebody for two years and others for three years so that it maintains a kind of continuity of corporate knowledge. The Department of Health considers it good practice for board appointments to be staggered to make sure that there is a rolling consistency of knowledge and experience.

Clause put and passed.

Clause 127: Casual vacancies —

Hon NICK GOIRAN: Does the minister need to provide written reasons for their decision to remove a member from office under clause 127(4); and, if yes, would those reasons be made publicly available?

Hon SUE ELLERY: There is nothing in this clause that requires the minister to—did the member say “publish”? 

Hon NICK GOIRAN: To provide written reasons for their decision.

Hon SUE ELLERY: To provide written reasons, no. The removal of a board member by the minister may occur if there is neglect, misconduct or incompetence. “Misconduct” is defined to include conduct that renders the member unfit to hold office as a member even though the conduct does not relate to a duty of that office. A board member may also be removed on grounds of mental or physical incapacity that is impairing the performance of the member’s duties or for absence without leave from three consecutive meetings of the board of which the member has had notice. I am advised that this clause is consistent with Western Australian practice and is considered essential for good governance. Nothing prescribes that the minister must provide written reasons; in some circumstances, indeed, if it went to personal circumstances of mental health or other personal reasons, one would expect that it might be prudent for the minister not to. Nothing precludes the minister from doing it; nothing requires the minister to do it.

Hon NICK GOIRAN: Further to that, nothing requires or precludes the minister from providing written reasons, but if there were written reasons, would they be made publicly available?

*Extracted from finalised Hansard*
Hon SUE ELLERY: Not automatically; not as a matter of course. It may be that it is appropriate, but it may also be that it is not appropriate.

Hon Nick Goiran: It would not be exempt from FOI.

Hon SUE ELLERY: No, it would not be exempt from FOI.

Clause put and passed.

Clause 128: Extension of term of office during vacancy —

Hon NICK GOIRAN: Is clause 128 consistent with other statutes setting out the parameters for officers appointed by a minister?

Hon SUE ELLERY: Yes, I am told that this is consistent with practice across the boards in Western Australia. Sorry, public boards in Western Australia.

Clause put and passed.

Clause 129: Alternate members —

Hon NICK GOIRAN: What acts or omissions are contemplated by clause 129(4)?

Hon SUE ELLERY: This is the same explanation that I gave to the question that the honourable member asked on clause 125(3). I may think that it is a clunky way of expressing it, but it is a standard provision. It means that anything that the alternate member does or does not do cannot be questioned on the basis that they were not an alternate member.

Clause put and passed.

Clause 130: Remuneration of members —

Hon NICK GOIRAN: What is intended to be the remuneration of the members of the Voluntary Assisted Dying Board?

Hon SUE ELLERY: The question was what the remuneration is expected to be. That will be developed in the implementation stage. The board will be subject to oversight by the Public Sector Commissioner and the Public Sector Management Act. The Public Sector Commissioner provides advice about the appropriate remuneration of any board. The commissioner forms a view on the level of obligation of board members, the time they would be required to be involved and their individual responsibilities. That advice is then provided to cabinet as part of the appointment process.

Clause put and passed.

Clause 131: Holding meetings —

Hon NICK GOIRAN: Under what circumstances might a special meeting be required to be called by the chairperson under clause 131(2); and, if a special meeting was called, how much notice would be required?

Hon SUE ELLERY: I am not going to be able to give the member specific examples because, like any board, special board meetings may be convened at any time by the chairperson —

Hon Nick Goiran: How much notice—a day; half a day; two days; a week?

Hon SUE ELLERY: — for a whole range of reasons. That is consistent with WA practice. On the implementation and the standing orders that the board might adopt to conduct its own affairs, I am advised that will be worked out during the implementation stage.

Hon NICK GOIRAN: Let us get some matters on the record now if it is going to be dealt with at the implementation phase. The problem here is we have a board that is going to be provided with information. When we asked about concerns previously, we were told that one mechanism is that the board could refer matters to the CEO. The CEO can carry out investigations, make referrals, start prosecutions and the like. All of those things are of no use to a patient who is being coerced or a patient who has lost decision-making capacity if that patient is now dead.

We know from an earlier debate that the normal time in which a voluntary assisted dying process can happen is as short as nine days. However, there is an express pathway that would allow for the process to happen as quickly as two days. If this provision says that a special meeting of the board may be convened by the chairperson at any time, but they need to give two or three days’ notice, for example, then that is hopeless for the person on the express pathway who is being taken advantage of. That is why I am raising this particular concern now. I understand the answer that the minister has given—that it will be looked at during the implementation phase—but for whoever is involved in the implementation phase, potentially even people in the chamber at the moment, I cannot emphasise enough how much we need to get this particular provision right. It is of no use to have a chairperson call a special meeting after a person is dead and, potentially, cremated or buried.

Hon SUE ELLERY: The honourable member is quite right; there are important functions to be carried out by the board, and those functions are at various points very timely. I am sure that in conducting its affairs and determining its own meeting procedures under clause 134, which we will get to in the minute, the board will need to develop a set of meeting procedures that allows it to meet the time requirements that from time to time will be more urgent than at other times.

Clause put and passed.
Clause 132: Quorum —
Hon NICK GOIRAN: Does the requirement set out at clause 132 meet with the standard board administration practised by government boards generally?
Hon SUE ELLERY: I am advised that yes, it does.
Hon NICK GOIRAN: To be clear, does that mean that on government boards a quorum is always three members?
Hon SUE ELLERY: This is standard when the board membership is five, so the quorum rate would depend on the size of the board.
Clause put and passed.
Clause 133: Presiding member —
Hon NICK GOIRAN: It is not clear to me why clause 133 is needed. If this clause were defeated or were not present, would this not be the case in any event?
Hon SUE ELLERY: I am advised that this is a standard provision that applies to other government boards and it makes it explicit that someone has to chair the meeting. It should be the chair or the deputy chair, but if they are not available, those present at the meeting must elect someone to act as the chair.
Clause put and passed.
Clause 134: Procedure at meetings —
Hon NICK GOIRAN: Rather than simply leaving meeting procedures to the board, is there not some sort of expected procedure for public sector boards and committee meetings that ought to be implemented?
Hon SUE ELLERY: I am advised that a—this is my word—mandatory set of board procedures is published and managed or advised by the Public Sector Commissioner. Then various boards, depending on their functions and roles that they carry out, can add to those specific provisions to meet their needs to carry out the functions under their particular statute.
Clause put and passed.
Clause 135: Voting —
Hon NICK GOIRAN: What matters pertaining to patient safety might the board be required to vote on?
Hon SUE ELLERY: I am not sure that we can be specific here. It is not anticipated that the board would function in a way that means it would vote on specific individual cases of individual patients. There might be a broader discussion about the form in which analysis is to be provided or whether it conducts a particular bit of research, and that matter might be subject to a vote. But I am not in a position to advise the member that the board will vote on these matters but it will not vote on those matters. I am not sure that any board functions like that. Most boards, if they are working well, will actually try to achieve consensus in decision-making, so I cannot tell the member that the board will be voting on the safety of a particular patient. It is not anticipated that that is the kind of thing that it would vote on.
Clause put and passed.
Clause 136: Holding meetings remotely —
Hon NICK GOIRAN: We have previously learnt that the intersection of federal law precludes some voluntary assisted dying conversations from taking place. What impact will this have on the board communications that occur via a carriage service?
Hon SUE ELLERY: The advice I have is that we do not expect that the commonwealth Criminal Code, and the particular sections to which the member referred, will have any application to the conduct of board meetings.
Clause put and passed.
Clause 137: Resolution without meeting —
Hon MARTIN ALDRIDGE: This clause states —
A resolution in writing signed or otherwise assented to in writing by each member has the same effect as if it had been passed at a meeting of the Board.
If an urgent matter arose that required the urgent consideration of the board, could it do what we do as committees, which is to agree to a circular resolution, say by email or even by a conference call, and have that resolution affirmed at the subsequent meeting of the board, whether that be remotely or not?
Hon SUE ELLERY: Essentially, the point of that clause is to allow resolutions to be reached without holding a meeting. That is just giving the head of power, if you like, for a resolution in writing signed or as otherwise assented to in writing by each member to have the same effect as if it had been passed at a meeting.
Hon MARTIN ALDRIDGE: “In writing” could be a reply to an email assenting to a particular resolution. Would that satisfy the requirement for it to be in writing?
Hon SUE ELLERY: I am advised, yes.

Extracted from finalised Hansard
Hon NICK GOIRAN: What types of resolutions are we talking about being made in this kind of context? The work of the Voluntary Assisted Dying Board is a matter of great seriousness and gravity and we need to make sure that the board is not left in a situation in which it is simply passing emails among each other when potentially it is a matter of life or death. What types of resolutions are we talking about? Are we looking to constrain the types of resolutions using this mechanism in comparison with more substantive ones?

Hon SUE ELLERY: There is not a prescription about what nature of things may be resolved without a meeting as opposed to others. Given the powers and responsibilities of the board, given the high expectations of the skills and experience that members of the board, the chair and deputy chair will bring to the board, it is anticipated that they will carry out their functions with the appropriate degree of gravitas that is required. However, there is no prescription before us that says that these kinds of matters may be resolved only in a physical meeting and these may not. It is about the board determining its own protocols about how it will deal with matters and carrying out its functions with the appropriate level of gravitas.

 Clause put and passed.

Clause 138: Minutes —

Hon NICK GOIRAN: Will the board minutes be made public?

Hon SUE ELLERY: I am advised that minutes would not, as a matter of course, be made available. They may well be subject to freedom of information requests. However, it is likely that if they were released under FOI, they would be redacted so that any personal information was not released.

Hon NICK GOIRAN: That is a darn sight better than the secret minutes of the Joint Select Committee on End of Life Choices.

Hon Sue Ellery: Fell into that, didn’t I!

Hon NICK GOIRAN: Better than that, at least that inquiry kept minutes, unlike the ministerial expert panel, which we were told could not even be bothered to keep minutes. I am pleased to see that a matter as serious as this will be treated accordingly by the board.

 Clause put and passed.

Clause 139: Disclosure of material personal interest —

Hon NICK GOIRAN: What would be considered a material personal interest in a matter being considered by the Voluntary Assisted Dying Board?

Hon SUE ELLERY: There is no legislative definition of the term “material personal interest”. The concept originates from Corporations Law and is espoused through common law. Material personal interest exists if the relevant interest is material; that is, the interest needs to be of some substance or value, rather than merely a slight, low-value or trivial interest. The materiality of an interest will depend on the particular circumstances of each case. It will be a matter of judgement for each member to determine. Any interest that has the capacity to influence the vote of a member is material, regardless of how it arises. A personal interest means that the interest must be an interest of the member themselves and not the general public, nor an interest of another person. It will not be personal if it is an interest of someone else only. The interest may not be personal if it affects the member as part of a wide group or class and in the same manner and to the same degree that affects the other members of the group or class, such as ordinary shareholders in a company. With respect to money, the interest need not be pecuniary. A member who fails to disclose a material personal interest commits an offence. There is a maximum penalty of $10 000 for that. That is a penalty in common in recent WA legislation for an offence of this type. The disclosure must be minuted. If the disclosure relates to a matter that is included in the annual report, the annual report must include details of any disclosure under this clause.

Hon NICK GOIRAN: Would membership in an organisation—for example, Dying with Dignity Western Australia—be considered a sufficient conflict worthy of disclosure?

Hon SUE ELLERY: I advise the chamber that essentially any interest that has the capacity to influence a member’s vote is material regardless of how it arises, but that will be a judgement for each member to make for themselves.

 Clause put and passed.

Clause 140: Voting by interested member —

Hon NICK GOIRAN: Would a breach of clause 140 be capable of investigation by the Corruption and Crime Commission?

Hon SUE ELLERY: If the person is holding a public office that fits within the definition of the CCC provisions, potentially that is the case.

Hon NICK GOIRAN: Is membership of the board sufficient to capture the member?

Hon SUE ELLERY: I do not have the CCC act in front of me. I just said that if they met the definition of a “public officer” under the CCC provisions then, potentially, yes, that is possible.

Extracted from finalised Hansard
Hon NICK GOIRAN: If it is not capable of being investigated by the CCC, who would have the capacity to do that investigation?

Hon SUE ELLERY: It may be captured by the CCC but if it is not, the Public Sector Commissioner might also have a role.

Clause put and passed.

Clause 141: Section 140 may be declared inapplicable —

Hon NICK GOIRAN: Will the minister with the carriage of the Voluntary Assisted Dying Act 2019, as it will be called, have oversight of, or any power to, overrule a decision to allow a member to vote on a matter on which they hold a material personal interest?

Hon SUE ELLERY: Yes. Clause 143 sets out the provisions in which the minister may in writing declare that section 140 or section 142 or both of them do not apply to a specified matter either generally or in voting on particular resolutions.

Hon NICK GOIRAN: We will get to clause 143 in a moment. My understanding of that particular provision is that it tries to set aside the provisions set out here and that would be in order for the minister to say that the board does not need to worry about dealing with that particular situation. Rather, what we are talking about here is the minister being concerned about some mischief and they want to override or overrule a decision and say that member of the board cannot participate in this particular instance because they hold a material personal interest. I think that is different from clause 143.

Hon Sue Ellery: I think you might be right.

Hon NICK GOIRAN: Does the minister have some other power to intervene in that situation?

Hon SUE ELLERY: I am advised no. If it helps the chamber, effectively clause 140 provides that if a person has a material interest, they must not vote. Clause 141 provides that the rule that states that the person must not vote does not apply if the person disclosed it and the board has passed a resolution that said about that particular declared interest that it is so trivial it does not matter. Hon Nick Goiran questioned whether the minister has the power to override that. I am advised the minister does not.

Hon AARON STONEHOUSE: To clarify, in the vote that would take place under proposed section 140, would the member with a conflict of interest be able to vote to overrule proposed section 140?

Hon SUE ELLERY: I take the member back to clause 140(1)(a). The person with the material interest must not vote and must not be present when that matter is being considered.

Hon Aaron Stonehouse: That would exclude them from voting under clause 141.

Hon SUE ELLERY: Yes, because it is about them and their particular interest.

Clause put and passed.

Clause 142: Quorum where s. 140 applies —

Hon NICK GOIRAN: Why is it necessary to reduce the quorum when a member is disqualified from voting on a matter due to a material personal interest? Could not the agenda item in question be laid down for later consideration when a quorum of three or more is present?

Hon SUE ELLERY: The honourable member himself pointed out that the nature of the board’s work will be critically time linked from time to time and it will not want to put off a decision that needs to be made quickly. Clause 142 allows for an exception to the general provision of a quorum of three. That method will ensure that the board can continue to function in what might be exceptional or rare circumstances. It is a common and standard approach to maintain the functions of the board, but I guess of particular relevance here is that the board needs to make time-related decisions and we do not want it to lose a quorum and therefore not be able to make those decisions.

Clause put and passed.

Clause 143: Minister may declare s. 140 and 142 inapplicable —

Hon NICK GOIRAN: Will a copy of the minister’s declaration under clause 143(1), which is required under clause 143(2) to be laid before each house of Parliament within 14 sitting days of the house after the declaration is made include the minister’s reason for the declaration and will it be considered a disallowable instrument?

Hon SUE ELLERY: I am advised that the nature of the material that will be tabled will not be a disallowable instrument. The minister’s declaration may include reasons; there is nothing in the bill that requires them to provide reasons. The provision that the declaration must be laid before the house within 14 days is consistent with WA practice and good governance. It is likely to occur when the minister has come to the view that a potential material interest is not a material interest but it is appropriate that there be transparency about that matter.

Hon NICK GOIRAN: Is clause 143 a Henry VIII clause?

Extracted from finalised Hansard
Hon SUE ELLERY: I do not see how it is. It lays the declaration before the chamber; it does not take any power away from the Parliament. I do not think it fits into the category of a Henry VIII clause at all. It is about informing Parliament and maintaining transparency; it is not about the delegation of decision-making.

Hon NICK GOIRAN: I am not concerned about the laying of the declaration on the table of the Parliament; that is an excellent transparency measure. I am concerned about clause 143(1) under which the minister can eliminate two sections of Western Australian statutory law—that is, sections 140 and 142. The minister, by way of edict—the bill refers to it as a written declaration—much like a Henry VIII clause, can come along with a pen and say, “Sorry, I’ve decided that sections 140 and 142 no longer apply.” Clause 143(1) is the provision in question.

Hon SUE ELLERY: I guess it is arguable; the honourable member might want to argue that. The fact that the decision made by the minister is laid before the Parliament is not normally a function of what constitutes the pure definition of a Henry VIII clause. In fact, the Parliament is being advised of the decision-making in this clause.

Hon NICK GOIRAN: So far I agree with the minister. The final point of contention is that I think the minister advised the chamber that it is not a disallowable instrument. Here we have a Henry VIII clause that allows the minister to decide that the law does not apply anymore because he or she has declared that sections 140 and 142 can be tossed away. He or she will let Parliament know, and that is where it stops; the Parliament has no power to do anything at that point. I would have thought that this is a concern. I suspect it would have been picked up had this bill been referred to the Standing Committee on Legislation, as originally suggested by Hon Rick Mazza. That decision has now been made, but is this something that the government is willing to take a closer look at? I realise that it is unlikely to do so at 8.30 pm on 4 December, given the Premier’s enthusiasm for this bill to pass before Christmas, but a full and comprehensive explanation to the chamber is needed about clause 143.

Hon SUE ELLERY: I have made the point that it is arguable that it is a Henry VIII clause. I do not think it is arguable that it is a pure Henry VIII clause because a component of it advises the chamber of the decision-making. We can have an argument about whether or not it is a Henry VIII clause, but the government believes that the provisions are an important part of the governance arrangements around the board, and we want to proceed with the provision before us.

Hon AARON STONEHOUSE: It concerns me that this clause grants a minister the power to unilaterally decide that parts of a statute do not apply. It seems to me that that would fit the definition of delegating legislative power to a minister without the ability to disallow. Members can call that what they like, but it is a delegation of legislative power without the ability for Parliament to claw back that power through disallowance. In any case, I am concerned about the effectiveness of section 143(2) as a transparency measure. I understand that a certain level of information may or may not be provided in that tabled declaration, but if that serves as perhaps a notice to Parliament that a declaration has been made, Parliament does not know the circumstances under which it was made. What information is retained by the minister or the board that might be subject to a freedom of information application, so that if a declaration is tabled, future Parliaments may know what to look for?

Hon SUE ELLERY: I have already outlined to the chamber in a couple of instances since I have been at the table the information that will be held by the board and be FOI-able. As long as it does not include identifying information of persons who cannot give their consent for the release of that information, the documents held by the board are FOI-able.

Hon AARON STONEHOUSE: Presumably, there would not be an official request form, but correspondence between the board and the minister would be FOI-able, and the minutes might make mention of the circumstances, and that information would probably be sanitised or —

Hon Sue Ellery: Redacted.

Hon AARON STONEHOUSE: — redacted, and that would be FOI-able. That is all I wanted to clarify.

Clause put and passed.

Clause 144: Establishment of committees —

Hon NICK GOIRAN: Will the committee established under clause 144(1) have the same powers as the board in carrying out its functions?

Hon SUE ELLERY: Clause 119 canvasses the delegation of the board. Clause 119(1) states —

The Board may delegate any power or duty of the Board under another provision of this Act to a member or to a committee established under section 144.

The honourable member asked whether the committee will have the power of the board. It will depend on what it has been delegated to do.

Hon NICK GOIRAN: Will the committee also be considered an agent of the Crown with the status, immunities and privileges of the Crown?

Hon SUE ELLERY: I am advised that yes, it will, because the committee is effectively part of and captured by the board.

Extracted from finalised Hansard
Hon NICK GOIRAN: Yet clause 124 states —

The Board consists of 5 members appointed by the Minister.

Now we have committee members who may not necessarily include those five members of the board—they may include some members of the board, but not necessarily all of them—so I am not convinced by that response. Nevertheless, can the minister indicate whether the minister with the carriage of this act will have any oversight or input into the determinations and appointments made by the board under clause 144(3)?

Hon SUE ELLERY: The provisions of clause 144(3) outline that the board may determine the membership and appoint members of the board or other persons as it thinks fit to be members of a committee. There is a catch-all provision for what role the minister might have back at clause 122, and we talked about the minister being able to give written directions to the board as long as they were not about a particular case. Theoretically, the minister might be able to say to the board that he or she wants it to appoint X, Y or Z to a committee, but we anticipate that the board will establish its own subcommittees, as boards of this nature do, using its own pool of expertise to recruit people to provide it with information or to perform the functions it requires of the committee, and for the committee to report to the board so that any decisions are ultimately made by the board and not the committee.

Hon NICK GOIRAN: What exactly do we think these committees will do for the board? During the debate so far, we have learnt that really the board is an expert group at catching forms. It will receive a whole stack of forms far, we have learnt that really the board is an expert group at catching forms. It will receive a whole stack of forms. It is not abundantly clear what these committees will be needed for when the board has such a limited role. We know they are not going to be monitoring life, and we know they are not going to be investigating; they are going to be referring. What do we anticipate that these committees will be doing?

Hon SUE ELLERY: The committee could be about anything that the board determines that it needs advice on or that it needs a group to be working on concurrently to the board conducting its business. I appreciate the description by the honourable member that this board constitutes nothing more than an organisation to capture forms. With the greatest of respect, we will have to disagree on the value and importance of the board, because we consider it to be considerably more important than that. For example, the board could set up a committee to look at the best way to record statistics. It could set up a committee to look at best practice policy for supply mechanisms. It could set up committees to look at any range of matters, which is what good boards do across a range of areas in health practice.

Clause put and passed.

Clause 145: Directions to committee —

Hon NICK GOIRAN: Will the minister have any oversight of the directions given by the board to the committee under clause 145?

Hon SUE ELLERY: I will rely on the advice I provided to the chamber before about the establishment of committees. There is a catch-all provision at clause 122 that enables the minister to give direction to the board about a whole range of things, except particular cases. There is a power that the minister could exercise if they chose to, but this is about how the board conducts its subcommittees, which is standard practice for a whole range of boards that operate within the broad range of clinical spheres that Health deals with every day.

Clause put and passed.

Clause 146: Committee to determine own procedures —

Hon NICK GOIRAN: Would it not be more appropriate for all of the committee’s procedures to be approved by the board or, indeed, by the minister?

Hon SUE ELLERY: That is not the normal practice across a range of boards. This provision says “subject to any directions of the Board”. It would be a very strange board that, in establishing a committee, did not say what it wanted it to do, particularly in this area, which is such an important one and deals with matters of such gravitas. The member may form the view that it would be better to do it a different way, but we have done it this way. This is the standard way that many boards covering a range of matters in Health and elsewhere conduct their business.

Hon NICK GOIRAN: It may be standard practice of boards and committees, but this will be the first time in Western Australian history that we will have a board in place overseeing Western Australian lives being taken. The standard processes of boards and committees are not particularly satisfying in that context. I would have thought that given the seriousness of this matter, as the minister says, we would ensure that the highest levels and standards apply. I think that the minister should take responsibility for any directions provided to the committee rather than it being up to the committee to determine its own procedures, to say nothing of the board. There are two other options, the board or the minister, neither of which is being taken. We are simply letting the committee do as it pleases.

Clause put and passed.

The CHAIR: Members, I am delighted to announce the arrival of supplementary notice paper issue 20, which is now being distributed for your edification as we move to clause 147.

Extracted from finalised Hansard
Clause 147: Remuneration of committee members

Hon NICK GOIRAN: What appropriation has been earmarked for clause 147, “Remuneration of committee members”?

Hon SUE ELLERY: I will give the same advice I gave the honourable member in response to his question about the remuneration of board members. From time to time the minister may make a decision that remuneration and allowances ought to be paid, and the minister would do that on the recommendation of the Public Sector Commissioner.

Clause put and passed.

Clause 148: Board to send information to contact person for patient

Hon NICK GOIRAN: Clause 148 requires the board to send certain information to the contact person for the patient. As we learnt earlier today, the contact person has some pretty onerous responsibilities, including having to return the substance in the event that the patient has revoked their decision to self-administer and the poison is still at their home. The contact person must bring it to the authorised disposer. The other circumstance in which the contact person must do that is, of course, when the patient has died, if any substance has been left over. The contact person has some pretty heavy responsibilities, not the least of which is that, if they do not comply and return that within 14 days of the date of revocation—a date of revocation they may not even know of—they can be subject to a very significant penalty. I would have to go back to the relevant clause, but I think it was imprisonment for up to a year. In that context, what type of information are we looking to provide to the contact person under clause 148? Will the board provide information to the contact person on how to gain access to the premises to collect the unused or remaining prescribed poison? Will the board provide information to the contact person about who is an authorised disposer, and the contact details of those authorised disposers?

Hon SUE ELLERY: The information provided by the board will remind the contact person of their requirements under the act, to return any unused or remaining voluntary assisted dying substance to an authorised disposer. It will advise the contact person of the support services available to assist them to comply with their requirements and to provide them support in their role as a contact person. It will advise the contact person who the approved disposers are. Furthermore, a list of approved disposers will be publicly available on the department’s website. They will be encouraged to formulate a plan with the patient to ensure that they can discharge their responsibilities, and it would be anticipated that included in that plan would be the establishment of how they gain access to the house et cetera. Additional information may be identified during the implementation stage and during stakeholder consultations.

Hon ADELE FARINA: I move —

Page 86, after line 11 — To insert —

(aa) includes the name and contact details of the authorised supplier, and of the authorised disposer, based closest to where the patient resides; and

This is a very minor amendment. As we have heard already, one of the roles of the contact person is to dispose of any unused substance and to deliver it to the authorised disposer. The contact person may also need to collect the voluntary assisted dying substance from the authorised supplier, in which case they need to know where to go to do that. I understand from earlier discussions that the government intends that this information will be provided on the relevant website, and that is great, but throughout regional Western Australia, access to the internet is not all that reliable. Given that the board will already be providing the contact person with information under this clause, I suggest that we amend it so that we also ensure that the contact person is given the details of the closest authorised supplier and authorised disposer, just to make it easier for them to carry out their functions under the act.

Hon SUE ELLERY: I indicate that the government will not support this amendment. We think that it is unnecessarily prescriptive, and it does not add to the bill. The provisions that the honourable member has set out include that the information needs to be based closest to where the patient resides. That may not be relevant for a particular patient. It is too prescriptive. It is anticipated that during implementation the Department of Health will look at the preferred scope of information to be given to the contact person, and it may be that the best way to proceed is to have a list of authorised disposers; it may also be that the contact person would need information on more than one authorised supplier in the hub-and-spoke model as well.

Hon NICK GOIRAN: I have heard a few things over the course of this debate, but this is right up there. Seriously, how can we suggest that of the contact person who has, as I said earlier, a responsibility to return the poison back to the authorised disposer on pain of being jailed for a year if they do not do so within 14 days of the revocation? That is the context that we are operating in here, and now the minister is saying that it is too prescriptive for this board to tell the contact person the name and contact details of the authorised supplier and the authorised disposer based closest to where the patient resides. That is too prescriptive, and too onerous for the board. We do not want the board to be able to do that. The person is in jeopardy of going to jail for up to a year, in actual fact through no fault of their own, and there are two circumstances I give to the minister. The first is that they have never been told about the revocation anyway, but because of a provision that we have already agreed to earlier in the bill we say, “Too bad if you don’t know; you have to return the poison within 14 days of the revocation.” That is scenario number one. Scenario number two is that the patient has died and they cannot actually enter the premises. I have asked repeatedly in debate on previous clauses what
mechanisms and supports are going to be provided by the board to assist the contact person. We keep getting told that we are going to sort this out in the implementation phase, and we are told that the implementation phase is going to be at least 18 months, which is pretty ironic, given that the Premier keeps telling everybody that, if we do not pass this bill, for every day that it does not pass there is another person dying in agony, and yet he does not tell people that he needs at least another 18 months to put this whole program in place. All Hon Adele Farina is doing is saying that we should take a moment, while we are here on 4 December anyway, to make sure that the board actually has to tell the contact person the name and contact details of the authorised supplier. The authorised supplier is something that the government would have determined. As I recall, when Hon Stephen Dawson was in the chair, he indicated to us that the CEO would sort out all these things. The government decides who the authorised supplier is, and the authorised disposer, and all we are going to be doing is saying to the contact person that these are the two people who live closest to the patient. There is no obligation on the part of the contact person to use those particular people. They could go and use one of the other authorised disposers or suppliers in order to comply with their onerous requirements under this bill. Why would we seriously want to block that person from having that information? It makes no sense to me whatsoever, and I would ask the government to reconsider what is plainly a very sensible amendment.

Hon AARON STONEHOUSE: I would like to make an observation here. I take the Leader of the House’s point that it is a bit prescriptive, and if we take her at her word, that information like this might be included in the information provided to a contact person anyway, then this might unnecessarily narrow the information that is provided. However, the language used in proposed new paragraph (aa)—to include the name and contact details of the authorised supplier and the authorised disposer based closest to where the patient resides—is not exhaustive. It does not say that we cannot include, as was suggested by the Leader of the House, a list of all available suppliers. It just says that, at the very least, at a minimum, we must include that information based on the nearest one to where the patient resides. If it is the intention of the CEO during the implementation phase to provide a list or several options to a contact person with information provided to them under clause 148, perhaps at the top of that list it will have the nearest one to where the patient resides. I think that is absolutely appropriate. I do not think we really need to be too concerned that the new proposed paragraph (aa) is too prescriptive, because it is not exhaustive. It will not exclude any information. I think it is wholly appropriate that we make it clear here, in the primary legislation, that we want this information provided to a contact person.

Hon MARTIN ALDRIDGE: I am surprised that the government is opposing this amendment. I thought it would do no harm and certainly, in some regional and remote locations, it could actually do some good. The way I look at it is that we should not make the assumption that the contact person has been on this journey with the patient right the way through. They might not have been there for the first or second practitioner or the referring practitioner; they may not have received the information that the patient has received. The contact person may be mistakenly of the view that they can just pop down to the local pharmacy and fill the script when the patient is ready to receive the substance. Although it has not been determined yet, we have heard that there will be a hub-and-spoke model for distribution of the substance; it will not be done through community pharmacies. That is about as much information as we have received through Consideration of the Whole so far. In regional Western Australia, that could mean a day’s travel there and back to the authorised supplier to actually procure the drug. If the contact person has not given consideration to that fact, it could well put the patient in the position of being able to access the substance at a time of their choosing, or may well delay their access to the substance at a time of their choosing. Similar points have already been made about the disposal of the substance. I struggle to see how this amendment could cause harm and, indeed, I think there could be circumstances in which it could actually improve the information that is provided to a contact person at a potentially very late point in the process, when there is limited access to information.

Amendment thus negatived.
Hon NICK GOIRAN: Given that the chamber has, in its wisdom, decided that we do not want to prescribe this information, will the government in any event ensure that this information is provided by way of the implementation period?

Hon STEPHEN DAWSON: Yes, we will.

Hon NICK GOIRAN: I find it ironic that the government will ensure that it is provided, but we have just said that we will not do it, but let us press on. What support services will be available to assist the contact person to comply with the requirements referred to in clause 148(a)?

Hon STEPHEN DAWSON: The specifics will be determined in the implementation phase, but following consultation, honourable member.

Clause put and passed.

Clause 149: Request for information —

Hon NICK GOIRAN: Could a current or former medical practitioner of the patient disclose the patient’s medical record without consent due to clause 149(2)?

Hon STEPHEN DAWSON: They cannot be compelled. It would be up to the practitioner if the information was provided. Good medical practice, though, would be for approval to be sought from the patient, or, if the patient was deceased, from the next of kin or the executor.

Clause put and passed.

Clause 150: Disclosure of information —

Hon NICK GOIRAN: Why is the minister not listed at clause 150?

Hon STEPHEN DAWSON: The minister is listed at clause 123; therefore, the minister is not required to be listed here.

Hon NICK GOIRAN: Apart from the people listed at clause 150, and the minister at clause 123, is there any other clause in this bill or any section in any other act that would require or enable the board to provide or disclose information with regard to the performance of its functions?

Hon STEPHEN DAWSON: If I can speak to the intent of this clause, the purpose of this provision is to enable public authorities, researchers and educational bodies to either directly or indirectly assist agencies to improve the services that they provide to the WA community. Often if there is no express provision re information sharing, this becomes a point of contention between agencies. We wish to offset this issue by including an express provision. This clause will help the board to carry out its function of continuing to improve the legislation and the way it will operate. For example, information may need to be provided to disability services organisations or palliative care networks that are involved in the provision of services to people accessing the voluntary assisted dying process. It is simply to make sure that the board operates in a manner that will enable the continued improvement of the legislation.

Hon NICK GOIRAN: Minister, I support the list in clause 150; I have no objection to that. However, I want to make sure that we are clear about who else is able to obtain information from the board. The minister has identified a clause—I think it was 122 or something —

Hon Stephen Dawson: It was 123.

Hon NICK GOIRAN: — that provides that the minister is able to obtain information from the board. I will give the minister some examples. Could the tribunal obtain information from the board? Could the Supreme Court obtain information from the board? Could a house or a committee of Parliament obtain information from the board? Who, other than the people listed in clause 150, and the minister, are able to access information from the board?

Hon STEPHEN DAWSON: I am advised that the tribunal could, the Supreme Court could, and Parliament could.

Hon ADELE FARINA: I move the amendment standing in my name at 495/148, which I think should actually read 150.

The DEPUTY CHAIR: Thank you. It is a typo, but I think we will stay with the current reference.

Hon ADELE FARINA: I move —

Page 87, after line 2 — To insert —

(c) either House of Parliament or a committee of either House; or

(d) a joint committee of both Houses of Parliament.

Again, this is a very minor amendment. I am recommending it to put it beyond doubt that the board is able to provide information to Parliament. It is similar to a provision that exists in the Corruption and Crime Commission Act 2003 and other legislation, so there is no reason there should be any great objection to including it in this bill. This bill has a number of clauses that restrict the provision of information for a whole host of reasons—a whole host of good reasons—however, Parliament exists and it needs to scrutinise the activity of government agencies. In order to do that, it needs to gain access to that information. The purpose of this clause is to put the question beyond doubt.

Extracted from finalised Hansard
Hon MARTIN ALDRIDGE: I would like to ask a question about this amendment. I support the intent of what Hon Adele Farina is trying to do, but I want to reflect on clause 150, where this will be inserted, where it says, “the board may”. My concern is that if this amendment is supported, we will include in this list —

(c) either House of Parliament or a committee of either House; or
(d) a joint committee of both Houses of Parliament.

If “may” indicates a discretion that the board has, my concern would be us passing a bill that says the board has discretion as to whether to provide information to a house of Parliament, whereas I believe its current standing is that under parliamentary privilege, Parliament is entitled to that information, unless there is some reasonable explanation that it be denied that information. My concern would be that whilst understanding the intent, it would perhaps be asserting a position that we are giving the board some discretion to not provide information to a house of Parliament.

Hon STEPHEN DAWSON: Perhaps I can assist in saying that the government is not supportive of this amendment. It is our view that it is unnecessary to include in the bill the amendment proposed by Hon Adele Farina. It is the right and privilege of Parliament to seek and receive de-identified information from the board, and it is certainly intended that the board perform such a role. Clause 150 of the bill gives the board additional power to disclose information to address disclosure related issues, often by other agencies. It is noted that the provision on the disclosure of information in clause 105 does not apply to the disclosure of statistical or other information that is not personal information.

Hon ADELE FARINA: I apologise, I did not note the word “may”. I have been in the Chair and trying to run this with parliamentary counsel in between; it has been difficult. I seek leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause put and passed.

Clause 151: Board to record and retain statistical information —

Hon NICK GOIRAN: The information required to be recorded and retained under clause 151 is, in my view, grossly inadequate. To maintain records and statistical information on voluntary assisted dying, I wonder whether the following should also be required to be recorded and retained by the board: the qualifications of medical practitioners who have been a part of the process; how many times administration of the substance was carried out by a practitioner; how many referrals were made to specialists in relation to diagnosis; how many referrals were made to specialists in relation to prognosis; how many referrals were made to specialists in relation to decision-making capacity; how many referrals were made in relation to coercion; how many deaths were practitioner administered; how many were self-administered; of those deaths that were practitioner administered, how many of those deaths were administered by an authorised nurse practitioner; what was the gender of the patient; what was the ethnicity of the patient; and, the end-of-life concerns cited by the patient that formed the basis for their request for voluntary assisted dying. With regard to the last point, the concerns of the patient, I note that that is precisely what takes place in Oregon. Its list includes: losing autonomy; less able to engage in activities making life enjoyable; loss of dignity; losing control of bodily functions; a burden on family friends and caregivers; inadequate pain control; fear of inadequate pain control; financial implications of treatment both curative and non-curative; and, it should also indicate the number or percentage of patients who cite each of these concerns. During the implementation phase will the government require the board to record and retain this information?

Hon STEPHEN DAWSON: I am advised that statistics will be appropriately determined following consultation with end-of-life researchers.

Hon NICK GOIRAN: Do we have some of these end-of-life researchers in Western Australia? Are they a prevalent group or class of individuals? Do we have any names of these end-of-life researchers, or will we be going to Oregon or Victoria or some other jurisdiction to consult these people?

Hon STEPHEN DAWSON: I am advised that there are some in Western Australia, including one named Lorna Rosenwax, but there could be others.

Hon MARTIN ALDRIDGE: I move —

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;

I will be brief, because I have said a little about this at clause 4, regarding principles. This amendment links in with the amendment that was passed at clause 4. I remind members that we passed an amendment to include a new principle, which states —

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;

Extracted from finalised Hansard
“Regional resident” and “metropolitan region” are terms defined in clause 5 by subsequent amendments. This amendment would include a new paragraph (ba) under clause 151, which requires the board to record and retain statistical information and would go to, as the amendment is very self-explanatory — participation in the request and assessment process, and access to voluntary assisted dying, by patients who are regional residents;

Without speaking to the substance of that, I foreshadow that there will be further consequential amendments and reference to an amendment down the track at 498/154 on the supplementary notice paper, which refers to the information to be provided by the board in an annual report. I seek the support of members of the chamber. It is important that, having established the principle, regional residents—no matter where a person lives in Western Australia—have the right to access the voluntary assisted dying regime, and that should this bill pass, we would in turn support the view that we should collect statistical information and publish that information with regard to a person’s access to the scheme.

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment. It has always been the intent of 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. This will assist in the interpretation of the bill, whereby specific reference will be made to regional residents regarding collection of data by the Voluntary Assisted Dying Board.

Amendment put and passed.

Hon ADELE FARINA: I have a question on clause 151(2), which provides —

The Minister may give a written direction to the Board requiring it —

... (b) to include that statistical information in its report under section 154(1).

If the minister does not provide that direction, does that mean that the board will not provide that statistical information in its annual report?

Hon STEPHEN DAWSON: No; I am advised it does not mean that.

Hon NICK GOIRAN: Earlier during the passage of this bill, one of the 52 amendments that the chamber agreed to—52 more than what happened in the other place—was an amendment in the minister’s name referring to the method by which the substance was self-administered. Will the board be reporting on the prevalence of the methods used?

Hon STEPHEN DAWSON: We would expect so, honourable member.

Hon NICK GOIRAN: One of the other 52 amendments that the chamber agreed to—52 more than in the other place—related to the use of an interpreter. Will the board be keeping statistics on the prevalence of interpreters in respect of this matter?

Hon STEPHEN DAWSON: Yes, it will.

Hon NICK GOIRAN: An excellent amendment—one of the 52 excellent amendments passed by this chamber; 52 more than the other place—was moved by Hon Adele Farina. I do not have it readily to hand, minister, but my recollection of it was that we agreed that the board would get information about the complications that arise after a substance has been prescribed. I am looking at clause 60. It was an amendment that was subsequently amended—it was at 481/60. It related to the details of any complications arising from the administration of the prescribed substance. In light of that, will the board retain and report on complications?

Hon STEPHEN DAWSON: The board will set out what it will report on, in addition to what it is required to report on under the bill. In addition, the minister can give direction to the board.

Clause, as amended, put and passed.

Clause 152: Board to notify receipt of forms —

Hon ADELE FARINA: I have an amendment standing in my name on the supplementary notice paper at new clause 152A.

The DEPUTY CHAIR: We are not there yet. We are dealing with clause 152.

Hon NICK GOIRAN: Why is the board required to provide a copy of an authorised disposal form or a practitioner disposal form to the CEO? As I recall, the minister previously indicated that this would all be done on a central database.

Hon STEPHEN DAWSON: The form could be drawn from the database. An extract or a clear setting out of required information will be sufficient to constitute a form. The purpose is the clear provision of written information.

Clause put and passed.

Extracted from finalised Hansard
New clause 152A —

Hon ADELE FARINA: I move the amendment standing in my name at 496/NC152A.

The DEPUTY CHAIR: Hon Adele Farina has moved the amendment in her name on supplementary notice paper 139, issue 20, at 496/NC152A—at page 87, after line 29, to insert. It is quite long. Unless a member wants me to read it out, I do not propose to read the clause. I do not want to read it, so I do not need to read it.

Point of Order

Hon NICK GOIRAN: I think we have dealt with this once before in the course of this debate. There are a lot of people following the passage of this particular bill —

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, if you want me to read the clause, you can just ask me to read the clause.

Hon NICK GOIRAN: Yes.

Committee Resumed

The DEPUTY CHAIR: New clause 152A states —

Page 87, after line 29 — To insert —

152A. Notification of complications relating to use of voluntary assisted dying substance

(1) This section applies if —

(a) a patient self-administers or is administered a voluntary assisted dying substance in accordance with this Act; and

(b) the patient suffers an adverse reaction to the substance or there is otherwise a complication relating to the self-administration or administration of the substance.

(2) Any family member of the patient who is aware that the adverse reaction or complication occurred may notify the Board of the adverse reaction or complication.

(3) Any person who witnessed the adverse reaction or complication may notify the Board of the adverse reaction or complication.

(4) If the Board receives a notification under subsection (2) or (3), the Board must —

(a) investigate the matter; and

(b) if appropriate, do 1 or more of the following —

(i) refer the matter to a person or body referred to in section 117(c);

(ii) in order to avoid a recurrence of the adverse reaction or complication, make recommendations to the CEO for changes to the poisons that are voluntary assisted dying substances or the dosages in which voluntary assisted dying substances are used;

(iii) in order to avoid a recurrence of the adverse reaction or complication, develop or review guidelines to assist medical practitioners who prescribe voluntary assisted dying substances for patients.

Hon ADELE FARINA: Hon Nick Goiran was correct when he said that an amendment was moved to clause 60. It required, in the case of a practitioner-administered voluntary assisted dying substance, the medical practitioner to report and inform the board of any complications that may have arisen during that process. A similar amendment in relation to self-administration of the substance was not supported because of some complications with the clause. From all the research that has been done in other jurisdictions, we know that depending on the location, the year of data being looked at and the substance being prescribed that between five per cent and 17 per cent of people have complications from the self-administration process. They may have difficulty swallowing the voluntary assisted dying substance because it is very bitter, or they regurgitate the substance, which means that they are not absorbing enough for it to be effective. A range of other complications may occur. If we are doing the right thing by people who want to be involved in this process, it is critically important for us to ensure that we are collecting that data, constantly improving the system, learning from and evaluating what has happened and then making the appropriate amendments, be that a change to the substance or a change in the dosage. If we are not collecting that information, we cannot make those improvements, and we will continue to see a portion of the people who self-administer through the voluntary assisted dying process not having the pain-free and peaceful death that they understood they would get by ingesting the substance.

Members will remember that I raised the situation of David Prueitt in Oregon, who self-administered a voluntary assisted dying substance and went into a coma. Three days later, he came out of that coma. He was clearly very

*Extracted from finalised Hansard*
distressed about the fact that he had not died, which is what he intended. There was an outcry at the time and a demand for an investigation to find out exactly what happened. The Department of Human Services, which oversees the scheme in Oregon, replied that it did not have the power to investigate, so it would not investigate. Understandably, the public outcry continued because people wanted answers. In the end, I think the Board of Pharmacy decided to look at it. It was very limited in its scope of what it could look at. The only finding that it could bring was that 100 per cent of the prescribed drug was given to the patient, David Prueitt, and he ingested it all. The board felt that perhaps due to the fact that he had taken a laxative, that may have affected the absorption of the voluntary assisted dying substance. We want to learn from that evaluation so we can put something into the medical practice guidelines for voluntary assisted dying so that doctors are able to provide that information to patients and tell them the things they need to do for the process to be effective. Sadly, at this point, we do not have a means of collecting that data in the case of self-administration. The purpose of this amendment is to enable family members who witness the self-administration of the voluntary assisted dying substance to notify the board of any complications or adverse reactions, and then the board could undertake an investigation. In view of the minister’s earlier comments that the government does not want the board to have an investigative function—that concerns me because if we do not have that investigative function, we cannot learn and improve—I am prepared, if it makes this amendment more palatable for the government, to change the term to “preliminary investigation”. Someone has to collect the data and then decide who to refer it to.

Looking at all the agencies that are identified in the bill before us to whom the board may refer a complaint, it is hard for me to identify from that list who will undertake the investigation. Clause 117(c)(i) states that the board is able to refer a matter to the Commissioner of Police. In this case, no crime would have been committed, so the Commissioner of Police would not be interested. The Registrar of Births, Deaths and Marriages is also mentioned. Again, the matter would not be relevant to their interests. The clause also refers to the State Coroner. It will not be relevant to the State Coroner, particularly if the case was similar to that of David Prueitt, because he did not die. Then we have the chief executive officer of the department of the public service principally assisting in the administration of the Prisons Act 1981. That person is not relevant. We have the Australian Health Practitioner Regulation Agency. Again, that is basically the national board that oversees the conduct of the practitioner. The chances are that there would be nothing untoward about the conduct of the practitioner, so that would not necessarily work either. Then we have a referral to the director of the Health and Disability Services Complaints Office appointed under the Health and Disability Services (Complaints) Act 1995, and also the CEO. The Health and Disability Services Complaints Office does not take complaints from family members, carers or witnesses; it will only take complaints from the patient.

In the case of David Prueitt, he lived; in other cases, there may be complications and the patient may still die. It may be a longer death than anticipated and it might not be pain free. The case cannot be referred to that body because the patient would need to be alive to effect a referral to that body. That really only leaves the CEO and the question of whether we want to give this function to the CEO or leave it more broadly open for the board to undertake that investigation. I do not think it would be a complicated investigation. The board would simply be trying to find out whether there was a prolonged death, whether there was some adverse reaction to the medication or whether there was some other complication, and for that to be reported back to the board so the board is then able to make informed decisions that might be needed about any changes to the legislation or the practice guidelines. This is all geared to what is in the best interests of the patient. I cannot see why anyone would have any objection to this amendment. It places no obligation on a family member, carer or witness to self-administered voluntary assisted dying. It simply leaves the door open for someone who witnesses a complication to report it to the board, and then the board will take some action. I think that is missing from the bill. This amendment would greatly improve the bill and address the gap that currently exists in it.

Hon STEPHEN DAWSON: The government opposes this amendment. It is our view that the amendment proposed by Hon Adele Farina is unnecessary and extends the board’s powers. New clause 152A(2) is redundant as it is already possible for a family member to notify the board, and does not require specific provision in the bill. Subclause (4)(a) requires the board to investigate the matter. Under the bill, the board does not have an investigative function, as has been pointed out by me and by the Leader of the House when she was at the table. The board has the power to refer matters for investigation. Clause 108 under part 7 of the bill provides for investigation by the CEO. As has been said, the board’s role is data collection and analysis, which is different from investigation, but it does have the power to refer to appropriate authorities.

Hon NICK GOIRAN: According to the minister, the investigation would be carried out by the CEO, who is the director general of the Department of Health. He is a very busy individual. No doubt he will then employ or subcontract investigators to do this task for him. Do those investigators already exist within the Department of Health?

Hon STEPHEN DAWSON: I am advised that there is a unit in the department—the medicines and poisons branch—that has investigators. We would potentially look at expanding the role of that unit during the implementation phase, once the guidelines are worked out, to enable it to carry out that task.

Extracted from finalised Hansard
Hon NICK GOIRAN: If there is already a concession by government that there is going to be a need to expand the number of investigators under the remit of the CEO, why not simply give those investigators to the board?

Hon STEPHEN DAWSON: The board does not have an investigative function and we want to keep it that way.

Hon NICK GOIRAN: There are not that many jurisdictions that have euthanasia, assisted suicide or voluntary assisted dying—however it is described in the variation jurisdictions. Do those jurisdictions have anyone who does these types of investigations—for example, do their boards and the like do these types of things?

Hon STEPHEN DAWSON: I am told that there are different mechanisms under each of the acts in the various jurisdictions, but they all do different things.

Hon NICK GOIRAN: Is it the case that in the Netherlands, regional committees do investigations?

Hon STEPHEN DAWSON: The Netherlands certainly does have regional committees, but I could not tell the honourable member whether they undertake investigations of the sort that he is talking about.

Hon NICK GOIRAN: Let me inform the minister that not only do they do the investigations, but also they even publish judgements about them to address exactly the situation that Hon Adele Farina is trying to address—to ensure that we learn from the mistakes that happen along the journey. We have previously had a debate about the fact that the substance that will be used in this particular regime in Western Australia will be an experiment, because there is no ability to do clinical trials on human beings with a substance that will guarantee the death of individuals. As we know from the very few number of jurisdictions that have been down this path already, they have had to experiment with the type of substance that is used. In one jurisdiction—I think it might have been Washington state—they had to try four times before they eventually got the right concoction to ensure the death of the person. This is pretty serious stuff. In the case of David Prueitt, which the honourable member raised with us, after ingesting the prescribed barbiturate, he spent three days in a deep coma. He suddenly woke up, turned to his wife and said, and I quote from page 136 of my minority report: “Honey, what the hell happened? Why am I not dead?” He survived for a further 14 days afterwards, before dying naturally from his cancer.

Since 2005—this is after the Prueitt case—five other people in Oregon have regained consciousness after ingesting the lethal substance. Forget about the Netherlands, Belgium, Luxembourg and those other jurisdictions that have this regime; I am talking about one jurisdiction—Oregon. I know that the government has said, and plenty of members have indicated, that this legislation is based on the Oregon model and the Victorian model. Indeed, in Oregon in 2010, two patients regained consciousness after ingesting medication. One patient regained consciousness 88 hours after ingesting the medication and subsequently died from the underlying illness three months later. The other regained consciousness within 24 hours and subsequently died from the underlying illness five days following ingestion. In 2011, two patients regained consciousness after ingesting the medication. One patient very briefly regained consciousness after ingesting the prescribed medication and died from the underlying illness about 30 hours later. The other patient regained consciousness approximately 14 hours after ingesting the medication and died from an underlying illness about 38 hours later. This is in the context of what we are apparently trying to organise for people in Western Australia—I have heard the phrase “go gently”. It does not sound to me to be a very gentle way of going when somebody can regain consciousness 88 hours after ingesting the medication and subsequently die from the underlying condition three months later, amongst other things.

This is the very problem. The minister, the government and the chamber have already agreed that some statistics on complications will be kept. That amendment moved by the honourable member that the government agreed to had my full support. What the honourable member is now trying to do, which also has my support, is to say that it is all very good to collect information about the complications, but then what will we do with it? Why did we even bother agreeing to the previous amendment to count and collate the complications if we are going to do nothing about it? Is it so that we feel good because we have kept data and we will table it in Parliament once a year? We are going to feel great about ourselves because we will table an annual report in Parliament that lists all the complications and the number of times that people have awoken from their lack of consciousness. We are going to feel good about that, but we are going to do nothing about it. That is pointless. If we support this new clause, at least then we will know with confidence that the board will investigate the matter, as the member said, maybe in a preliminary fashion—I do not particularly care whether it is in a preliminary fashion or otherwise—and, if necessary, then refer to any other body to avoid any recurrence of the adverse reaction. That is the most important thing of all.

After we have learnt that there have been complications as a result of the potion that has been authorised by the CEO—“potion” was the term used by the Attorney General in the other place—at least somebody will investigate it and ensure that a recurrence is avoided. I really do not understand the fundamental objection to this new clause, other than the government does not want to investigate these things. It does not want anyone to investigate these matters; it wants to make sure that they are kept secret. It is just like yesterday when we had a debate about whether any mention should be made of voluntary assisted dying on the death certificate and we said that no,
we do not want to do that; we do not want anyone to investigate and we want to make sure that the coroner is not involved. If we do not agree to this new clause, it seems to me that we will be agreeing to a cover-up. I cannot imagine that that would be appropriate on a conscience vote. I indicate that I support the amendment moved by the honourable member.

Division

New clause put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the ayes, with the following result —

Ayes (16)

Hon Jim Chown
Hon Peter Collier
Hon Donna Faragher
Hon Adele Farina
Hon Nick Goiran
Hon Rick Mazza
Hon Michael Mischin
Hon Simon O’Brien
Hon Martin Pritchard
Hon Tjom Sibma
Hon Charles Smith
Hon Aaron Stonehouse
Hon Dr Steve Thomas
Hon Colin Tincknell
Hon Alison Xamon
Hon Ken Baston (Teller)

Noes (19)

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

New clause thus negated.

The DEPUTY CHAIR: I will leave the chair until the ringing of the bells.

Sitting suspended from 10.02 to 10.15 pm

Clause 153: Execution of documents by Board —

The DEPUTY CHAIR: Honourable members, it may come as some surprise to know that we are dealing with the Voluntary Assisted Dying Bill 2019. We are currently up to clause 153. The question before the chamber is that clause 153 stand as printed.

Hon NICK GOIRAN: Minister, it has been well noted during our debates that the board will be receiving a great number of documents under this legislation. However, what type of documents will it need to execute?

Hon STEPHEN DAWSON: I am advised that it could be that it is engaging an expert or it could have to sign off the annual report to the minister.

Clause put and passed.

Clause 154: Annual report —

Hon NICK GOIRAN: Why does clause 154 not require the board to include information on the number of referrals made by the board under clause 117(c), and to whom those referrals were made?

Hon STEPHEN DAWSON: Clause 154(2) sets out what it must include. Subclause (2)(b) provides for the board to include any information that it considers relevant to the performance of its functions.

Hon NICK GOIRAN: Under clause 117(c), one of the functions of the board is that it can refer to a raft of people. Seven discrete agencies or individuals are listed. This has been given sufficient importance in the bill to be listed as a function of the board. It strikes me that the board should include in its annual report how many referrals it has made under that particular provision. For those reasons, I move —

Page 88, after line 19 — To insert —

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

Hon STEPHEN DAWSON: The government does not support this amendment. The amendment proposed by Hon Nick Goiran details the inclusion of the number of any referrals made. My advice is that this does not add qualitative value and is, in any case, unnecessary. As I have pointed out, clause 154(2)(b) provides for the board to include any information that it considers relevant to the performance of its functions. The functions of the board at clause 117(c) relate to referrals that may be made, and it is implicit in the bill that this detail would be included in the annual report.

Hon NICK GOIRAN: If it is implicit, we will make it explicit by agreeing to my amendment. I was with the minister right until the end when he said that it was implicit that it would be included in the annual report anyway. I notice that one of the objections was about the quantity of information that might be provided with regard to the referrals at clause 117(c) being of no particular value. Would we as a chamber not want to know that the function

Extracted from finalised Hansard
we have provided the board at clause 117(c) is useful? If, year after year as the annual reports continue being tabled we are continually told that there have been zero referrals under clause 117(c), at some point in the history of this scheme someone might reasonably ask the question, “What is the point of that referral function? It’s never being used.” To give another example, clause 117(c) indicates that a referral can be made to the chief executive officer of the department of the public service that is principally assisting in the administration of the Prisons Act. I would be concerned if those were the only referrals that were reported every year, because it would be an indication that the only time any referrals were taking place was when a person in prison was trying to access voluntary assisted dying. This is the type of information that we have just agreed, at clause 117(c), to be sufficiently important as to give the function and power to the board to refer to these particular bodies. As the minister has indicated, it is implicit that it will be included as part of their annual reports; I would have thought so, too. It is not clear to me what the manifest objection would be to including in the annual reports something that is implicit in any event.

Hon AARON STONEHOUSE: I indicate that I wholeheartedly support this amendment. It increases transparency, it will increase accountability and it will ensure that information that I think will be valuable to this Parliament will appear in these reports, whether implicit or not. I agree with Hon Nick Goiran that if it is implicit that that information would appear in an annual report, it would certainly do no harm to be explicit about it. I do not see that agreeing to this amendment would cause any mischief; it would merely provide a little further clarity around what goes into these reports.

**Division**

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

Ayes (18)

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<th>Hon Martin Aldridge</th>
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<th>Hon Martin Peitchard</th>
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<td>Hon Jacqui Boydell</td>
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Noes (17)

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Amendment thus passed.

Hon MARTIN ALDRIDGE: I move —

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.

Just briefly, this follows on from the amendments that the chamber made earlier this evening at clauses 4 and 151 with regard to the collection of statistical information and the retention of that information by the board. Inserting this provision into clause 154 will require the board to report that information. Similar to the previous two amendments, I seek the support of the chamber in this respect.

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment. Our reasons for this were given at clause 151, so for reasons already given, we support the amendment.

Hon NICK GOIRAN: I take it, honourable member, that by agreeing to this amendment at 498/154, we are pre-emptively also agreeing to the amendment at 499/154?

Hon MARTIN ALDRIDGE: Yes, that is a good point, and I had planned to raise it in my brief contribution. The amendment we are now dealing with makes reference to clause 151(1)(ba), which is the amendment I mentioned that we passed earlier this evening, having regard to the access standard established under proposed new clause 154A. Members will see that a proposed new clause 154A stands in my name on the supplementary notice paper. Should this amendment pass, I intend to move an amendment to establish that standard.

Amendment put and passed.

Clause, as amended, put and passed.
New part 9A —

Hon MARTIN ALDRIDGE: I indicate that I will move a new amendment from the floor. I will explain the reasons for that once I have moved it. I move —

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.

In order to facilitate debate and avoid the need for a further supplementary notice paper, I have moved that amendment from the floor. I have signed the amendment, and it is now being circulated. I apologise to the chamber. As members would be aware, the words “Part 9A — Access standard” have been omitted from my proposed amendment on supplementary notice paper 139, issue 20. If that is not corrected, proposed new clause 154A will have to sit under part 9, which deals with the operations of the board. It is more appropriate that this amendment sits under new part 9A, as I had originally intended. Therefore, the amendment I have moved from the floor is slightly different in that respect from the one on the supplementary notice paper.

I hope that this amendment will assist all Western Australians who wish to access voluntary assisted dying to understand how they will be able to do so. I have spoken during the course of this debate, including during the second reading debate, about some of the great difficulties and challenges faced by people who live outside our metropolitan region in accessing the simplest and most basic of medical services, including medical practitioners. Obviously as the bill before us reaches an advanced stage, those barriers will present significant challenges. That is notwithstanding the challenge that will be faced with the operation of the federal Criminal Code Act. I have spoken about that challenge previously. I stand with the government in understanding the challenges it will face in those aspects of voluntary assisted dying that could have been delivered more readily through technologies such as telehealth. A number of issues face regional Western Australians. The government has made a commitment that every Western Australian will be given access to voluntary assisted dying. The amendment that was made at clause 4, “Principles”, with the government’s support, reflects that intention.

I must point out that this proposed standard will apply to all persons ordinarily resident in Western Australia. Subclause (2) refers more specifically to the facilitation of access to voluntary assisted dying for regional residents. The amendment provides that the CEO will be required to issue the access standard, the CEO may modify or replace the standard, and the CEO must publish the access standard on the department’s website. This is an important measure for the operation of voluntary assisted dying should this bill pass both houses of Parliament.

With those few words, I encourage all members to support this amendment, which will ensure that people within our electorates and constituencies are given a fair opportunity to access voluntary assisted dying and have a full understanding of how that access will be facilitated.

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment. The access standard to be published by the CEO will articulate how access to voluntary assisted dying will be facilitated to all Western Australians. As Hon Martin Aldridge pointed out, subclause (2) provides that the standard must have particular regard to access in regional areas. I acknowledge that throughout this debate, honourable members have expressed concerns about equity of access to both palliative care and voluntary assisted dying. The government shares that same determination to ensure that the best possible palliative care is available to all Western Australians, and that every Western Australian, regardless of where they live, has equity of access to voluntary assisted dying. I understand that the Minister for Health will also instruct the department CEO to publish a charter of patients’ rights to illustrate what all Western Australians can expect.

Hon NICK GOIRAN: What advice has the government obtained about the impact of federal law on proposed new clause 154A(4)?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: I am advised that nothing will be published that will offend the commonwealth restrictions.

Hon NICK GOIRAN: Could that mean that nothing is published at all?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: Why not, minister?

Hon STEPHEN DAWSON: The short answer is that the commonwealth code is very specific, and this standard is broader than just the restrictions in the commonwealth act.

Hon NICK GOIRAN: Could it be the case that the restriction applies to subclauses (1)(b) and (c) but not necessarily to subclause (1)(a)?

Hon STEPHEN DAWSON: Possibly. Those issues may need to be tailored so that we do not breach the commonwealth act.

Hon NICK GOIRAN: To be clear about what we might be agreeing to in practice, despite the good intentions of the member, we might be agreeing to the state having to put together an access standard that would include subclauses (1)(a), (b) and (c). It would then be heavily redacted. The only part that could be put on the department’s website would be subclause (1)(a) —

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

Subclause (1)(b), “prescribed substances”, might also need to be redacted. As an aside, I think the government’s position, as explained during this debate, is that it does not want anyone to know what the prescribed substances are. Subclause (1)(c), “information about accessing voluntary assisted dying”, might also need to be redacted. I want to be clear about the likely outcome, given the ongoing debate about the impact of federal law.

Hon STEPHEN DAWSON: The Department of Health in WA is aware of the provisions in the commonwealth Criminal Code Act 1995 about use of carriage services for suicide-related material and the instruction given to medical practitioners in Victoria. If the bill becomes law, there will be an implementation period of at least 18 months before the Voluntary Assisted Dying Act becomes operational. This time period will enable the Department of Health, in consultation with the commonwealth, to develop appropriate administrative measures to ensure compliance with state and commonwealth laws. The answer to Hon Nick Goiran’s question is no. The access standard would still be developed and be able to be provided through relevant bodies through information packages, but there may be a restriction in what exactly appears on the website and whether some information may need to be redacted.

Hon MARTIN ALDRIDGE: I thank the minister for that response. I think the minister went to this issue. My understanding is that the line in the sand, if you like, that Victoria has drawn is about the patient to practitioner—or to other person—communication and avoiding being captured by the federal Criminal Code Act, which contains offences relating to inciting or inducing a person to commit suicide. Victoria publishes information generally on its government websites. Notwithstanding that, if matters need to be redacted from public information, with regard to this provision to establish the access standard, would anything prevent a minister tabling that standard and therefore protecting that standard by privilege so that it cannot be impeached or questioned in a place outside Parliament?

Hon STEPHEN DAWSON: My advice is possibly. It is a complex legal argument. During the implementation phase, we will work out how this could be done. The information will be provided to relevant bodies in a hard copy, essentially; however, what appears on the website may need to be restricted based on the commonwealth act. That detail relating to the commonwealth act would be worked out at a later stage during the implementation phase. The point that the member made about privilege is a good one, and I will certainly bring it to the minister’s attention. I want to acknowledge the work that the Minister for Health has put into this amendment. I certainly want to acknowledge that Hon Martin Aldridge has been having conversations with the minister about this issue, and we have landed in a good place. We are certainly cognisant of the commonwealth act. We will take into consideration those points I have made tonight.

Hon ADELE FARINA: In response to the question posed by Hon Martin Aldridge, yes, the minister could table the access standard in Parliament and it would be protected by parliamentary privilege, but any distribution of that access standard by any individual, in order to get the information out to regional people, would not be covered by privilege. We would run into the same problem if it falls foul of the federal Telecommunications Act 1997.

Hon STEPHEN DAWSON: I add that if it were passed on by a carriage service, it would breach the commonwealth act.

New part put and passed.

Clause 155: Transfer of coordinating practitioner’s role —

Hon NICK GOIRAN: The coordinating practitioner transfer form is required to be signed only by the original practitioner—that is, the coordinating practitioner who wants to transfer out of the role. That form is not required to be signed by the consulting practitioner who consents to taking on the role. Why is the consulting practitioner not required to certify that they have consented to taking on the role of coordinating practitioner and the attendant responsibilities of that role?
Hon STEPHEN DAWSON: The consulting practitioner who consents will then be on subsequent forms. I am advised it is unnecessary to state that they consented. Professional obligations apply to the coordinating practitioner not to misrepresent the agreement to transfer. Further, clause 155(5)(d) provides for the date when the acceptance was given, and that is sufficient.

Hon NICK GOIRAN: Why is the consent of the patient not required to be obtained by a coordinating practitioner before they transfer out of the role?

Hon STEPHEN DAWSON: I am told the usual practice will be that the original coordinating practitioner will discuss this with the patient in the first instance.

Hon NICK GOIRAN: That may be the usual practice but it does not have to be the practice. I draw to the minister’s attention clause 155(2), which states —

The transfer of the role can be —

(a) at the request of the patient; or

There is no issue there. But the other circumstance is —

(b) on the original practitioner’s own initiative.

They may say, “I’ve had a gutful of this particular patient. I’m not dealing with this patient anymore. I’m out, and I’ve now found another practitioner who has accepted the role”, as per clause 155(4). That subclause states —

If the consulting practitioner accepts the transfer of the role, the original practitioner must —

(a) inform the patient of the transfer …

We are creating a mechanism by which one guy goes out and says, “I’ve had enough”, and he transfers to another practitioner. The other practitioner says yes, and the patient has no say. Surely that cannot be right. Whenever there has been an opportunity during the course of this debate, the government has waxed lyrical about how this whole approach is a patient-centric model. It seems to me that this gap that has been identified works contrary to that patient-centric approach. I have no doubt the minister will tell me that this will be good clinical practice and that this is how it should be done. I totally agree that that is how it should be done, but that is not how clause 155 reads. Can an amendment be made to clause 155 to ensure that the patient has to consent to the transfer?

Hon STEPHEN DAWSON: As the honourable member pointed out, the transfer may be at the patient’s request, but otherwise the patient cannot force the practitioner to remain in the role by refusing consent to the transfer. If the patient did not agree or did not like their new coordinating practitioner, they could seek another coordinating practitioner.

Hon NICK GOIRAN: If that were the case, would they have to start the whole process from the very beginning?

Hon STEPHEN DAWSON: If it was not transferred in accordance with this clause, yes.

Hon ADELE FARINA: Hon Nick Goiran asked—I apologise if I am repeating it, but I am sure the minister will tell me if I am—what happens if the original coordinating practitioner dies. The original coordinating practitioner would then not be in a position to transfer the role in accordance with this provision, so what happens if that person dies?

Hon STEPHEN DAWSON: They would not be in a position to transfer in that case. The process would have to start again.

Hon NICK GOIRAN: I will make a comment at this point. I find it interesting that we have identified an obvious problem with regard to the patient-centric model. All the proponents who spoke very loudly during the course of the second reading debate about autonomy and “my life, my choice” are absolutely silent on this particular issue. We are about to pass it—why? Because it is five minutes until 11.00 pm and everyone is too tired, so we are not going to be bothered to move an amendment to sort out this problem.

Clause put and passed.

Clause 156: Communication between patient and practitioner —

Hon NICK GOIRAN: Regardless of the legalities of the use of audiovisual communication in the voluntary assisted dying request and assessment process, does the government consider audiovisual communication, including Skype services and the like, to be sufficient to enable both a coordinating and a consulting practitioner to adequately assess a patient’s eligibility for access to voluntary assisted dying, including making very important assessments about the patient’s decision-making capacity and whether the patient is subject to any coercion?

Hon STEPHEN DAWSON: I am told that there may be situations in which this is appropriate and other situations in which it is not.

Extracted from finalised Hansard
Hon NICK GOIRAN: With regard to the federal law intersection issue, the minister might recall that at some earlier point in the debate a letter was provided. I think it might have been pursued by Hon Martin Aldridge, but somebody managed to extract it from the government. It is a letter written by the Attorney General of Western Australia to the commonwealth Attorney-General. In this letter from Hon John Quigley dated, I think, 20 August 2019—it is either 20 or 28 August; anyway, it is August this year—it says —

I have taken advice at the highest level and it is my view that communications about voluntary assisted dying via a carriage service do not contravene the Cth Criminal Code.

Has there been any update on the status of the government’s view? During the course of this debate, I recall asking whether an administration decision could be done via a carriage service and I was told no, because of the commonwealth Criminal Code Act. It appears that the government’s position has perhaps evolved since August. It would be helpful, before we pass clause 156, to get the latest update from the government on this issue.

Hon STEPHEN DAWSON: I am advised that there has been no update since we last discussed the issue. Perhaps it was discussed under clause 1; it was certainly discussed early in the debate.

Hon NICK GOIRAN: We have had conversations since clause 1. During debate on whatever clause deals with an administration decision, I can recall—I can go back to the Hansard if I need to—specifically asking about that. The answer that I received was that an administration decision cannot happen via a carriage service. That is obviously different from other parts of the process. During the debate—well after clause 1—we were told that if a patient rings the doctor, there is no issue with that. Things might be enlivened when the doctor is communicating to the patient, which depends on the stages of the process. For example, if the consulting practitioner is talking to the patient during that second phase of the whole process—trying to ascertain whether the person has decision-making capacity—there is no problem. If the consulting practitioner is trying to identify whether the person has a terminal illness and whether they think the person is going to die within the next six months, there are no problems with any of those conversations.

Provisions under this bill require the applicant to have been resident in Western Australia for a period of 12 months. There are provisions that require an identification process to take place. None of those provisions contravene the commonwealth law. There are certain provisions, like the administration decision, under which the patient has to decide whether to proceed with the practitioner or carry out the process themselves. I recall being told by the minister during that debate that that would be a problem under commonwealth law. I think the position has changed since we debated clause 1. Before we pass clause 156, we need a clear statement from the government about exactly what does and does not contravene commonwealth law.

Hon STEPHEN DAWSON: I referred to clause 1 because that was the last time I could pinpoint exactly when the issue was addressed, but of course it was addressed at other times during the debate over the past few weeks. I say again that if the bill becomes law, there will be an implementation period of at least 18 months before the Voluntary Assisted Dying Act becomes operational. This time period will enable the Department of Health to develop, in consultation with the commonwealth, appropriate administrative measures to ensure compliance with state and commonwealth laws. Assessments may need to be undertaken in person with either the patient travelling to the practitioner or the practitioner travelling to the patient. If the bill passes and this is required, WA Health will provide packages to support access for regional patients when needed. The training for health professionals will reflect the outcome of the ongoing consultations between the state and the commonwealth. We are confident, though, that, as in Victoria, this issue will not compromise health professionals or prevent eligible Western Australians from accessing voluntary assisted dying. The parameters of what can and cannot be discussed will be the subject of further consultation with the commonwealth.

Hon NICK GOIRAN: For the present time, as we are about to pass clause 156, is the minister able to at least advise the chamber that some communications about voluntary assisted dying via a carriage service contravene the commonwealth Criminal Code Act, but not all communications?

Hon STEPHEN DAWSON: Some may but not all. We cannot give a legal opinion on that until the implementation phase.

Hon NICK GOIRAN: I agree with the minister. I am going to get rid of this letter from the Attorney General, John Quigley, because it is not worth the paper it is written on. He tried to tell people that, in his view, the communications about voluntary assisted dying via a carriage service will not contravene the commonwealth Criminal Code Act, in an attempt to try to persuade, either intentionally or unintentionally, and mislead members about the truth on this. It is no wonder the Attorney General was confused about this matter, given that he refers to the substance as “potions and the like”. He has received absolutely no assistance whatsoever from the “My Life, My Choice” report because, as the minister confirmed earlier, there is nothing in the report about that, despite the fact that the committee was asked to look at the intersection with federal law. It ignored that. We do not know whether it ignored it because the minister kept it secret, despite the fact that I asked for it to be released. We also know that the ministerial expert panel—the panel that consists of some experts—has said nothing about this.

Extracted from finalised Hansard
particular issue. In that context, no wonder the Attorney General, the chief law officer of Western Australia, is confused and has written rubbish that now needs to be assigned to the wastepaper basket. It is one thing for the Attorney General to be confused; it is no good for the 36 members of this place to be confused when we are going to pass a clause that indicates that communication between a patient and a practitioner can happen by audiovisual communication, but then snuck into the back of the clause, subclause (4) states —

However, subsections (2) and (3) do not authorise the use of a method of communication if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth.

When asked what that might mean, we were told to wait for the implementation phase and all will be well. At that point, we would no longer have a vote. The bill would have already passed and it would be too late.

Hon STEPHEN DAWSON: I certainly do not believe that the Attorney General was trying to mislead or deceive the chamber. I do not want to leave the chamber with that hanging. The Attorney General has been trying to deal with a complex issue that will not be fully resolved, as I have indicated, until a later stage—until the implementation phase of the bill.

Clause put and passed.

Clause 157: Information about voluntary assisted dying —

Hon NICK GOIRAN: What operation will clause 157(4) have in light of the commonwealth Criminal Code Act 1995?

Hon STEPHEN DAWSON: I indicate to the honourable member that we will work with the commonwealth to ensure that we do not impinge on commonwealth act provisions.

Hon ADELE FARINA: Would it not be more appropriate if we inserted at the start of subclause (4) the words “subject to section 156(3)” so that at least it would draw people’s attention to the problem with the telecommunications law, which we have at the beginning? It just seems to me strange that in clause 156 we make reference to that problem, but in clause 157 we do not.

Hon STEPHEN DAWSON: The issue that the honourable member has raised is provided for in subclause (5). We do not propose to change subclause (4).

Clause put and passed.

Clause 158: CEO may approve training —

Hon NICK GOIRAN: We had a discussion on clause 100 about training being provided to doctors to identify undue influence and coercion. The minister might remember that I flagged that I had this amendment standing in my name. I now move —

Page 93, lines 10 and 11 — To delete “abuse or coercion;” and substitute —

abuse, coercion, duress or undue influence;

Hon STEPHEN DAWSON: It will not surprise the honourable member to find out that the government does not agree —

Several members interjected.

Hon STEPHEN DAWSON: It is certainly not for the reason that we did not agree to the 52 or however many amendments that have been moved previously, and this makes an extra one. As I have indicated previously at least one time—in fact, multiple times—when the honourable member put forward a similar amendment, we do not support any amendment to insert the words “duress or undue influence”. As I have indicated previously, both “coercion” and “abuse” are terms commonly understood by health practitioners and the wider community and thus are appropriate for use in the principles clause of this bill and, indeed, in other places. My advice multiple times previously has been that this amendment would add unduly technical, legalistic words that do not advance the legislation.

Hon NICK GOIRAN: We had this discussion on clause 100, which refers to a crime being committed. It 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 asked the minister whether a doctor in Western Australia would have to understand what undue influence and coercion are and whether they would need to be trained about those things so that they could report the matter to the police, and the minister jumped up and said yes. I said to him on clause 100 that I would pause there and take it up again on clause 158, “CEO may approve training”. The minister told me on clause 100 that it is very important for Western Australian doctors to know the difference between undue influence and coercion. The minister may even recall that I asked for an explanation of the difference between the two, and this massive silent filibuster took place at that point when advice was taken to try to ascertain the difference between the two. After all that information was obtained, an explanation was provided, and that is why I wanted to be sure that doctors would understand the difference.
With all due respect, minister, there is a very big difference between the government opposing this and it opposing the original amendment to the principles clause. At that time, the explanation provided to members was that the government does not want to use unnecessarily legalistic language in the principles clause because it wants every Western Australian to be able to understand it, and we voted on that and that is fine. This is a very different thing. We are not talking about every Western Australian; we are talking about doctors being trained to understand their responsibilities in accordance with what is approved by the CEO under the legislation. The minister indicated to me on clause 100 that it is very important for doctors to understand what undue influence and coercion are so that they can report the matter to the police. In fact, it is one of the tenets of this bill—that is, a patient is able to proceed through the process only if a practitioner is sure that they are not suffering under coercion and the like. It seems to me that we cannot expect practitioners to understand those things if we do not train them in the first place. I fail to see what would be objectionable under clause 158 to the CEO approving training relating to the following matters. We would be saying that the training could include training about abuse, coercion, duress or undue influence. I ask the government to reconsider its position and support the amendment.

Hon AARON STONEHOUSE: If I have the right number, I think we discussed something similar to this on not just clause 100, but also clause 83. In fact, we discussed it in quite some detail on clause 83. Clause 83 refers to the eligibility criteria and it makes it clear that an eligible applicant may apply for a review of a decision of the just clause 100, but also clause 83. In fact, we discussed it in quite some detail on clause 83. Clause 83 refers to We would be saying that the training could include training about abuse, coercion, duress or undue influence. I ask me that we cannot expect practitioners to understand those things if we do not train them in the first place. I fail to see what would be objectionable under clause 158 to the CEO approving training relating to the following matters. We would be saying that the training could include training about abuse, coercion, duress or undue influence. I ask the government to reconsider its position and support the amendment.

Hon AARON STONEHOUSE: If I have the right number, I think we discussed something similar to this on not just clause 100, but also clause 83. In fact, we discussed it in quite some detail on clause 83. Clause 83 refers to the eligibility criteria and it makes it clear that an eligible applicant may apply for a review of a decision of the coordinating practitioner for a patient in a first assessment that the patient is or is not acting voluntarily and without coercion. I think it may appear in another clause, but the number eludes me at the moment. It is right that at that time there was concern that that language might be too legalistic, but I pointed out that merely including a reference to “coercion” leaves aside a wide range of abuse that may occur. In clause 100, there is a specific penalty for a person who, through dishonesty, undue influence or coercion, induces another person to self-administer a prescribed substance, which is appropriate. But how do we prevent it from getting to that point? It seems to me that it is incredibly important that medical practitioners are trained in how to recognise those things. They will be the last line of defence, so to speak, to protect patients from being coerced, unduly influenced or somehow induced to take a voluntary assisted dying substance. It is all good and well to have a penalty after a patient has died, but ideally we want to prevent it from getting to that stage, and providing adequate training to medical practitioners is part of that process.

As to whether we need to spell out duress or undue influence, when we discussed this matter on previous clauses, I said that I do not think that reference to “duress” is necessary, as duress implies some element of violence or force and I think it is already covered under coercion. However, it is very important to have reference to “undue influence”. The term “abuse” may capture undue influence, depending on the reading of it, but it is not guaranteed. It would be much safer to spell that out clearly. Undue influence is a well-understood concept in contract and common law. It is perhaps a valid criticism to say that the average member of the public does not understand what undue influence is. But we are not talking about the average member of the public; we are talking about the CEO and the training that the CEO has to provide to medical practitioners. It is quite reasonable to accept that the CEO of the Department of Health would understand what undue influence is; and, if he does not, I think we have a problem. A reference to “undue influence” is absolutely appropriate. It would cover the types of relationships that exist within families. It is appropriate to include it to prevent the kind of elder abuse that a lot of us are worried about. An overbearing family member who is pushing, nudging or steering a family member to go down the path of voluntary assisted dying would not necessarily be covered under abuse. They would certainly not be covered under coercion. I believe that would be undue influence. It would also cover a situation in which someone is in a position of authority—a medical practitioner, perhaps a boss or a religious or spiritual leader. Those types of relationships would be covered by undue influence but not necessarily by abuse and certainly not by coercion. By leaving out undue influence, we are leaving a type of relationship that may be misused completely uncovered by the training provided under clause 158. I think it is imperative that we include, at the very least, undue influence. Therefore, as I did previously, I support the amendment put forward by Hon Nick Goiran.

Hon ALISON XAMON: I rise to indicate some concern about this amendment. I want to be very clear that when we had the debate previously about incorporating the words “duress or undue influence” after the words “abuse” and “coercion”, I was quite happy to have that additional explanation in the clause. I am concerned that incorporating those words in this clause may have the unintended consequence of minimising previous provisions in the bill that refer only to abuse and coercion. When we had the debate on this issue previously, as I heard it, we were assured that abuse and coercion in the broadest possible sense was intended to incorporate elements of duress and undue influence. On that basis, I hope that the bill will be read as incorporating all four elements automatically within the use of those two terms. I am concerned that by somehow introducing the two terms at this point in the bill, it may serve to undermine the assertion that abuse and coercion as previously described are intended to incorporate all four elements. Can the minister please confirm that the way the words “abuse” and “coercion” are used previously in the bill is automatically intended to include duress or undue influence? Of course, if they do not include duress or undue influence, we should look at incorporating those terms. Otherwise, I do not want to inadvertently undermine the full effect of the clause in which these words appear previously in the bill.
Hon STEPHEN DAWSON: It does feel like groundhog day because this was debated not just at clause 1; this issue has been debated multiple times. I am looking at honourable members’ smiling faces; they are also reminded of the fact that it has been dealt with numerous times. My advice is that, yes, they are sufficiently wide terms to include all.

Hon ADELE FARINA: I can understand the concern raised by Hon Alison Xamon, but if we accept this amendment, it is not the first time we have incorporated the words “undue influence”. We already did that at clause 100, which states —

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

Penalty: imprisonment for life.

It carries a hefty penalty. I fail to understand why including “undue influence” in clause 158 would create any problems, because we already have it. This clause is about training. Hon Aaron Stonehouse is absolutely right; we will be relying on our medical practitioners as the first line of defence. They will have to pick up all these issues and a whole lot of other issues, and they need to be trained to identify and pick up these issues and to deal with them. I take Hon Aaron Stonehouse’s point, which is supported by Hon Alison Xamon’s comments, that perhaps we could eliminate the word “duress” so that we have consistency with clause 100. But to make the argument that incorporating it into a training program will somehow offend the rest of the bill is just ridiculous.

Hon NICK GOIRAN: I seek leave to alter the amendment standing in my name to delete “duress”.

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

Ayes (17)
Hon Martin Aldridge
Hon Nick Goiran
Hon Tjorn Sibma
Hon Alison Xamon
Hon Jim Chown
Hon Rick Mazza
Hon Charles Smith
Hon Ken Baston (Teller)
Hon Peter Collier
Hon Michael Mischin
Hon Aaron Stonehouse
Hon Dr Steve Thomas
Hon Donna Faragher
Hon Simon O’Brien
Hon Martin Pritchard
Hon Colin Tincknell

Noes (18)
Hon Jacqui Boydell
Hon Colin de Grussa
Hon Alannah MacTiernan
Hon Dr Sally Talbot
Hon Robin Chapple
Hon Sue Ellery
Hon Kyle McGinn
Hon Darren West
Hon Tim Clifford
Hon Diane Evers
Hon Samantha Rowe
Hon Pierre Yang (Teller)
Hon Alanna Clohesy
Hon Laurie Graham
Hon Robin Scott
Hon Matthew Swinbourn
Hon Adele Farina
Hon Martin Pritchard
Hon Colin Tincknell

Amendment, as altered, thus negatived.

Hon NICK GOIRAN: Will every Western Australian medical practitioner need training on the first request requirements?

Hon STEPHEN DAWSON: I am advised that they will need educational information, but they will not necessarily need training.

Clause put and passed.

Clause 159: CEO may approve forms —

Hon NICK GOIRAN: The approved forms required under the Victorian voluntary assisted dying scheme are provided for in schedule 1 of the Voluntary Assisted Dying Act 2017. The forms that are required under the Western Australian scheme are not provided in a schedule to the bill, as we discovered earlier. However, will they be tabled once they have been approved?

Hon STEPHEN DAWSON: I am advised that it is not really intended that they will be tabled. They will be linked to the database, which will be locked down and available only to some people.

Clause put and passed.

Clause 160: Interpreters —

Hon NICK GOIRAN: Who will ensure that the interpreter used in a request and assessment process is not ineligible to act as an interpreter under clause 160(2)(b)?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: I am told that in practice it will be the practitioner who is involved in the circumstance, but I am aware that standard information about interpreters is already gathered in the medical system, including their accreditation number et cetera. It is proposed that a similar process will happen.

Hon NICK GOIRAN: As part of that process, will the interpreter be required to certify that they do not fall into one or more of the categories listed in clause 160(2)(b)?

Hon STEPHEN DAWSON: In practice, we would expect that, honourable member.

Hon NICK GOIRAN: Can an interpretation service be provided through audiovisual communication or by telephone?

Hon STEPHEN DAWSON: I have provided this answer before at an earlier stage of the debate, but I will provide it again to the honourable member. It is unlikely that the requisite intent for the commission of the Criminal Code Act offences would be satisfied by an interpreter who was merely assisting the doctor and patient to communicate. This is one of the matters that will be closely worked on in consultation with the commonwealth if the bill is assented to.

Hon NICK GOIRAN: This is my final question on clause 160. Has the government considered the eighth report of the Joint Standing Committee on the Corruption and Crime Commission entitled “The More Things Change…: Matters Arising from the Corruption and Crime Commission’s Report on Operation Aviemore: Major Crime Squad Investigation into the Unlawful Killing of Mr Joshua Warneke”, and in particular the evidence contained in that report relating to the use of interpreter services and the impact of this upon the wrongful conviction of Mr Gene Gibson?

Hon STEPHEN DAWSON: I am advised that the government is acutely aware of the difficulties for some Aboriginal communities and the need for accredited interpreters.

Clause put and passed.

New clause 160A —

Hon NICK GOIRAN: I move —

Page 94, after line 18 — To insert —

160A. Parliament to establish joint standing committee

(1) The Houses of Parliament are to establish a joint standing committee on palliative care and treatment and voluntary assisted dying comprising an equal number of members appointed by each House.

(2) The functions and powers of the joint standing committee are determined by agreement between the Houses and are not justiciable.

This is a matter that I have considered for quite some time. Members will see that it has been on the supplementary notice paper for a substantial period. That is indicated by the fact that it is denoted by the number 74—in other words, it was the seventy-fourth amendment that was put on the supplementary notice paper. I note that the amendment was just given notice of by Hon Martin Aldridge was number 499. I gave notice of this amendment very early on in the piece. Its genesis was the Joint Standing Committee on the Corruption and Crime Commission, on which I served as chair for eight years, and also the Joint Standing Committee on the Commissioner for Children and Young People, on which I had the opportunity to serve for four years.

If this amendment is passed, it will be the third time a Parliament will have decided to enshrine in legislation an obligation on the part of the Parliament to establish a joint select committee. My rationale for it is not particularly complicated; it goes something like this. The Corruption and Crime Commission has extraordinary powers, so it was quite understandable for the Parliament of the time to decide it wanted to have some oversight of a body that held those extraordinary powers. If we compare and contrast that with the Commissioner for Children and Young People, the Commissioner for Children and Young People performs a very important role in our society but does not have the same extraordinary powers that the Corruption and Crime Commission has. Both those institutions are, nevertheless, oversighted by a parliamentary committee. I have repeatedly heard members on both sides of this debate, both for and against voluntary assisted dying, say how important and significant this debate is to the community. If it is as significant as people say it is—and it is ultimately the matter of a person’s life—should there not be some form of oversight provided by the Parliament, or will this be the last time we decide to have any role in this matter?

We already know from the course of the debate and consideration of clause 1 through to the last clause we considered, clause 160, that the board will provide only the most modest oversight. Hon Adele Farina earlier asked for the board to be given the opportunity to investigate, and the government said no. That is fine; that was the decision of the chamber, on the government’s recommendation. But ought not there be oversight for something as significant as this? That is the first question members need to answer. The second question relates to Hon Martin Aldridge having quite successfully prosecuted an argument in this debate about issues to do with regional access. Who is
going to supervise that? He put forward an amendment, which was agreed to by the chamber, that provides for an access standard. That is a good thing, because the member has now managed to extract a commitment from the government that it will have to table this access standard for parliamentary consideration. Which committee is going to look into that to ensure that the government adheres to that standard?

The committee I have proposed will look at both palliative care and voluntary assisted dying. I have included both because throughout the course of the debate the government has made it clear that it is committed to both. I speak as the co-chair of the Parliamentary Friends of Palliative Care, a group that was established not long after the defeat of Hon Robin Chapple’s private member’s bill in 2010. I established that group with the member for Girrawheen. I say to members: no matter who is on the treasury bench, whether it is a Labor or Liberal government, we need to create an incentive for the government of the day to provide palliative care to the regions, in particular, but also to the metropolitan area. Do members think that over the last couple of years this government would have put as much money into palliative care as it has, were it not for this bill? I believe that the majority of members know in their heart of hearts, when they exercise their conscience vote, that were it not for this bill, there is no way in the world that the government would have provided as much funding to palliative care. When we looked at the establishment of the Joint Select Committee on End of Life Choices two years ago, some of my colleagues said to me, “Why are you bothering to get involved in that committee? Can’t you see what’s going on?” I said to them, first of all, “Never vacate the space”, which is my longstanding philosophy. Secondly, I said, “If this whole process does nothing else but provide greater emphasis on and resources to palliative care, then that’s a good outcome for Western Australia, and I want to be part of that.”

Once this bill passes, as it inevitably will at some point this week—and then it will go down to the other place, which will have to deal with the horror of the 50-plus amendments it said it did not need—what incentive will there be to exert continued pressure on either a Labor or a Liberal government to ensure proper access to palliative care in the regions? One way we can make that happen is by agreeing that there should be a joint standing committee of both houses of Parliament to look into those issues and to oversee the voluntary assisted dying process. For those reasons, I seek members’ support.

Hon TJORN SIBMA: I rise to support the amendment moved by Hon Nick Goiran, and I do so while being quite obviously on the other side of this debate. I express my support for the amendment for exactly the same reasons as have been enunciated. The significance of this bill has also been expressed by all members of this chamber. When we are on the precipice of passing a bill of this significance, I think it warrants a significant measure of parliamentary oversight. I also concur with the views put that the status of palliative care, particularly in regional Western Australia, would not have reached this crescendo of interest and action were it not for this debate. I actually see that as a positive thing. Part of the reason for my decision to support the bill is contingent on the Minister for Health’s commitment to provide a discrete service line item in future health budgets, which I think will hold future governments to account for their ongoing support of palliative care services. I think that is a good thing. We also need to ensure, as custodians of the public’s trust—people put here by the people of Western Australia—that we provide the utmost oversight to legal regimens as they apply to end-of-life choices. I will leave it there, but I commend the amendment, and I hope all members of this chamber support it.

Hon AARON STONEHOUSE: I rise to indicate my support for the amendment; I think it is wholly appropriate. If we are looking at how we might provide oversight of and accountability to this regime going forward, it is worth noting that clause 162 provides for a statutory review of the legislation. I do not really hold much stock in statutory reviews; they are reviews done within the executive government, and Parliament does not really have too much control over how they are conducted. Neither is it new for there to be parliamentary reviews of legislation; we heard two examples from Hon Nick Goiran, and I might give members another recent example from the forty-first report of the Standing Committee on Legislation, which looked into the Ticket Scalping Bill 2018. In recommendation 7, under the heading “16. Review of Act”, the report states —

(1) An appropriate Standing Committee of the Legislative Council must review the operation and effectiveness of this Act, and prepare a report based on the review, as soon as practicable after the 3rd anniversary of the day on which section 6 comes into operation.

That obviously refers to the Standing Committee on Legislation. In this instance, with such a complex piece of legislation, there is a need to review not only the legislative instrument of the bill but also the quality and coverage of palliative care across the state. It is appropriate to establish a new standing committee, built for that specific purpose, rather than sending it to the Standing Committee on Legislation, which in my view would be rather limited in its scope of looking at the provision of palliative care.

I supported this bill at the second reading. I have certainly been critical of some of its clauses, and I have endeavoured to ensure that there are adequate safeguards, but foreshadowing my likely support of the bill at the third reading—depending on what it looks like at the end of the Committee of the Whole House—I think it is appropriate, even for those who support voluntary assisted dying and this bill, to ensure that there is adequate parliamentary oversight and a parliamentary review of the legislation. Members on the government side of the chamber may not be in that
position in a couple of years, or in six years. They may want to be assured that their regime is being rolled out effectively, by whatever government succeeds it. The best way to ensure that is done is through a parliamentary committee that has been given oversight of this legislation. I implore all members to think for themselves, exercise their conscience and see the merit and benefit of establishing a joint standing committee that will have the power to review not just this bill but palliative care across the state.

Hon STEPHEN DAWSON: The government is not supportive of the amendment that stands in the name of Hon Nick Goiran. We do not believe that the Voluntary Assisted Dying Bill is the appropriate mechanism to establish such a joint standing committee. On rare occasions, a joint standing committee is required to be established under an act. Hon Nick Goiran in his contribution rightly gave the example of the Corruption and Crime Commission, so I will not go over that again.

Many members have expressed concern about the issues of palliative care and treatment that are sought to be included within the parameters of the proposed clause. I draw to honourable members’ attention that the Minister for Health has given a commitment that the WA Health budget will include discrete reporting of palliative care services, as was mentioned by Hon Tjorn Sibma, to ensure transparency and accountability of the resources allocated by the state government for palliative care. Commencing in the 2020–21 state budget, the “Significant Issues” section of the WA Health budget statement will include a standalone table and supporting commentary illustrating the funding, expenditure and services that have been provided for palliative care.

Although we do not support the amendment standing in Hon Nick Goiran’s name, I indicate to the chamber that the government would be supportive of the establishment of a joint select committee into palliative care. My suggestion is, and I give the commitment, that we would at the first opportunity after the bill is passed, so in February 2020, move a motion along these lines —

That this house establish a joint select committee into palliative care in Western Australia.

(1) That the committee inquire into and report on —

(a) the progress in relation to palliative care and implementation of the recommendations of the Joint Select Committee into End of Life Choices;
(b) the delivery of the services associated with palliative care funding announcements in 2019–20;
(c) the delivery of palliative care into regional and remote areas; and
(d) the progress on ensuring greater equity of access to palliative care services between metropolitan and regional areas.

(2) That the standing orders of the Legislative Council relating to standing and select committees will be followed as far as they can be applied.

(3) That the joint select committee report to both houses by November 2020.

(4) That the Legislative Assembly be requested to agree to a similar resolution.

The reason we have suggested that the committee report in November next year is that it would not be appropriate to give the committee 12 months in which to report, in light of the fact that an election will be held soon afterwards. Therefore, we want to limit the reporting date to November.

We do not support the proposed amendment. We do not believe it is appropriate that this bill includes the establishment of a committee. However, as I have indicated, we would support the establishment of a joint select committee into palliative care, and we will move that motion early in the new year. I am hopeful that those members who have rightly expressed concerns about palliative care will support this proposal and will take my word that the government will move this motion early in the new year after this bill is passed.

Hon NICK GOIRAN: With respect, I think the government has missed the point. The point of my proposed amendment is that it does not matter whether the Labor Party or the Liberal Party is on the treasury bench. Parliament has the opportunity now to put a fire under the government’s backside to ensure that it does something about palliative care. The minister’s proposed joint select committee that will start in February next year and finish in November next year is all well and good. I say that particularly on a partisan basis, as a Liberal, because it will enable the Liberal members of Parliament to keep attacking and criticising the government for its lack of movement on this issue. I want to move past that. I want to ensure that we take a bipartisan approach to palliative care so that no matter which party is on the treasury bench, someone will always be watching and saying, “What are you doing about palliative care? Don’t blame the former government. You’re there now. What are you going to do about it?” This amendment would achieve that. I also want to ensure that the committee is enduring, because whichever party is on the treasury bench typically has more influence and greater numbers, and it is much more difficult to get these types of committees up.
Division

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

Ayes (16)

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Noes (19)

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New clause thus negatived.

Clause 161: Regulations —

Hon NICK GOIRAN: What regulations does the government consider will be required to be made to give effect to this legislation?

Hon STEPHEN DAWSON: This clause is a general regulation-making power allowing the Governor in Executive Council to make regulations for or with regard to any matter or thing required to be prescribed to give effect to the voluntary assisted dying act. The bill does not require any regulations be made. The bill has been drafted as a comprehensive piece of legislation to operate as is. The bill has far more detail than the Victorian bill, with CEO approvals required for certain aspects within the purview of the Department of Health. This clause serves as a futureproofing mechanism; however, it is not anticipated at this stage that any regulations will be made under this bill.

Hon NICK GOIRAN: Could regulations be made around the activities of care navigators?

Hon STEPHEN DAWSON: My advice is that it is unnecessary. It would be a standard operational issue for the department to deal with.

Clause put and passed.

New clause 161A —

Hon NICK GOIRAN: I move —

Page 94, after line 22 — To insert —

161A. Regulations about care navigators

(1) In this section —

care navigator means a person approved by the CEO to facilitate another person’s access to voluntary assisted dying.

(2) The Governor may make regulations for or in relation to how the State will regulate the function and powers of care navigators.

(3) The power to make regulations under section 161A(2) must not be exercised unless —

(a) a draft of the regulations to be made under section 161A(2) has been laid before each House of Parliament; and

(b) both Houses of Parliament pass a resolution originating in either House approving the draft of the regulations, with or without an amendment.

(4) If the resolution under section 161A(3) approves the draft of the regulations with an amendment, the power to make regulations under section 161A(2) must not be exercised unless the amendment is made to the draft of the regulations.

(5) The Interpretation Act 1984 section 42 does not apply to regulations made under section 161A(2) of this Act.

Extracted from finalised Hansard
Members will recall that we touched on this issue early in the debate, particularly under clause 1, when it was identified that care navigators will be one of the instruments and mechanisms used by the government to facilitate access to voluntary assisted dying in Western Australia. Some members identified that there is going to be a difference, particularly because of the use of carriage services and the like, and the ongoing confusion with regard to commonwealth law. The government solution to that is to ensure that through care navigators, Western Australians will have access to voluntary assisted dying. We went through quite a lengthy process to identify that the government will spare no expense whatsoever. Indeed, if needs be, if a person in regional or rural Western Australia needs access to a care navigator and an interpreter, the government will fund that. It will fly the person out there. It is the same with regard to the consulting practitioner, the coordinating practitioner, the interpreter and indeed even the administering practitioner. We discovered that up to eight people would be possibly flown out to regional Western Australia. What became clear as part of that debate is that there is no definition of care navigators anywhere in the bill, and the government said, “We’ll sort all this out during the implementation phase.”

By supporting this amendment, we are not requiring the government to make regulations about care navigators, we are simply saying, “If you do, it needs to be tabled in Parliament; we need to agree to them first”, and at that point they will then have full effect. The necessity for this particular amendment is simply the Governor being unable to define for us who the care navigators will be. The government has been unable to indicate the process around its regime, and, in particular, we know that there will be some care navigators, according to the government, who will not fall under the same auspices and oversight regime of some of the medical and health practitioners. Indeed, we found out that social workers might be included as part of this. This amendment will ensure that whoever is in government will be able to put together some regulations, if it wants to, around care navigators to regulate that service and ensure that Parliament is aware of them and approves them.

**Hon STEPHEN DAWSON**: I indicate that the government is not supportive of this amendment. As we know, the making of regulations involves an exercise of legislative power, and the purpose of tabling regulations is to enable them to be considered by Parliament, which may disallow the regulations. Proposed clause 161A excludes the operation of section 42 of the Western Australian Interpretation Act 1984, which is the provision that requires all regulations to be laid before Parliament and subjected to disallowance. It is unusual for the operation of section 42 of the Interpretation Act 1984 to be excluded. The regulations cannot be made unless approved. This is a more rigorous process than normal, particularly as the purview of care navigators is something that is appropriate to fall under the management of the Department of Health and managed operationally at that level. We do not believe it is appropriate to require the role of care navigators, which is to assist patients who need support in obtaining information about or access to voluntary assisted dying, to be subject to regulation.

**Hon NICK GOIRAN**: This new clause does not do that. It does not mandate that it has to be subject to regulations; it is just saying that if the government puts together some regulations—look at proposed subclause (2)—the Governor may make regulations. If the government’s objection is proposed subclauses (3), (4) and (5), it should move an amendment to delete those subclauses.

**Hon AARON STONEHOUSE**: I note what the minister pointed out, and that there is a slightly different way to go about allowing for regulations, but at the very least, proposed subclauses (1) and (2) of the new clause are very sensible and important to have. The government has gone to great pains to detail and describe the eligibility of coordinating practitioners, consulting practitioners, administering practitioners and all the other roles of people involved throughout the process of voluntary assisted dying. Through the interrogation of clause 1, we discovered a new hidden class of persons involved in the process of voluntary assisted dying—the care navigator. Through the questioning of clause 1, we found that it may be appropriate to have this person, especially when we run into difficulty with the commonwealth Criminal Code Act around using a carriage service to communicate suicide. If we are going to have that role, it is important that Parliament has some oversight of the eligibility of the person filling the role of care navigator and has the ability, at the very least, to disallow. I see that Hon Nick Goiran has gone a little further; rather than the regulations being accepted proforma, his amendment will allow them to be accepted by a resolution of both houses of Parliament. It goes a little further; that is, the Houses of Parliament need to take positive action to approve the regulations rather than them being moved proforma, in the absence of a disallowance motion. I would be happy to entertain either form—either relying on section 42 of the Interpretation Act or accepting the process laid out in new clause 161A(3). The principle that has been put forward by Hon Nick Goiran is sensible and not really controversial. If a new role is involved in the process of voluntary assisted dying, it is appropriate that Parliament has some oversight of that role. We are delegating quite a lot of power to the CEO of Health for the operation of this bill. Whenever possible, Parliament needs to retain its power to disallow regulations and to disallow the delegated legislation that will come into effect as a result of that power delegated to the CEO. Whether we accept the mechanism created under new clause 161A(3) or we rely on section 42 of the Interpretation Act, either way the principle behind this amendment is very sound, and I support it on that basis.

*Extracted from finalised Hansard*
Division

New clause put and a division taken, the Deputy Chair (Hon Matthew Swinbourn) casting his vote with the noes, with the following result —

Ayes (13)

Hon Jim Chown
Hon Rick Mazza
Hon Charles Smith
Hon Ken Baston (Teller)

Hon Peter Collier
Hon Michael Mischin
Hon Aaron Stonehouse

Hon Donna Faragher
Hon Simon O’Brien
Hon Dr Steve Thomas

Hon Nick Goiran
Hon Tjorn Sibma
Hon Colin Tincknell

Noes (22)

Hon Martin Aldridge
Hon Colin de Grussa
Hon Alannah MacTiernan
Hon Dr Sally Talbot

Hon Jacqui Boydell
Hon Sue Ellery
Hon Kyle McGinn
Hon Darren West

Hon Robin Chapple
Hon Diane Evers
Hon Martin Pritchard
Hon Alison Xamon

Hon Tim Clifford
Hon Adele Farina
Hon Samantha Rowe
Hon Pierre Yang (Teller)

Hon Alanna Clohesy
Hon Laurie Graham
Hon Robin Scott

Hon Stephen Dawson
Hon Colin Holt
Hon Matthew Swinbourn

New clause thus negatived.

Clause 162: Review of Act —

Hon NICK GOIRAN: This is an unusual provision because the government has selected the second anniversary. What was the basis for that decision?

Hon STEPHEN DAWSON: We have taken into consideration the implementation period. Rather than a normal three-year review period, it will be about three and a half years.

Clause put and passed.

Clause 163: Act amended —

Hon NICK GOIRAN: The explanatory memorandum states, under clause 163 —

This clause provides that Division 2 amends the Constitution Acts Amendment Act 1899 (WA).

Does the explanatory memorandum contain an error?

Hon STEPHEN DAWSON: I am advised it is an error, honourable member; it should say division 1.

Clause put and passed.

Clause 164: Schedule V amended —

Hon NICK GOIRAN: Why is it deemed necessary for the Voluntary Assisted Dying Board to be included in the list of bodies in the Constitution Acts Amendment Act 1899, of which membership must be vacated on election to the legislature?

Hon STEPHEN DAWSON: I am advised it is usual practice for boards to be on that list, honourable member.

Clause put and passed.

Clause 165: Act amended —

Hon NICK GOIRAN: Why is it deemed necessary for division 2 to make any amendments to the Coroners Act 1996?

Hon STEPHEN DAWSON: A consequential amendment is required to the Coroners Act 1996 to exempt deaths brought about by voluntary assisted dying. Otherwise, these deaths would fall within the definition of a reportable death and result in the automatic involvement of the coroner.

Clause put and passed.

Clause 166: Section 3A inserted —

Hon NICK GOIRAN: The explanatory memorandum states —

This clause does not prevent the Coroner from voluntarily investigating the death … where a contravention of the Voluntary Assisted Dying Act is suspected since such a death may be a reportable death.

How would the coroner be made aware of a death when a contravention of the voluntary assisted dying act is suspected?

Hon STEPHEN DAWSON: The medical practitioner who is certifying the cause of death may advise, or the family or the board may advise.

Clause put and passed.

Extracted from finalised Hansard
Clause 167: Act amended —

Hon NICK GOIRAN: Why is it deemed necessary for division 3 to make any amendments to the Guardianship and Administration Act 1990?

Hon STEPHEN DAWSON: This clause makes it clear that nothing in the Guardianship and Administration Act 1990 authorises the making of a treatment decision, whether in an advance health directive or otherwise, in relation to voluntary assisted dying. Voluntary assisted dying cannot be included in an advance health directive as a treatment decision for a person’s future treatment for the purposes of part 9B of the Guardianship and Administration Act. Furthermore, a treatment decision on voluntary assisted dying cannot be made under the Guardianship and Administration Act.

Clause put and passed.

Clause 168: Section 3B inserted —

Hon NICK GOIRAN: In light of the wording of proposed new section 3B, inserted into the Guardianship and Administration Act 1990 via clause 168, is voluntary assisted dying considered by the government to constitute a treatment for patients in Western Australia?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: In which case, can the minister explain the wording outlined in the clause?

Hon STEPHEN DAWSON: It is for the avoidance of doubt and it is at the request of the Public Advocate.

Clause put and passed.

Clause 169: Act amended —

Hon NICK GOIRAN: Why is it deemed necessary for division 4 to amend the Health and Disability Services (Complaints) Act 1995?

Hon STEPHEN DAWSON: The intent is to make clear that the Health and Disability Services Complaints Office is able to consider voluntary assisted dying as a health service for the purposes of receiving and assessing a complaint under the Health and Disability Services (Complaints) Act 1995.

Clause put and passed.

Clause 170: Section 3 amended —

Hon NICK GOIRAN: The minister will see that there is a separation in proposed subparagraphs (i) and (ii) between palliative health care and voluntary assisted dying. On that basis, is the government able to confirm that this separate inclusion of voluntary assisted dying is because it is not a health service that falls within palliative health care?

Hon STEPHEN DAWSON: I confirm that it is not part of it.

Clause put and passed.

Clause 171: Act amended —

Hon NICK GOIRAN: The Medicines and Poisons Amendment Regulations (No. 2) 2019 were tabled by the government on 19 November 2019. What impact do they have on this bill?

Hon STEPHEN DAWSON: I am advised that they have no impact because this legislation has not passed yet.

Hon NICK GOIRAN: The minister indicated in earlier parts of the debate that these various acts that we are now in the process of amending have some bearing on the Voluntary Assisted Dying Bill. Some regulations were tabled the other day—on 19 November 2019, less than a month ago. It is not the case that just because they were tabled before this bill passes, they have no bearing upon this bill. They may well impact upon the bill. I do not know the answer to that; I am just making sure. The answer cannot be just because it was tabled beforehand. It would make as much sense as saying that the Medicines and Poisons Act passed through Parliament in 2014 and has bearing on this particular bill. Clearly, it does. It is referenced many times throughout the bill and, indeed, division 5 will amend sections of that act. I want categorical confirmation that those regulations that were tabled on 19 November 2019 have nothing to do with voluntary assisted dying or any element of the process.

Hon STEPHEN DAWSON: They have no unintended consequences for the bill.

Clause put and passed.

Clause 172: Section 3 amended —

Hon NICK GOIRAN: Why is it necessary to include the definition of “voluntary assisted dying substance” in section 3 of the Medicines and Poisons Act 2014 when that section already includes definitions of “schedule 4 poison” and “schedule 8 poison”?

Extracted from finalised Hansard
Hon STEPHEN DAWSON: This clause inserts a new definition of “voluntary assisted dying substance” into section 3 of the Medicines and Poisons Act 2014. The definition refers to a schedule 4 or schedule 8 poison that is a voluntary assisted dying substance as defined in clause 7(2)—namely, “for use under this Act for the purpose of causing a patient’s death”.

Clause put and passed.

Clause 173: Section 7 amended —

Hon NICK GOIRAN: Why is it deemed necessary to alter the definition of “prescriber” in section 7 of the Medicines and Poisons Act 2014 when the current definition is sufficient to encompass authorised suppliers of schedule 4 and schedule 8 poisons under this bill?

Hon STEPHEN DAWSON: The new definition of “prescriber” distinguishes between a schedule 4 or schedule 8 poison, other than a voluntary assisted dying substance, and a voluntary assisted dying substance. A prescriber in relation to a schedule 4 or schedule 8 poison, other than a voluntary assisted dying substance, is an authorised health professional who has authority to prescribe the poison; however, a prescriber in relation to a voluntary assisted dying substance is a person who is authorised under the legislation to prescribe the substance. This amendment is required because the coordinating practitioner for the patient is the only person who may prescribe a voluntary assisted dying substance under the legislation.

Hon NICK GOIRAN: What requirements for the use or administration of a schedule 4 or schedule 8 poison will be prescribed by the regulations?

Hon STEPHEN DAWSON: I am sorry; the honourable member is going to have to ask that question again. I did not hear it; there was some noise in the chamber.

Hon NICK GOIRAN: What requirements for the use or administration of a schedule 4 or schedule 8 poison will be prescribed by the regulations?

Hon STEPHEN DAWSON: There is nothing.

Clause put and passed.

Clause 174: Section 14 amended —

Hon NICK GOIRAN: In what circumstances is a person currently permitted to supply a schedule 4 or schedule 8 poison under the Medicines and Poisons Act 2014?

Hon STEPHEN DAWSON: It is set out in section 14(1) of the Medicines and Poisons Act 2014. Does the member want me to identify section 14(1)?

Hon Nick Goiran: Yes, please.

Hon STEPHEN DAWSON: Section 14(1) states —

A person who manufactures or supplies a Schedule 4 or 8 poison commits an offence unless the person does so —

(a) under and in accordance with an appropriate licence or a professional authority; and

(b) in accordance with the regulations.

Hon NICK GOIRAN: Why is it deemed necessary to amend section 14 of the Medicines and Poisons Act 2014 with the insertion of proposed subsection (3A) under clause 174(3) and (4)?

Hon STEPHEN DAWSON: It is because there are additional restrictions in the Voluntary Assisted Dying Bill in relation to supply.

Clause put and passed.

Clause 175: Section 28 amended —

Hon NICK GOIRAN: The amendment at clause 175 provides that there are grounds for taking action against an authorised health professional under division 2 of part 3 of the Medicines and Poisons Act 2014 if the health professional or an employee or agent of the health professional has, in connection with the person’s administration, manufacture, possession, prescription, supply or use of a poison, contravened the Voluntary Assisted Dying Bill. What grounds for taking action may arise and what contraventions of the legislation are covered by this amendment?

Hon STEPHEN DAWSON: Division 2 of part 3 of the Medicines and Poisons Act 2014 gives the CEO of the Department of Health the power to impose conditions on, suspend or cancel a person’s professional authority—authorisation under section 25 to administer, possess, prescribe, supply or use a medicine or authorisation under section 26 to relevantly manufacture a medicine. The amendments to section 28 of the Medicines and Poisons Act 2014 mean that a contravention of the legislation may be treated in the same way as contraventions of, for example, the Medicines and Poisons Act 2014, the Misuse of Drugs Act 1981 and the commonwealth Therapeutic Goods Act.

Clause put and passed.

Extracted from finalised Hansard
Clause 176: Section 83 amended —

Hon Nick Goiran: Why does clause 176 provide that regulations referred to in section 83(1) of the Medicines and Poisons Act 2014 cannot make provision in relation to the supply or prescription of a drug of addiction that is a voluntary assisted dying substance that is supplied or prescribed for the purposes of this bill?

Hon Stephen Dawson: This amendment is required because the legislation makes separate provision for the prescription and supply of a voluntary assisted dying substance.

Clause put and passed.

Clause 177: Section 115 amended —

Hon Nick Goiran: The explanatory memorandum states —

The effect of the amendment is that the maximum penalty for an offence contrary to sections 14(1), 14(2), 14(3) and 14(4), 21 and 22 in respect of a voluntary assisted dying substance prescribed, supplied, possessed or used for the purposes of the Voluntary Assisted Dying Act is a fine of $45,000 and imprisonment for 3 years. Without this amendment, the maximum penalty would only be a fine of $45,000.

However, according to the current section 115 of the Medicines and Poisons Act 2014, the penalty for an offence relating to a drug of addiction defined in section 77(1) of that act as a schedule 8 poison or a schedule 4 reportable poison is a fine of $45,000 and imprisonment for three years. In light of this, can the minister clarify whether the explanatory memorandum is in error?

Hon Stephen Dawson: It is not wrong. We had to make an insertion for the purposes of a voluntary assisted dying substance, so it is not just the schedule 4 or 8 poison.

Clause put and passed.

Clause 178: Act amended —

Hon Nick Goiran: The explanatory memorandum states that the consequential amendments in clause 178 are required to ensure that a person who is authorised to do something under the legislation does not commit an offence under the Misuse of Drugs Act 1981. Without the consequential amendments proposed in division 6, which provisions of the Misuse of Drugs Act 1981 would be at risk of being breached by someone authorised to do something under the Voluntary Assisted Dying Bill?

Hon Stephen Dawson: I am advised that it is sections 5, 6, 7 and 7B.

Hon Nick Goiran: Are there any circumstances in which a patient is currently able to lawfully possess a prohibited drug under the Misuse of Drugs Act 1981; and, if so, what drug is it lawful to possess and what laws or regulations are in place to ensure drug safety and security?

Hon Stephen Dawson: There is a general authorisation provision under subsection (5)(b) and specific requirements under sections 6(3), 7(3), and 7B(7). One example is that a person does not commit a crime contrary to section 7(1) of the MDA if he or she is authorised to have possession under the Medicines and Poisons Act.

Hon Nick Goiran: The second part of that question was: what is the drug that is lawfully permitted in those circumstances?

Hon Stephen Dawson: I am told that all schedule 8 poisons and some schedule 4 poisons are prohibited drugs under the Misuse of Drugs Act 1981.

Hon Nick Goiran: Are there any circumstances in which a patient is currently able to lawfully self-administer one of these prohibited drugs under the Misuse of Drugs Act 1981?

Hon Stephen Dawson: I am advised that the use of opiates in palliative care would be an example of that.

Clause put and passed.

Clause 179: Section 5C inserted —

Hon Nick Goiran: Is the new section 5C inserted by clause 179 necessary for inclusion in the Misuse of Drugs Act 1981 in light of the amendments proposed in division 5 of part 11 of this bill?

Hon Stephen Dawson: I am advised that it is required.

Hon Nick Goiran: Since division 5 of part 11 amends the Medicines and Poisons Act 2014 in relation to schedule 4 and schedule 8 poisons approved by the CEO for use in voluntary assisted dying, would not section 5B of the Misuse of Drugs Act 1981 then also cover the preparation, selling, supply, possession and use of schedule 4 and schedule 8 drugs for voluntary assisted dying?

Hon Stephen Dawson: I am advised, no, there has to be a special provision.

Clause put and passed.

Extracted from finalised Hansard
Clause 180: Section 5 amended —

Hon NICK GOIRAN: In light of clause 180 and section 5 of the Misuse of Drugs Act 1981, where does the government anticipate voluntary assisted dying substances will be prepared by authorised suppliers? While the minister is taking advice on that question, could he also deal with this supplementary question: in that same respect, where does the government anticipate that the voluntary assisted dying substance will be sold and supplied from by authorised suppliers?

Hon STEPHEN DAWSON: I am advised that this has been touched on earlier, honourable member. Essentially, this will be dealt with during the implementation period of the bill.

Clause put and passed.

Clause 181: Section 6 amended —

Hon NICK GOIRAN: This goes to the tricky issue of the contact person having to return the substance. I seem to recall that the government moved an amendment at some earlier point in the bill to remove the obligation, possibility or even power for the patient to return the substance. Does that impact on this clause in any way? As I understand it, it will be an offence committed under section 6 of the Misuse of Drugs Act if a self-administration decision is revoked but the voluntary assisted dying substance is not returned to an authorised disposer within the required time frame, which from memory is 14 days. I want to be clear about who will be held liable in those circumstances. Will it be the patient or their contact person? I know that we moved an amendment earlier to remove the patient, but is any supplementary or consequential amendment required at this point?

Hon STEPHEN DAWSON: I am told that the amended clause, which was clause 72, is about labelling of the voluntary assisted dying substance; it is not about authorisation.

Clause put and passed.

Clause 182: Section 7 amended —

Hon NICK GOIRAN: Which prohibited plants referred to in section 7 of the Misuse of Drugs Act can be used to cause the death of a person and will likely be approved by the CEO for use as a voluntary assisted dying substance under the legislation?

Hon STEPHEN DAWSON: The issue will be dealt with during the implementation phase. We are not presupposing the work of the clinical panel.

Hon NICK GOIRAN: So why is this amendment necessary, minister?

Hon STEPHEN DAWSON: The effect of the amendments in this clause is that a person will not commit an offence contrary to the Misuse of Drugs Act 1981 by reason only of the person having in their possession a prohibited plant, if the person proves that he or she was authorised to do so under the act.

Clause put and passed.

Clause 183: Section 7B amended —

Hon NICK GOIRAN: What drug paraphernalia will be required to be used in conjunction with voluntary assisted dying substances in accordance with the act, and will this paraphernalia be provided to the patient or their agent or contact person by the authorised supplier of the voluntary assisted dying substance?

Hon STEPHEN DAWSON: Again, this issue will be dealt with during the implementation phase. We are not presupposing the work of the clinical panel.

Clause put and passed.

Clause 184: Section 27 amended —

Hon NICK GOIRAN: Why is it deemed necessary to amend section 27 of the Misuse of Drugs Act 1981 under clause 184?

Hon STEPHEN DAWSON: The effect of the amendments in this clause is that if a voluntary assisted dying substance is seized, acquired or detained under section 26 of the Misuse of Drugs Act 1981, the substance may be disposed of in accordance with section 27. If no person is to be tried with the commission of an offence in relation to the substance, a police officer may release the substance to a person authorised by or under the act to have possession of the substance. If a person is tried for the commission of an offence and the substance has not been destroyed, the court which tries the person must give a person claiming to be authorised by or under the act to have possession of the substance an opportunity to show cause why the substance should be released to him or her. The court may make an order to release, destroy or forfeit the substance.

Clause put and passed.

Title put and passed.

Report

Bill reported, with amendments, and, by leave, the report adopted.

Extracted from finalised Hansard
As to Third Reading

HON STEPHEN DAWSON (Mining and Pastoral — Minister for Environment) [12.57 am]: I move —

That the third reading of the bill be made an order of the day for the next sitting of the house.

Point of Order

Hon SIMON O’BRIEN: Possibly this is in hand, but my understanding of the suspension of standing orders arrangements to enable these sittings to be held was that at the conclusion of today, we were to complete not only the committee stage but also any recommittal. Supplementary notice paper 139, issue 20, bears a number of amendments intended for consideration upon recommittal of a number of clauses. I am just wondering whether that will happen, because we will not get a chance otherwise.

The PRESIDENT: Member, I understand that nobody has asked for a recommittal to deal with any of those matters. Where was I?

Debate Resumed

Hon STEPHEN DAWSON: Madam President, just before that point of order, I had moved that the third reading of this bill be made an order of the day for the next sitting of the house.

Question put and passed.

Legislative Council

Thursday, 5 December 2019

[page 9879]

VOLUNTARY ASSISTED DYING BILL 2019

Third Reading

HON STEPHEN DAWSON (Mining and Pastoral — Minister for Environment) [11.13 am]: I move —

That the bill be now read a third time.

HON RICK MAZZA (Agricultural) [11.14 am]: Seeing as no-one else is going to stand, I might as well kick us off on the third reading debate! I have a few comments to make about the bill.

When I started with my contribution to the second reading debate, I was probably around 70–30 opposed to the bill, but as we have gone through the process of the Committee of the Whole House, I have found problems reconciling a number of issues. The major one is the self-administration aspect of the bill, which I think is quite a relaxed arrangement—a bit lackadaisical—with the security of the substance and that no witness will be present with the patient at the time they self-administer the substance. I am still very uncomfortable with that. The other issue that I have had some problems trying to reconcile is that the death certificate will not have any mention whatsoever that someone accessed voluntary assisted dying. To me, the death certificate should be a straight record of fact. Why there is resistance to that, I do not know.

After going through the process of the second reading debate and committee, I will now say that I am 100 per cent opposed to this bill. When we get to vote on the third reading, I will definitely oppose it.

HON MICHAEL MISCHIN (North Metropolitan — Deputy Leader of the Opposition) [11.15 am]: I would like to preface my remarks with some general observations about the manner in which the Voluntary Assisted Dying Bill 2019 has been managed in this place and give credit where it is due to Hon Stephen Dawson as the minister responsible for the control and conduct of this legislation in this place. Having experienced the pressures of being at the committee table and managing legislation in this place myself and having seen others do it, I can well appreciate the burden on Hon Stephen Dawson over the last several sitting days that we have been dealing with this in the Committee of the Whole for long hours and with some very detailed and forensic examination of the minutiae of the bill, which is quite proper. I think it is a tribute to his character that he has dealt with it at all times in a parliamentary manner, with courtesy, with respect for other members, with patience and very professionally. I do not often try to speak on behalf of other people, but I would be surprised if anyone would cavil with that assessment of the manner in which he has conducted himself. Credit where it is due because it is not every sitting session that we have to deal with a bill of this character, importance and complexity. Having experienced the pressures of being at the committee table and managing legislation in this place myself and having seen others do it, I can well appreciate the burden on Hon Stephen Dawson over the last several sitting days that we have been dealing with this in the Committee of the Whole for long hours and with some very detailed and forensic examination of the minutiae of the bill, which is quite proper. I think it is a tribute to his character that he has dealt with it at all times in a parliamentary manner, with courtesy, with respect for other members, with patience and very professionally. I do not often try to speak on behalf of other people, but I would be surprised if anyone would cavil with that assessment of the manner in which he has conducted himself. Credit where it is due because it is not every sitting session that we have to deal with a bill of this character, importance and complexity. By way of that, I should also pay tribute to the advisers who were assisting him, who, of course, had to put up with the same burden over the whole course of the Committee of the Whole. Although I note that from time to time they were doing it in relay, it is a considerable burden on them because they have to have the facts and the information at their fingertips, so I give credit to them for the work that they have done and the manner in which they have assisted the government. That is not to say that I necessarily agree with the answers we got from the government or with the government’s attitude, but I am not casting that reflection on Hon Stephen Dawson, who I think did the best that could be done.
I think it also proper that I should acknowledge the efforts of Hon Nick Goiran, who has spent a great deal of time examining this legislation and has been committed to examining the whole concept of euthanasia or voluntary assisted dying or whatever we might call it. Although one may have different opinions about whether certain clauses ought to have been examined in the way he examined them or the level of questioning he engaged in, or the like, when he dealt with that, he carried most of the burden of the examination of this legislation and was certainly across his brief. I think that took the burden off other members who may have had questions about the legislation and how it would operate, its defects and the like. He was entirely proper in the way that he questioned the operation of the legislation and in the issues that he raised, and, to my mind, carried the burden for other members. That is not to diminish the contribution of other members. I think we have had some very, very good contributions. I have a bias, of course, to the examination and critical examination of the bill and the exposure of its shortcomings, both in a policy sense and the manner in which it has been drafted. But the fact that a number of members raised the same issues as well as different issues and questioned the operation of the bill in the way that they did assisted in understanding how it was meant to operate, exposed any flaws that there may be and explored any undesirable consequences, and they tried their best to expose any unintended consequences that may have been overlooked or ignored by the government. I would like to thank them.

There are some who spoke more than others on this bill, and tedious though it may have been for the media and the supporters of the bill outside this chamber, we have ended up with a better bill. Quite a number of amendments have been passed that have improved its operation and tried to overcome potential defects that would have had undesirable consequences in the future. I would like to acknowledge—I do not mean to diminish the contributions of others—particularly Hon Alison Xamon, Hon Martin Pritchard, Hon Adele Farina, Hon Aaron Stonehouse and Hon Martin Aldridge for the work they did on that. I know many members supported the bill in principle or without qualification but nevertheless felt the need to try to improve it. In that sense, boring as it may be for those spectators looking forward to the final result, I think that this house has discharged its responsibilities most ably and properly. Some might say it has been the death of democracy; I think it has been an example of how it ought to work.

As I have said, credit to Hon Stephen Dawson is not to endorse the way that the government has dealt with this bill. I foreshadowed in my second reading contribution that I considered that this bill and the whole idea behind the scheme has been politically weaponised, and the management of that and the debate outside this place has been an example of it. I make a couple of points that arose out of the consideration of the bill in detail by the Committee of the Whole House.

One that I think is still fresh in everyone’s mind is the manner in which the government dealt with the Law Society of Western Australia submission that was provided last week—I think it was Wednesday—to the Premier, the Attorney General and the responsible minister, the Minister for Health. The fact that that submission did not find its way to the minister managing the bill on behalf of the government in this house just astonishes me. That it did not find its way here with the minister having been graced with a briefing on the issues pointed out in that submission smacks either of incompetence on the part of the government or a deliberate desire to ignore anything that might reflect badly on the bill’s drafting. That is, at the very least, poor, but it was also a disservice to this house and to the minister managing the bill in this house. There has been a lot of talk about how long the debate has gone; that is just one example of how the consideration of this bill by this place could have been expedited. Instead of the minister having to spend minutes trying to work his way through the implications of what had been written down in that submission and made available to the expert committee, he could have had a briefing note on it and rattled off the answers immediately. But he did not, and hence more time was wasted, because the minister had not been properly briefed and supported by his government and ministers who put him out here as the point man for this legislation that they say is so important, and because they simply rejected the very idea of any amendments in the other place. If those things had been canvassed properly and some sensible amendments that have now been agreed by the government had been passed there, we would have saved an enormous amount of time and effort, and it would have shown a sign of good faith rather than us having a sense of suspicion over the government’s proposals on this legislation.

I have to say, more broadly, if this had not been turned into a political weapon, if the government was genuinely trying to ensure that this legislation is the best it could be and to expedite its passage with some level of collaboration with members with different views, there were other ways of going about it. A green bill could have been issued and published in which all the considerations could have been raised and agitated and considered by government and some compromise or at least understanding achieved. It could have been considered, as we were always urged to do by the then opposition when we were in government, by a committee of this place, which could have gone through the issues in detail and dealt with them by the hearing of evidence and submissions, with quiet deliberation, considered thought and advice behind the scenes, and come up with recommendations. This has been done with other legislation such as the residential parks legislation, which has solved a number of problems that were agitating members at that stage. Many things could have been done, but it seems that this is so urgent that it had to be done before Christmas because lives and people’s suffering is at stake, yet we are told that it will take at least 18 months—I suggest longer; I suggest it will be along the lines of two years, if not more—before this scheme is put in place. It has been revealed that much of the basic work is still to be done. We still need to resolve the issue
of how the commonwealth and its electronic communications legislation will interact with the proposals that the government has for the bill’s operation and issues of that nature. We still have to see forms. We still have to see regulations. We still have to have training regimes put into place. All of that could have been done in parallel to the passage of this bill and in parallel to its proper consideration.

I make a prediction that at some stage in the next 12 or up to 18 months that we are told it will take to get this scheme active, the government will identify various problems that will need to be addressed by way of legislative amendment, and we are going to have to go through all this again with an amending bill before this act can come into effect. I also predict that that is not going to happen before the next election, because that would be a sign of failure. The government will hope to delay any amendments until after the next election, hoping that if it is still in government, it can then slide this stuff through, and if it is another government, it can blame that other government for not putting the bill into effect and for trying to tamper with its perfect model that emerged from the Legislative Assembly some weeks ago—but we will see.

I turn now to a couple of matters that have most exercised my mind. There are a number of issues—I will not go through the whole bill, by any means—but one of the most egregious is the prohibition, the injunction, the government has imposed on the proper and full revelation of certain relevant facts in death certificates. Instead of leaving the regime as it is, for a practitioner to say what the practitioner feels necessary in a death certificate, the government has said: no; do not say anything about voluntary assisted dying. Do not say anything about the fact that the deceased had administered to them a schedule 4 or 8 poison; do not mention that.

The only argument against it is that it is a respect for privacy—I did not think that death certificates were meant to be subject to people’s privacy, otherwise we would not have anything in them at all, let alone any mention of suicide—and respect for people’s dignity. These are all value judgements. That is the best the government could come up with for legislating for medical practitioners—do not put relevant information on the death certificate that they sign-off on. This house has made that decision, but I think that is an astonishing thing. That is a scandal; it is a stain on this Parliament. That should not happen. Where do we go to next to pander to suppositions about people’s privacy and dignity? Are there any other things that we are going to legislate on that should not be revealed in documents that are meant to be documents of truth that are submitted to coroners and the like, who are charged with the responsibility of investigating deaths in our community, and of accountability? Are there any other things that might upset someone that we are going to legislate on to ensure that people do not reveal that truth—that relevant information? I find that astonishing and disappointing. It is one of the factors that I am taking into account in maintaining my position that I cannot support this bill.

The other sad thing is the limited oversight that will be provided by the board. The board is, essentially, a statistic and information-gathering body, but it does nothing else. It seems not to be able to take any action to address things, and it will give some bland information from time to time. I suspect those who will be appointed to the board will be sympathetic to the scheme that is proposed under this legislation. They then will have an interest in ensuring that any defects in the way that it operates will not be revealed to the public and certainly not revealed to this Parliament in which people can fearlessly say something about it. That raises the question then of why the government opposed a standing committee that would have allowed oversight of the operation of the scheme and allowed some leverage in respect of the balance against voluntary assisted dying and ensured that people have appropriate palliative care. It may very well be right that palliative care ought not to be included in such a standing committee under this legislation—so be it—but that there should not be some parliamentary oversight of a legislative scheme that involves the state-sanctioned termination of the lives of patients, or the self-administered termination of the lives of people of the state, strikes me as astonishing.

Notwithstanding that members of the government and some other members have claimed that schemes like this in other jurisdictions have worked perfectly and that there is nothing to see that has gone wrong, is belied by Hon Nick Goiran’s dissenting report to the Joint Select Committee on End of Life Choices and the various examples he has provided during the course of the consideration of Committee of the Whole House. It seems that this legislation has been structured and its architects have crafted it in a way that would allow as little scrutiny as possible of its problems and defects and that they are trying to make sure that any undesirable consequences of the scheme, when it finally comes into operation, will not be revealed or be difficult to determine. That raises the question to me of what is the government trying to hide. I suspect that the government well knows that although this can provide an enormous amount of comfort and relief to the people who can take advantage of it and want to take advantage of it—so be it. I entirely agree with that—the government is also conscious that it can be misused and abused, and that there will be people who will be killed under the sanction of this who did not want to be or whose lives could have been saved and prolonged. I raise two examples—I am sorry if I embarrass members—the misdiagnosis or the false and erroneous prognosis given to Hon Peter Collier’s mother and the experiences related by Hon Adele Farina about how doctors managed to railroad her father into surgery that he did not need or want, and without him realising what he was getting into until it could have been too late. That happens. We have an example in Dr Lancee in Western Australia, who—according to her, because we do not know because the police have not been able to ascertain the facts because of lack of cooperation—says she killed a patient.
Whether she did so out of mercy or at the patient’s request, we just do not know; but here is a legislative sanction for all that, if this is operating correctly, whereby a couple of doctors can just do what a person has been persuaded by their family would be best for all to do.

Other things could go wrong with this legislation, and the government is well aware of it, but it is prepared to take that risk. That is the thing that I find most disturbing. If there are other sorts of experiences here, as have been evidenced in other jurisdictions, I want to make sure that we know about them. This government seems to be intent on ensuring that it will be as difficult as possible to find out, and there will be no accountability to this Parliament. Therefore, that once again reinforces me in my position that I cannot support this bill. Were this bill to be properly and carefully crafted, were it to be examined and a regime put in place to ensure that it was being conducted properly and to reveal any defects that could come out and to address those defects in a timely fashion, I might think otherwise, but I just cannot support it in its current form. I am disappointed that the amendments that were aimed to try to overcome at least those significant defects failed by a bare margin, but that is the will of the house—so be it. But disappointed, I am.

As I said in my second reading contribution, I have sympathy for the objectives of the bill, but the lack of accountability, the potential for things to go wrong, the lost opportunity to ensure that those could be cured, the attitude of the government, which appears to me to be that any mistakes or anything that could go wrong will be buried along with the deceased, disturbs me and I cannot sanction that. This scheme is calculated to bury its own mistakes. I have sympathy for the objectives. I said that in my second reading contribution. I said that as far as I am concerned, I may very well at some time want to take advantage of the scheme myself if it is in place. I do not know; I hope not. I hope it never comes to that. However, my responsibility is more than just self-interest and I think that those who have spoken and examined this bill have also put aside their personal preferences and self-interest in order to ensure that what is being legislated for the peace, order and good government of Western Australia and its citizens is the best it could be before embarking down this new path.

I am not persuaded the bill is anywhere near as good as it should be; however, it is far, far better than it was when it entered this place some weeks ago. I commend members for their contribution to the debate and for doing their best in accordance with their conscience and their judgement to ensure that the bill is improved.

HON AARON STONEHOUSE (South Metropolitan) [11.40 am]: I thank members who have engaged in this process actively. I am not sure of the final tally of hours committed to this debate at this point, but after a few late sittings it is worth noting the hard work put in by members who have participated in the debate and tried their hardest to enhance the legislation and to ensure that adequate protections are in place for the Western Australian public. I refer to members such as Hon Nick Goiran, with whom I very much disagree on the question of voluntary assisted dying—I think people ought to have a right to make that choice. Fundamentally, we disagree, but I think both of us through the Committee of the Whole House have been engaged to ensure adequate protections and transparency around this process. Hon Michael Mischn, Hon Jacqui Boydell, Hon Martin Aldridge, Hon Rick Mazza, Hon Adele Farina and Hon Martin Pritchard have all been actively engaged in this process and have put forward well-thought out amendments. Although not all amendments were successful, the members acted in good faith to ensure the voluntary assisted dying regime will be the very best we can produce.

I thank also Minister Dawson, Minister for Environment, for his professional and courteous conduct during this process. It has been a long and drawn-out Committee of the Whole House process, but the minister has conducted himself to the highest standard. It is a credit to him how he has conducted himself through this.

Through the committee we have been able to enhance quite substantially this bill and the protections in it. I do not want to go over all the amendments that were agreed to through that process, but it is worth noting that the prohibition on healthcare workers raising with patients voluntary assisted dying was a very sensible amendment. In fact, it is a matter that I am surprised was overlooked in the drafting of the bill. It provides some vindication for the perhaps tedious, at times, interrogation of this bill that issues like that were identified and corrected. Along with that amendment was a requirement for medical practitioners who initiate conversations about voluntary assisted dying to provide information on palliative care to their patients. We have also seen a prohibition on coordinating, consulting and administering practitioners being family members or beneficiaries in a patient’s will. Again, that is a prohibition that I thought would have been present in the bill when it was presented to the Legislative Council. It is quite alarming that it was not, but I am glad that we were able to correct that mistake. Clearly it was a mistake because the government supported the amendment to correct that and any reasonable person would expect that a medical practitioner involved in this process would not have a conflict of interest.

Through a range of amendments we have ensured that there is greater disclosure of information between medical practitioners and patients, but also between medical practitioners and the board. This will certainly help to ensure that patients are fully informed and also ensure that accurate records are kept for the board and decisions made by medical practitioners will be accountable.

We have ensured that a record will be kept of interpreters used. Additionally, the defeat of the government’s proposed amendment to remove a conflict of interest for one of the witnesses to a signed declaration is an absolute win for commonsense. The two amendments that have had the largest impact on protecting the lives of innocent
people are the prohibition on medical practitioners with a conflict of interest and the prohibition on witnesses with a conflict of interest. If ever there was an opportunity for mischief or abuse, it was through the absence of those two prohibitions. Those have been corrected through the Committee of the Whole House. It took a long time to get there, but ultimately that will improve the safety of this regime.

There are a few things I am disappointed we have not been able to get out of the Committee of the Whole House process, and a few things I wish we had not got. An amendment was put forward by Hon Martin Aldridge to insert a principle of this bill that entitles regional residents to the same level of access to voluntary assisted dying as metropolitan patients. It is not that I disagree that all people should have access to voluntary assisted dying; it is a principled opposition to the idea that the state should be in a position whereby it is obliged to provide voluntary assisted dying to all people. I said it during earlier debate and I will say it again: I would much rather merely lift a prohibition on voluntary assisted dying than have the state become a facilitator of voluntary assisted dying. I appreciate the counterargument that the state is tangled up in this to a degree, but there is a vast difference between allowing someone to exercise their autonomy, to take their life if they wish and to seek help to do it, and the state becoming a provider of voluntary assisted dying. There is a very big difference between those things. I am afraid that we are going down the path of the state becoming a dealer in voluntary assisted dying, which makes me quite uncomfortable.

Unfortunately, I was unsuccessful in securing protections for conscientious objectors. If this bill passes, it will oblige medical practitioners with a conscientious objection to be involved in the voluntary assisted dying process. I think that is unconscionable. I think that it is wrong to coerce medical practitioners into being involved in this process if they disagree with it. It is not done in Victoria and it is not done in Oregon—in fact, I am not aware of it being done in any jurisdiction where voluntary assisted dying is legal—but we will do it here in Western Australia. In a bill in which we have gone to pains to ensure that there is no coercion leveraged against patients, we will be leveraging the power of the state to coerce medical practitioners. That is absolutely wrong.

Unfortunately, another aspect of this bill is that it will compel medical practitioners to lie on official records. Medical practitioners will be prevented—from recording on the death certificate that voluntary assisted dying had anything to do with the death of the patient. That is unfortunate. It sets a very bad precedent whereby the integrity of official records is degraded and whereby the law tells or compels somebody to lie. I think when we tell people that they cannot tell the truth on official government records it undermines not just the integrity of public records, but the integrity of the law itself. It is part of, perhaps, an aspect of social engineering to pretty up voluntary assisted dying. I absolutely support the right of someone to make that choice, but we should not wrap this up in cottonwool and pretend it is something that it is not.

The bill also, unfortunately, contains no undue influence checks in the capacity assessment and no training requirement for medical practitioners around undue influence. If a single amendment could have improved the safety provisions in the bill, it would have been an amendment to include undue influence provisions. The absence of such a provision will put people at risk. We considered undue influence amendments during the debate on several clauses of the bill. Not including them in the capacity assessment and the training provided to medical practitioners will put people’s lives at risk; the degree to which is hard to say. Clearly, the dictionary definition of “coercion” includes an element of violence or force—everybody knows that—whereas undue influence does not. Undue influence can happen in relationships between a teacher and a student, a doctor and a patient, a parent and a child and a carer and the person for whom they care. There is not necessarily violence or force in that relationship but inappropriate pressure can be placed on a person. If we are concerned about elder abuse, we absolutely should include undue influence in the training for medical practitioners and the capacity assessment. Its absence has me concerned about the safety of vulnerable people and the elderly in particular.

In the end, the Committee of the Whole House process has enhanced the bill and improved the available protections. No voluntary assisted dying regime will be 100 per cent safe; that is ultimately impossible. Legislation is always nuanced and there are trade-offs. Giving people the freedom to make their own choices will always come with some level of risk. We have done our best to mitigate those risks. I will not stand in the way of allowing people the freedom to exercise their own autonomy. I hope that the issues I have raised during my third reading contribution will become part of a later statutory review. I hope the Parliament will have an opportunity to review these laws soon. I am not sure what it will take to establish a joint standing committee, but I urge legislators now, and those to come, to pay close attention to this regime to see whether the protections that were put forward in amendments over the last two days that were not accepted might be considered in the future.

With that, I commend the bill to the house.

HON ROBIN CHAPPLE (Mining and Pastoral) [11.52 am]: I rise to make my contribution to the third reading of the Voluntary Assisted Dying Bill 2019. As many members would be aware, this has been a long journey for me comprising many other journeys and, as with all journeys, I have witnessed different things, visited many places and met countless people. It has been enlightening, uplifting, confronting, tinged with sadness and full of love. My contribution to the third reading will be relatively short. Reading Hansard from almost the last 19 years will fill in many of the gaps and map out my entire position and history of contributions in far more detail than I have time for today.
In January 1988, my mother was first admitted to Sir Charles Gairdner Hospital. She passed away in July the same year. That period set me on my own journey in ways that I did not understand at the time; indeed, I did not understand that it would eventually lead me to this place today, some 31 years later. I was always concerned that the manner of Dorothy Margaret Chapple’s death had not been good. I carried that with me without knowing how to deal with it. The care my mother had been given by all medical professionals at that time was absolutely exemplary but futile.

It was not until February 2001, when I was elected to this place for the first time, taking my seat on 22 May 2001, that a new pathway opened up for me to move forward on this journey. At the time, the Greens took over the role of what had been vacated by the Democrats and it was at this time that I met with retiring member Hon Norm Kelly, who was first elected to this chamber in December 1996. Norm had a passion for the pursuit of what was then referred to as voluntary euthanasia. He had attempted four times to introduce what I describe as the birthplace of compassionate legislation in WA. His first attempt was the Voluntary Euthanasia Bill 1997. His second attempt was the Voluntary Euthanasia Bill 1998. His third attempt was the Voluntary Euthanasia Bill 2000, which was introduced in May 2000. Finally, because of prorogation, the Voluntary Euthanasia Bill 2000 was again introduced in October the same year. In my discussions with retiring member Hon Norm Kelly, I agreed to carry on the mantle of his previous attempts. As a newcomer to this place, it took me almost a year, with the help of a number of people, to re-craft Norm’s bills into legislation that I was happy with. This was done with the help of Elize Steynberg—she had worked for Norm in his electorate office and had moved on to working for my colleague Hon Dee Margetts—and also with the help of the organisation then called the WA Voluntary Euthanasia Society.

The PRESIDENT: Member, I am going to interrupt you. I say to you with all due respect that the third reading debate is quite narrow and really what you should be reflecting upon is how the bill has come out of committee. The chamber has already made a decision on matters dealt with in the second reading and committee stages. I appreciate why you are doing so, but I fear that perhaps you are going back over some of the historical and policy issues that have led to similar bills in this place. I ask you to perhaps focus on what has come out of the committee stage for this bill. The third reading is really about why you will or will not support this bill at the third reading. I am trying to encourage you to perhaps focus on that element, if you can, please.

Hon ROBIN CHAPPLE: Thank you, Madam President. I was actually just moving into that area, having done a bit of scene setting.

We developed many relationships and those relationships became part and parcel of the various aspects of the direction that was taken by Amber-Jade Sanderson, MLA, member for Morley, who in June 2017 moved to establish the Joint Select Committee on End of Life Choices, which comprised four members of the Legislative Council and four members of the Legislative Assembly. Members of that committee found that we had a great deal of commonality in the way we addressed matters. The committee was exceptionally well supported by the committee staff: Mathew Bates, Michele Chiasson and Marion Huntly. The committee met for 12 months before producing its final report “My Life, My Choice” on 23 August 2018. In November 2018, the McGowan government announced that it would introduce legislation into Parliament to enable voluntary assisted dying in Western Australia and moved to set up the Ministerial Expert Panel on Voluntary Assisted Dying, which comprised a number of eminent people. The Voluntary Assisted Dying Bill 2019 was introduced in the Legislative Assembly on 6 August 2019. During the deliberations of the legislation in the other place and leading up to and during the debate here in the Legislative Council, I have had the support of many marvellous people, including Steve Walker, Noreen Fynn, Dinny Laurence, Belinda Teh and Dr Alida Lancee. Yesterday, in the early hours of Thursday, 5 December, at 1.00 am, after 100 hours of deliberation in the Legislative Council, the Voluntary Assisted Dying Bill 2019 passed the committee stage. I now conclude my commentary on the journey that has led me to this moment.

It gives me great pleasure to support the third reading of the Voluntary Assisted Dying Bill 2019, but, equally, it gives me great pleasure to acknowledge and thank all the many marvellous people I have met on this journey. From those whom we met within organisations supporting dignity in dying, to those wonderful people we met at the end of their lives during our committee investigations, and to Max, whom I met and formed a friendship with, albeit unfortunately briefly, as a result of our visits with Silver Chain. My final thanks must go to the hardest working group of people that I have come across in a long time—that is, the incredible ministerial staff who helped Minister Stephen Dawson and the Leader of the House, Hon Sue Ellery, in conducting what has been an incredibly civil debate. The civility demonstrated throughout this debate is commendable and something we should aspire to in all future debates in this place. Those people I want to single out are Marion Huntly, Daphne Fernandes, Amanda Bolleter, Lisa Furness, Carol Conley and, indeed, Hon Malcolm McCusker, AC, QC.

For me, personally, this is a very special day. My mother passed away after a long and painful ordeal with terminal illness. I made a promise that I would do all that I could to change the law and allow people in pain, like my mum, to access voluntary assisted dying. Today, decades later, I can finally say, Mum, we did it.
HON DARREN WEST (Agricultural — Parliamentary Secretary) [12.01 pm]: My contribution to the third reading will also be brief. I am particularly proud to be standing here as a member of the McGowan government that has got this very important piece of legislation to its third reading in the Legislative Council. Members will recall that in my inaugural speech in 2013, I mentioned the need for legislation to address voluntary assisted dying. Here we are in 2019 having now got the legislation to the final stages of a very long process. Members will also recall that I was comfortable to support the bill without amendment. Although there have been amendments to the bill, none of those amendments change the fundamentals of the bill. We have before us a very good piece of legislation that is very similar to what was brought into this chamber and the second reading stage. I will continue to support this legislation for the reasons that I set out in my speech at the second reading.

I acknowledge the people who have helped to get us to this point — no-one more so than the Minister for Environment, Hon Stephen Dawson, for the tremendous work he has done; the Leader of the House, Hon Sue Ellery, at the table; and all the advisers who for countless hours answered the really hard questions and addressed the scrutiny that this bill certainly deserved. I acknowledge all the other members from both houses who were involved in the debate, especially here in the Legislative Council. I sat back wistfully and made no contribution through the committee stage. I thought the debate brought out the conservative and progressive in all of us. I noted some unusual voting blocs during divisions on amendments and at various stages of the bill. It is very healthy to be able to bring the views of our political parties as well as our own views into the debate, particularly when a conscience vote is available — that was particularly noticeable and welcomed. I also acknowledge the work of Belinda Teh and all those from Dying with Dignity Western Australia and the members of the public as well who have aligned with those organisations, many of whom are with us today in the public gallery. Many members of the public have approached me over the last six to 12 months about this bill by either dropping into my office, phoning or emailing and expressing their views. Those views helped to shape this legislation into what it is today. All those public views have been expressed to members of Parliament and those members have brought those views into Parliament and helped to shape this bill through the select committee process, the Ministerial Expert Panel on Voluntary Assisted Dying, the original drafting of the legislation, and, most importantly, the committee stage of the bill. The Legislative Assembly has also done a lot of work on scrutinising this bill. After the third reading, the bill will be sent back to the Assembly for its final passage hopefully as soon as next week. The Agricultural Region was overwhelmingly supportive of the legislation that was put forward. Its constituents are still overwhelmingly supportive in my view and continue to express that support to me. I thank everyone who has done that over the last several months.

This bill is about choice and about love. I support people in Western Australia having the capacity, when they are terminally ill and facing a certain death, to choose when to end their life. That is very important to me and it is very important to my electorate. I am so pleased that we have been able to work together as a Parliament to get a very important piece of legislation that will shape the future of Western Australia to this point. I support this bill wholeheartedly and I encourage other members to do so as well.

HON MARTIN PRITCHARD (North Metropolitan) [12.05 pm]: I wish to make a short statement. I thank my constituents and others for sharing their experiences and advice. Unfortunately, it was not possible to reflect the differing views as in most cases they were diametrically opposed. I have tried to look at each clause and vote on each amendment in a way that reflects my desire to provide the best outcome for all Western Australians. I note that I have been on the losing end of most of these votes, but I am truly content that the house has reached its position. I would like to express my admiration for Hon Stephen Dawson and his advisers, and for Hon Nick Goiran and indeed the many others for the way in which this debate has been conducted.

Now that we have nearly completed our deliberations, I can declare that I will be supporting this bill, but with some reservations. It is my sincere hope that it achieves all its aims without any of my fears coming to fruition.

HON COLIN TINCKNELL (South West) [12.06 pm]: I will also be brief today. I want to indicate right from the start that I cannot support the Voluntary Assisted Dying Bill 2019 in its current form. I thank all those who have contacted me during this time. My experience has been that support for this bill has been 50–50. An enormous effort has been put in by many passionate people who represent themselves, their family and their loved ones, and I respect that. I would also like to agree with Hon Martin Pritchard who said that the debate in this house has been very good. People have spoken their truth and their belief; and they have represented their constituents well. To Minister Dawson, Hon Nick Goiran and all the other contributors, I thank you a great deal. I also thank the people who put up amendments and fought for what they believe in, and I thank the people who put up amendments that did not succeed. This bill is in a better condition than it was before the 50-odd amendments that have enabled major improvements.

It is my belief that palliative care still has a long way to go. The absence of a joint standing committee into palliative care is a big mistake. It could have helped palliative care and made sure that, no matter who wins government in a year or so, there is some safety in the promises made in this house and the other place.

My main concern with this bill is that we must protect the lives of, and look after, the people of Western Australia. There have been some major missed opportunities in that area. I really worry about vulnerable groups; I have put that on the record. The death certificate issue has no integrity and that is a real problem.

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I will now make one little statement: it is inevitable that the bending of society’s rules, corruptions and mistakes in an imperfect system will lead to vulnerable people being coerced, bullied and abused into taking their own life or being killed without their consent. That is my major concern. I thank everyone for their efforts.

HON ROBIN SCOTT (Mining and Pastoral) [12.09 pm]: I will do my best to give a short response to the third reading of the Voluntary Assisted Dying Bill 2019 and to articulate it in the best way I can. There were only two main contestants in this whole debate, and they were Hon Stephen Dawson and Hon Nick Goiran. Both were heavyweight contestants. Like professional boxers, they threw blows at each other, and both corners lost and won. Hon Stephen Dawson was very kind with some of the amendments that were moved, not because he is a kind person, but because he saw that the amendments were good amendments and he gave ground. Hon Nick Goiran was fortunate enough to make those amendments to improve this bill.

I have had many emails regarding Hon Nick Goiran, criticising the way that he has been holding up this debate, which he has not been. He was doing the right thing. He was exercising his right to put forward his points of view as a member of Parliament. There has also been a lot of pretentious waffle and backslapping, and I find it all unnecessary and very disappointing.

To Mr Malcolm McCusker and his team, I say well done. I will support the bill.

HON TJORN SIBMA (North Metropolitan) [12.10 pm]: I have been in some conflict with myself this morning about whether I would speak on the third reading of the Voluntary Assisted Dying Bill 2019, but I have made the decision to do so, albeit very briefly. I just want to observe the conduct of the last few weeks. I pay credit to the moral courage demonstrated by my friend and colleague Hon Nick Goiran. We are obviously on very different sides on this issue, but I do not think anybody can doubt the sincerity of his commitment to the cause and the professional manner by which he went through discharging his responsibilities as a legislator.

It is as a legislator that I came to this debate, not as an advocate. That will be reflected in the record of voting on divisions. In certain divisions I was on the same side as people opposed to the bill in principle and, obviously, the reverse. I make the observation that there is probably no such thing as a perfect piece of legislation, but this legislation has been significantly and comprehensively improved. I think that is absolutely the most important outcome. I also reflect that the civility and patience demonstrated by all contributors to the debate in this house was exemplary. I just wish it was matched by those external commentators. I will make two observations. I think that something of this moral significance required far more gracious political leadership by the Premier than was demonstrated. I lament what was said and done outside this chamber. I also make the observation that rumours of the death of democracy have been greatly exaggerated. I hope that those external commentators who have too easily taken in the lines fed to them take the opportunity to reflect on the role of this house and how it has conducted itself. This house has discharged its role and responsibility to the fullest measure, and it has been important not only in the context of this debate, but also in the broader context of the role of the Legislative Council in this Parliament in Western Australia. We are here to review legislation and we are here to stop executive overreach and expedience.

I came to this debate with the view that there was a pressing need for legislation of this kind to provide remedy for people for whom there is no real remedy. I am convinced of the rightness of and the necessity for this legislation, but I come to this vote with greater confidence that the legislation has been improved, and I will be voting for it at the third reading.

HON MARTIN ALDRIDGE (Agricultural) [12.14 pm]: I want to make a short contribution to the third reading debate on the Voluntary Assisted Dying Bill 2019, and like Hon Tjorn Sibma I was not planning on making one, so it will be brief. It was remiss of me during the Committee of the Whole House, particularly as we reached the advanced stages last night, not to extend my thanks to the minister at the table and also to the Minister for Health for the way in which they engaged with me and other members in good faith on amendments. I think that resulted in a better outcome and probably an expedited passage of those provisions, by achieving in the end the bulk of what was intended. I also want to acknowledge, as other members have done, the significant contribution of the advisers at the table. I think there will probably not be another bill like this anytime soon that will see such an investment made by those members of the public service who provided advice to the minister when answering questions asked by members of this chamber. I have enormous gratitude to those public servants who extended themselves professionally, and I am sure personally, over the protracted course of this debate.

I am obviously disappointed that some amendments were not supported, but many were. I must say that some of those amendments were amendments of substance. They were not grammatical corrections, as has been suggested by members outside this place in the last 24 hours; that is, that the 55 amendments of the Legislative Council were merely grammatical and therefore were not of any considerable substance. I do not think any member who sat through the course of this debate could agree with such an analysis.

Some interesting things have happened during this debate, and they have brought me at various occasions to question the extent to which members were engaging their own consciences. We saw some extraordinary things happen. I think the most prominent example was the division with no members voting no. I am not sure whether that has ever occurred in parliamentary history. It could be something that we could write to the publishers of

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I would particularly like to thank the house for the amendments I moved and succeeded in having passed. I think they will go some way to address some of the concerns I had about access to voluntary assisted dying, which I outlined during my second reading contribution, and also some important transparency and accountability measures to make sure we continue to focus on those issues in the future.

I would like to give some recognition to the government, and I have done this on several occasions. I said last night that I stood with the government in the difficulty it faces in delivering a scheme such as this and indeed in delivering health and medical and health care generally in remote regional parts of Western Australia. With the support of those amendments we have affirmed our collective aspiration to do better in this regard. Many members have talked about the improvements in palliative care and how they may not have come about if not for this bill, and I think there is much more to be done in that space. I welcome the commitment by the government to pursue a select committee on palliative care to undertake some work in 2020 prior to the 2021 election.

Obviously, there are many other people involved in this debate whom I want to recognise, such as the expert advice of our clerks and the support of our attendants. As I said when debating one of the suspensions of standing orders, these people who assist us on a daily basis always number fewer than us; therefore, the demand on them is often greater than on us individually. I have enormous respect for them. During these times of extended sitting hours, days and weeks, we really expect a lot of them. This morning, Hansard sent me an email at 3.16 am—I am sure, probably several hours after we were all tucked up in bed—with the final draft daily Hansard. Staff were still working at that hour of the morning dealing with the business that transpired on the last sitting day.

I want to indicate in closing that I agree with some of the comments that have been made about this bill, or indeed any bill. I do not think that any bill can ever be described as perfect and not requiring amendment. As we progressed through the course of the consideration of this bill, I challenged myself on several occasions. There were a few line-ball calls when I thought I could have gone either way. I often reflect back on my decision to support sending this bill to a committee to examine some of those things in greater detail, which obviously was not supported by the house. For me, several clauses turned on the debate that happened on the floor of this chamber. I entered the chamber with a preconceived idea about how I was going to vote on a particular matter, which changed in the course of the debate. That is not a death of democracy; that is democracy in action. Many members, in the course of this debate, challenged some of the things that I thought I was rock-solid on, and changed my view. In saying those few words, I indicated in my second reading contribution that I was supporting the bill at that stage, and with the 55 amendments that have been made throughout the course of the last few weeks, I will continue to support the bill at the third reading.

**HON PETER COLLIER (North Metropolitan — Leader of the Opposition)** [12.21 pm]: I stand to make a few comments on the third reading of the Voluntary Assisting Dying Bill 2019. As everyone said in their second reading contributions, this is such a vital piece of legislation, and it is, whether we agree or disagree with it, a part of history. This is the only occasion during the 16 years I have been a member of this place on which every single member, apart from you, Madam President, has made a contribution to debate on a piece of legislation. That is not the death of democracy; that is democracy in action. Many members, in the course of this debate, challenged some of the things that I thought I was rock-solid on, and changed my view. In saying those few words, I indicated in my second reading contribution that I was supporting the bill at that stage, and with the 55 amendments that have been made throughout the course of the last few weeks, I will continue to support the bill at the third reading.

With that said, this piece of legislation desperately needed respect, and I will allude in a moment to a comment that you made, Madam President. I can say hand on heart that we have achieved that in this chamber—this microcosm that is the Legislative Council. We reflect society better than the other place. We have representatives from right across the state and from various ideological groupings, and we should wear that as a badge of honour. To every single person in this chamber who stood up and made a contribution, and that is pretty much everyone—well done. They are reflecting not just what they feel, but who they represent. I think we have done a good job, guys.

I want to pay tribute to Hon Stephen Dawson. I get on well with the minister, and I think the manner in which he handled this bill was extraordinary. To sit there hour after hour, dealing in some instances with extraordinarily complex questions, and to hold his nerve on pretty much every occasion, is testament to his character. I would like to thank him. I would also like to thank his advisers, who I think were exceptional. I was in awe of the fact that, no matter what the subject, and how difficult the question was, they always managed to come back with an answer, so congratulations to them. I also thank the chamber staff, as has already been alluded to—the chamber staff, clerks, Hansard et cetera. When we deal with a bill like this, which none of us have been previously engaged in, certainly not to this degree, we stand up and talk relentlessly, and the chamber staff are basically the engine room underneath that makes sure it all operates magnificently. Thank you very much to the chamber staff, and associated parliamentary staff.

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I want to make a couple of comments. I said at the outset that I was not going to support this bill at the second reading. The two pivotal reasons behind that decision were, firstly, that I felt that we were putting the cart before the horse because palliative care facilities, particularly in the regions of Western Australia, are appalling; and, secondly, I just have a fundamental belief in the sanctity of life. They were the two contributing factors for me to come to the decision that I did in not agreeing to the second reading. As I said, the respect that was shown across this chamber was second to none. It was really good and really heartening, but—I have got to say this—I just wish that respect had been shown by members in the other place, particularly the Premier. With all due respect, Madam President, I have been so disappointed with the manner in which the Premier has handled the consideration of this piece of legislation in the Legislative Council. The Premier can do what he likes in the other place—that is entirely up to him—but to pass judgement on the manner in which we pass legislation in this place, not once or twice, but almost on a daily commentary basis, is not deserving of the first minister of Western Australia. It is necessary to comment on a few of these areas, because they need to have a response. In his third reading contribution on 24 September 2019, the Premier said —

I remind members, and all Western Australians, that we are nearing the end of a two-and-a-half-year process, which has come at 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.

I repeat, he said that it should be above politics. That lasted for two paragraphs. The Premier went on to say —

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.

Given that pretty much every time my name appears in the newspaper, it is associated with the word “powerbroker”, I cannot help but take that personally, and I am sure that Hon Nick Goiran will agree with that. I say quite categorically, yet again, to this chamber that the Liberal Party respected this bill and the integrity it brought with it in terms of the significance of changing a cultural tenet of our society. I challenge the Premier to find one member of the Liberal Party or any other member of this chamber who has been intimidated, approached or in any way cajoled on this piece of legislation. If he cannot do that, I call on the Premier to make an apology. There has been absolutely no coercion whatsoever on the part of the Liberal Party. We did not discuss this bill in terms of voting patterns in one of our party room meetings—not once. I have not spoken to any one of the members who sits beside me or behind me about this issue and how they intended to vote. I want that to be on the record, because I cannot help but take that personally, and I am sure that Hon Nick Goiran will agree with that. I say quite categorically, yet again, to this chamber that the Liberal Party respected this bill and the integrity it brought with it in terms of the significance of changing a cultural tenet of our society. I challenge the Premier to find one member of the Liberal Party or any other member of this chamber who has been intimidated, approached or in any way cajoled on this piece of legislation. If he cannot do that, I call on the Premier to make an apology. There has been absolutely no coercion whatsoever on the part of the Liberal Party. We did not discuss this bill in terms of voting patterns in one of our party room meetings—not once. I have not spoken to any one of the members who sits beside me or behind me about this issue and how they intended to vote. I want that to be on the record, because those comments of the Premier were, quite frankly, offensive.

Then we get down to the process, which is significant, because this piece of legislation, as we all know, is extraordinarily significant for our society. It is literally a matter of life and death and we needed time to discuss, debate and forensically assess this piece of legislation. Apparently, the Legislative Assembly thought it was perfect with the Voluntary Assisted Dying Bill. I allude to a media statement from Hon David Templeman on Tuesday, 29 October 2019, titled “Adjustment to Legislative Assembly sitting schedule”, which reflected comments that were made at the beginning of the year. The first dot point states —

- Three additional sitting weeks were added to 2019 schedule for the purposes of debating Voluntary Assisted Dying legislation

We were provided with three additional weeks to deal with the VAD bill. Through consultation with the Leader of the House and all other party leaders, we came to the conclusion that six weeks would get us through, and we were provided with six weeks to get through the VAD legislation. That is in the government’s own words. When we commenced debate on 15 October 2019, Madam President, in her always professional and measured manner, spoke of the significance of this legislation when she stated —

Before I give the call to Hon Nick Goiran, I will remind members that we have in front of us a very complex, complicated and contentious bill. Obviously, members will be speaking about very personal

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matters and, at times, it will be emotional. It is a bill on which their respective parties have given all members a conscience vote. All I ask is that we treat each other with respect during this debate and note that there is a difference of opinion around the chamber.

Hear, hear! Madam President, they were very fine words. I mean that quite sincerely. I have to say that we did that. I never felt that disrespect was generated, towards either me or someone who had an alternative viewpoint to anyone else. That is testament to where we are in the prism of the Legislative Council. Two weeks after we started debate, the Premier commenced his tirade. On Thursday, 31 October 2019, an article under the heading “MP is trying to wreck the bill: Premier” stated —

Premier Mark McGowan said Mr Goiran’s behaviour in Parliament was disgraceful.

“It’s worse than filibustering, it’s just trying to wreck the bill,” he said.

“This is a guy who because he doesn’t think he can win the vote, he’s now just going to delay it so much that it can never get to a vote.

“It’s unacceptable to me. I think it’s unacceptable to the … majority of Western Australians.”

That makes for a nice script and a nice headline on the news for a day, but it does not reflect the reality of the situation. That was two weeks into our six weeks of debate on this piece of legislation, and it continued day in and day out. Members will be pleased to know that I do not intend to stand here today and read in every one of those comments by the Premier, but they get the point. However, I will comment on one that I thought was quite shrill and, quite frankly, unbecoming of a Premier. Under the headline “‘Shameful’ VAD antics”, an article in The West Australian on Friday, 22 November 2019—be mindful that we still had two weeks to go—stated —

A furious Mark McGowan has lashed the Liberals for what he says are the “shameful and undemocratic” antics of its MPs standing in the way of voluntary assisted dying laws.

What happened to this being above politics? As we know, that did not even last two paragraphs. It continued —

“Parliamentarians have an important job to scrutinise legislation, but that is not what Nick Goiran is doing. Mr Goiran’s disgraceful antics must stop. It’s selfish and a stain on the Parliament of Western Australia.

“It’s clear he will do and say anything to delay this legislation and stop it from going to a vote.”

Mr McGowan again called for a final vote before Christmas, saying every week there was a delay was “another week a dying West Australian in pain and suffering is being denied their choice”.

I say to the Premier that it is not an issue of leadership; it is an issue of life and death. This piece of legislation deserved ruthless scrutiny, which it received. It is not about Hon Nick Goiran, Liza Harvey or Peter Collier. It is about the Legislative Council of Western Australia doing its job. If we, as a chamber, fall to the level of, quite frankly, the shrill comments of the Premier on a matter like this, we may as well go fishing. The bicameral system of government has existed since the Magna Carta over 800 years ago, and it is one of the checks and balances that we have in this community. If not for the Legislative Council, that piece of legislation, which now has 55 amendments, would have become law as it stood, because it would have been bulldozed through the Legislative Assembly. That is what would have happened. Yet now it is most definitely an improved piece of legislation because of the good work and the multifaceted experience and contribution of the members of this chamber.

I have a couple more comments, but, in conclusion to this aspect, I will say that the Premier gave us an additional three weeks to deal with this legislation. Today, Thursday, 5 December, is the end of that three weeks. Guess what! We are going to finish it. I know that people will say, “What about all the extra hours?” I remind members, including those who are commenting, that there has not been one occasion since I have been in this chamber that we have not provided additional hours at the end of a parliamentary session—not once! Members might say that there has been nothing like this. I assure members that this is like nothing else. When was the last time that we dealt with a piece of legislation that will effectively change a tenet of our society? I am not arguing for or against the bill. I am asking when was the last time we had a piece of legislation of this calibre. I remind members that in June 2013, a few weeks after I took over as Leader of the House in this chamber, I sat in that chair in the committee.
stage for the entire night on a bill that the now government did not oppose. I sat there from 10 o’clock in the morning to quarter to 10 the next day, with an hour or so off. What happened to Mark McGowan’s criticism of the Legislative Council then? It was his party. It was a duties bill, for goodness sake, that the government did not oppose. This is not a duties bill. This is a bill that will literally be the difference between life and death.

We have done what we have always done with a collective unity of purpose in this chamber. The Leaders of the House have negotiated a way through to ensure that the government could get through its legislative agenda. We talked to our various parties, the Leader of the House moved a motion, we agreed to it, and we sat those hours. That is what we do every time. Never once in the last three years that we have been on the opposition benches has the Liberal Party defaulted on its agreement with the government. On every single occasion we have met the obligations and requirements that have been put in front of us by the government. I will finish on this aspect, but the reason I am continuing is that the Premier did not make just a flippant one-off comment. It has been absolutely relentless. We need to remind ourselves, guys, that if we succumb to comments by members down in the other place, it will be, quite frankly, time to go fishing. The best part about what has gone on over the last six weeks is that many people have been directly involved in the process. We should wear that as a badge of honour.

Just to conclude, as I commented when I started, the two most pivotal reasons I could not support the second reading of the bill were what I saw as a serious deficiency in palliative care in Western Australia. I would like to think we will get to a situation in which every single person in Western Australia will have access to adequate palliative care. If they do have access to that palliative care and still make the decision to go down the path of voluntary assisted dying, I can wear it. But we are not even close to that. I acknowledge that the government invested additional funding in the last budget to palliative care, but it will be years down the track before we know whether there are sufficient resources for palliative care.

This is a great story, as I mentioned to members. When I was 16, my mother in Kalgoorlie got terminal cancer. We had to sell the shop and the house and I went to live with my sister to do my last year at school. It was a terribly distressing period of my life, but they had to do that because they did not have the facilities in Kalgoorlie. Have we moved on from that? Is it any better now? Do the people in Kalgoorlie have access to comprehensive palliative care? This came out in the debate. No, they do not. In the goldfields, funding for WA Country Health Service palliative care gets a person 12 visits a year, or one per month; and, in Esperance, four visits per year, or one every three months. That is not adequate; it is not even close to being adequate. Six months ago, my niece brought her son down from Kalgoorlie to have his tonsils out. I had my tonsils out in Kalgoorlie when I was six years old, so we are going backwards. You cannot even get your tonsils out in Kalgoorlie anymore. My point is that as far as palliative care is concerned, I wonder whether people with a terminal disease would make the same decision. I do not think anyone in this chamber will ever know, because we will never know whether the people in the Kimberley, the Pilbara, the South West Region, the Agricultural Region or the Mining and Pastoral Region, or in some areas of the metropolitan area or outer metropolitan area—right across this great state of ours—will have adequate palliative care.

Having said that, we have made some significant improvements in a number of the medical aspects of this bill. I would like to acknowledge yet again the tremendous relationship I developed with the Australian Medical Association, initially with Mark Duncan-Smith, the vice president, and with Michael Gannon, the former president, and the current president, Andrew Miller, who I think is an outstanding individual. Over the last three months, I worked with them constantly, and also, I have to say, with the health minister, Hon Roger Cook. The AMA started as far out as it could possibly go with an ambit claim for what it wanted. It was never going to get it, but it worked with Hon Roger Cook, and the amendments that went through with the consent of this chamber and the dialogue between the AMA and Roger Cook mean that this bill is now a better bill. That is what it is all about. I would like to once again sincerely thank Hon Roger Cook for the collaborative and sincere manner in which he has dealt with both the AMA and me personally.

Finally, of course, for me, it gets down to the sanctity of life. That to me is paramount. I have not changed my view; I will not support the third reading of this bill. I hope that those who disagree with me, not so much in this chamber because I know they will respect my decision, but those who have sent me emails or letters telling me what they will do or not do to me in terms of voting et cetera, treat me not as a philistine, a non-believer, but as just someone who has an opinion. A number of people in our community have a similar opinion to mine. That does not mean we have horns; it just means we might have a different view on this issue. Quite frankly, if you come and have a coffee with me, you will find that I am not too bad after all.

If we start pillorying minorities or minority opinions, we may as well give it up again. This chamber is a perfect example of minorities. If we decided that the minority groups in our society were not worthy of a voice, we would not have in this chamber the Greens, the Liberal Democrats, Pauline Hanson’s One Nation, the Independent, the Nationals WA or the Shooters, Fishers and Farmers Party. It would be just the two major parties and they would smash it out. I appreciate and acknowledge that my views are part of a minority on this issue, but it is a voice that needs to be heard. I was inundated with communications throughout the length of debate on this legislation. Contrary to the views I have heard from other members or from published opinion polls, they were overwhelmingly against voluntary assisted dying. I do not know why; that is a simple fact. We kept a record of absolutely everything. I will

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say that the fact that as a chamber we have accepted and respected the minority views, whether they be through
amendments or the bill itself, is testament to where we are at as a chamber. That is why I love the Legislative Council.
All I ever wanted to do was to be in the Legislative Council. I never countenanced a notion of the Legislative Assembly.
This, if anything, has shown me exactly why my move into this chamber has been vindicated.

We have been through this extraordinary process together as a chamber. Although I might disagree with the
majority of members on this occasion, I have regarded being a contributor to the passage of this legislation as
a unique privilege and I thank you very much.

HON SIMON O'BRIEN (South Metropolitan) [12.46 pm]: The Voluntary Assisted Dying Bill that emerges
from the Committee of the Whole stage, and now is being contemplated in the third reading debate, is in better
tick than it was when it went into the Committee of the Whole stage. It is in better condition than it was when it
came out of the Legislative Assembly and was transmitted to us here. In the last day or so, when a colleague had
succeeded in proposing an amendment that made a great addition to the bill, I said, “Well done.” I said that because
I thought that the amendment had great merit and would provide certain protections and benefits to the people of
Western Australia in due course. I also said well done to that member because, with that single action, amongst
many I might add, they demonstrated what this Legislative Council is all about—its role and its value. The things
that were not capable of being done in another place due to misplaced arrogance, pride or vanity were delivered,
in part, from this house. It will be interesting to see the response when, in due course, we transmit our message
back to the Legislative Assembly. Well done to that member and to every member who was able to recognise that
when things could be done to improve this bill, instead of digging in their heels from one perspective or another, said,
“Yes; I will expose myself to a bit of pain and push for this.” Congratulations for taking that initiative, congratulations
for pushing and congratulations also where you succeeded. This house and all our constituents are ultimately the
winners from the course of action that that member and so many members took during the committee stage.

I want to contribute briefly to this third reading debate by acknowledging the many people who have contacted
me, particularly by email, about this bill, their concerns and what they want me to do. They have been pretty evenly
matched. There was a huge number of emails, far too many for me to respond to individually. I did respond to
them early on, in the last six to 12 months, but more recently there have been too many to respond to adequately, so
through these remarks I thank people for corresponding with me to let me know their views. Although, collectively,
those views are irreconcilable, they showed me what interest and strongly held views there are for and against this
area of public policy.

This example of the Legislative Council working properly and doing its job properly has been touched upon by other
speakers already, including, most recently, the Leader of the Opposition, and I support those sentiments very, very
strongly. That is one of the main lessons to come out of this process. I join some others in expressing my regret in
having to witness, in the course of this debate, some of the gratuitous commentary of those almost exclusively
external to this house. I have heard that sort of thing said before by an increasingly public commentariat that cannot
wait while due process is followed in this Parliament. On this occasion, some extremely regrettable and misinformation
and an unjustified allegation made against one of our colleagues, Hon Nick Goiran. Comments have been thrown
against us as a house and those of us who hold a view that this bill should not be passed, but there has been a specific
focus of attack, in some cases extending to hatefulness, against Hon Nick Goiran, alleging that he and others who
might share his policy view are condemning loved ones to suffer in agony because they question a clause of the bill.

The fact is that if the policy contained in this bill becomes law, it is not going to be implemented and available to
anyone until at least the second half of 2021. When people use words like “sadistic” to describe my colleague and
allege that by his actions in scrutinising this bill along with all the rest of us, he is somehow delaying people in agony
from receiving comfort, that is wrong, vicious, ill-informed and reprehensible. Through all that, Hon Nick Goiran
has stuck to his principles. Although there may have been occasions late on one day or another when some
long-suffering Chair of Committees might have perhaps been wishing that people would get on with it a bit
quicker, the fact is that this member was doing his job, and he did it very well. Although it is un fashionable, I am
not going to stand by and let those ill-informed critics prevail without giving some sort of response.

Everyone knows where I stand on this bill as an article of policy. In my second reading contribution, I referred to
this as a “policy of despair” that I would have none of. That remains my view. I am concerned that the measures
contained within this bill apply to a very small number of cases. A lot of people out there think that there is going
to be a possible benefit to them or their loved ones if they find themselves in very difficult end-of-life circumstances
in due course, and they are going to be very disappointed when they find that, in fact, there is no capacity for this
bill to give them comfort. Indeed, I have corresponded with people who demand that we immediately pass this bill
to deal with some emerging situation in their own family, in which they have someone suffering from dementia
who, for all sorts of reasons, would not be a “beneficiary” of this bill’s provisions anyway. I think people
misunderstand that the initiatives of this policy have a very limited focus. That worries me for a couple of reasons.
First, I think that this legislation is going to be presented as a great achievement, which will then take the
government’s focus away from dealing with the vast number of people who do not have adequate end-of-life care

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available to them. That worries me. The second thing that worries me is that even with all the criticisms of this policy that might come from different quarters, there inevitably will be the attitude from some that it is a good start. That then leaves the question hanging: where is it going and where is it going to end? That brings us back to the fundamental question on the policy threshold that it would appear we as a society are about to cross.

I think it is an unfortunate situation that we are seeing populist initiatives being taken in a very shallow way, promoted in a partisan political way, potentially at the expense of the vulnerable in our community. I will not be supporting this bill at its third reading, just as I have opposed euthanasia over the last 20-something years when it has been raised in this place from time to time. I do so with respect to those who hold a contrary view, even if they do not want to extend respect to me and others who hold my view.

Madam President, members, powerbrokers, may I just conclude by offering my thanks again on your behalf to our Deputy Chairs of Committees, Hon Martin Aldridge, Hon Robin Chappell, Hon Adele Farina, Hon Dr Steve Thomas and Hon Matthew Swinbourn, who have endured a great deal without complaint. Their professionalism in the way that the committee stage has been conducted has been exemplary, and I thank the Deputy Chairs individually for that.

HON JACQUI BOYDELL (Mining and Pastoral — Deputy Leader of the Nationals WA) [12.58 pm]: I rise very briefly before the luncheon break to say that I will make a short contribution to the third reading stage of this very significant legislation before the Legislative Council, the Voluntary Assisted Dying Bill 2019.

I think, from the outset, all members have known since 2017, when the government set up the Joint Select Committee on End of Life Choices, that should the committee make a recommendation that a bill come before the Legislative Assembly and the Legislative Council, it would be very significant legislation for every member to scrutinise. No doubt, through the process of the Legislative Council’s Committee of the Whole, the level of scrutiny that I think the people of Western Australian expect has been achieved. People want an outcome from that—there is no doubt about that—and they have been clear that they want an outcome before the end of the year. I think that all members have been very conscious of the fact that we want to deliver an outcome for the people of Western Australia.

Sitting suspended from 1.00 to 2.00 pm

Hon JACQUI BOYDELL: As I was saying before we broke for lunch, the community of Western Australia has been invested in this bill right from the beginning and wants an outcome from the Parliament before the end of this year. The Legislative Council, in particular, has been able to deliver to the people of Western Australia a bill, which, I think the house would agree, is definitely a lot stronger and contains some of the considerations and concerns of its members. The ongoing management and implementation of the Voluntary Assisted Dying Bill 2019, should it pass, is a matter of concern for all members of this place and the people of Western Australia, particularly the minister’s commitment to establish next year a committee to investigate and report to the house on palliative care in Western Australia, particularly in regional Western Australia. It is a good thing that that committee will hold the government to account on its commitments to the delivery of palliative care across Western Australia and it will shine a spotlight on that area. I think all members agree that palliative care needs improvement in Western Australia. There is no doubt that that has been one of the great outcomes of the process of the Voluntary Assisted Dying Bill 2019.

As I said prior to lunch, this process was undertaken in 2017 when the Joint Select Committee on End of Life Choices was established. The committee had 12 months to deliberate and then report to the house. Then the Ministerial Expert Panel on Voluntary Assisted Dying conducted its consultation throughout Western Australia. I went to a number of those consultations. I have been on the journey of this bill from the outset. I believe that it has been exceptionally important and I wanted to hear what people thought about it. I was surprised to hear some of the feedback given to the ministerial expert panel, in particular, when I journeyed around the state and participated in some of the forums. People are concerned about the management of the end-of-life care for their loved ones. This is not just about elderly people; this is about people above the age of 18 years being able to make a decision about how they manage their end-of-life care. There has been a lot of concentration on making sure that there is no elder abuse. I agree with all those things, but this is not just about the elderly; this is about people of all ages and types either being able to come together with their families to make decisions about their end-of-life care or to make private decisions about how they manage their last days with a terminal illness. I think that is a fantastic outcome for people.

All along I have believed that the patient is above all else in this consideration, because this is about the patient making a choice. I have tried to stay focused on that during the debate. A lot of complex issues have been brought before the house and a lot of contributions have been given by members on those complex issues. I think that I have listened intently to all of them. Every member of this house has made decisions about how they would vote on clauses and amendments put before the house and, at the end of the day, on the entire bill. Some of those decisions have been exceptionally difficult—there is no doubt about that. I suggest that some members have been caught almost on the fence when amendments were put before the house and had to make a decision in the last seconds of the bells ringing. Those situations were pressured, but members gave them due consideration. Sometimes when we reflect on the decisions that we have made, we think that, given the other side of the argument, we could have made a different decision. However, I say to members who reflect on their decision-making that the Legislative Council has undergone an exceptionally good process and we have arrived at the point that we are at today.

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As other members have said, no bill is perfect, but the Voluntary Assisted Dying Bill, should it pass the house, will also undergo an enormous amount of scrutiny by members of this house during the implementation phase. I do not dispute that at all. The government has asked members to trust that some of the issues that they raised will be addressed during the implementation phase, particularly when amendments have been put to the house and been lost. The government needs to consider how some of those members’ concerns will be addressed during the implementation phase. If the government does not do that, this will be a point on which potentially ongoing negative scrutiny of the voluntary assisted dying process will occur, which, no doubt, the people of Western Australia do not want—they want the right system.

I have had—as all members have—many people contact me about this bill, asking us to just get on and vote for the bill, particularly when the media have raised the comments of the Premier. I have spoken with those people face to face, through email or over the phone, and have said that we are getting on with voting on the bill. But I have also said, “What about death certificates? What about being a family member? What about self-administration?” When I have raised those controversial parts of the bill with people, they have actually said, “Oh, yes, I hadn’t actually thought about it in that way. So, actually, yes, do take time to consider how that should be delivered through the bill.” When I have had the chance to speak to people about the length of time that the Legislative Council has taken to scrutinise the bill, which I do not think is an inordinate amount of time for such a complex bill, they actually understand and respect the process. It has been a point of engagement with people; it has been a point on which people have been able to engage with the Parliament of Western Australia and to understand the processes of the Legislative Council. When the media or members of the public ask me about this, I have said that I believe that members have conducted themselves with genuine intent and that they want the right outcome for the bill at the end of the day. All members do that in the process of every bill. The government of the day—we have done this when we were in government—put a bill to the house and said, “We’ll address the concerns in the regulations, but trust us in the legislation.” What has highlighted that process during the voluntary assisted dying debate is that the public of Western Australia has invested in this issue. That has been a great thing.

In my closing comments I thank Hon Stephen Dawson for his approach to his negotiations with members of the house when they may have had a different view from the minister. He has listened. The government has taken on the ideas and concerns of this house and has tried to recognise and reflect some of the commentary through the amendments to the bill that the government has undertaken. That has been a very good process.

Hon Nick Goiran has carried the burden of many members of this house and has led the scrutiny of this bill. I thank him for that. I thanked him for that this morning when we left the house. Through his scrutiny of each clause and through the debate he brought to the house, members have learned and will, as a result of that, continue to scrutinise the implementation phase, and that is absolutely the right thing to do. It disappoints me that the Legislative Assembly did not have the opportunity to do that. I am disappointed by the commentary, particularly by the Premier, and that has been touched on by other members today. It was unnecessary commentary by the Premier. All members of Parliament ultimately understand that they need to respect the ideas that other members bring to the house. There is value in that because not all of us are right all the time. It is disappointing to me that particularly the Premier, whom we expect to respect the process of the Parliament more than any other member of Parliament, has chosen not to do that. I will not reflect on his commentary. I think that reflects more on him than it does on any member of this house who has undertaken their duty as a member of Parliament to scrutinise the legislation. That has been an unfortunate process. Despite that, and the pressure that has been felt from outside the house, I have not felt that pressure in this house. All members have been respectful of the debate and the ideology of each individual member. That has been a great process. I thank members for that.

I thank my other colleagues, particularly Hon Martin Aldridge, Hon Rick Mazza and Hon Aaron Stonehouse. We sit together here and we have talked enormously about a number of issues throughout the ongoing debate in the house. It has been a really worthwhile process for me to be able to have that discussion with members as we are live debating the clauses. I thank also Hon Roger Cook for the way he has engaged with members of the house through this process. He really has worked hard to try to address with a very genuine intent some of the issues members have had and with amendments that the National Party and Hon Martin Aldridge have put to the house. I respect the minister for that and I thank him for that. He has been genuine in the way he has done that from the outset. To the advisers and staff involved, thank you very much. Although there has been negative commentary from the outside, on a reflective perspective, this has been a very positive process for the people of Western Australia and for the Legislative Council.

HON ALANNAH MacTIERNAN (North Metropolitan — Minister for Regional Development) [2.14 pm]: I am anticipating from the comments of members that the Voluntary Assisted Dying Bill 2019 will pass the third reading. This really is an extraordinary victory for the people of Western Australia. I believe it is a victory for humanity, for compassion and for the rights of Western Australians to make critical decisions about their end of life. I have absolutely no doubt that without the active involvement and engagement of our community—as Hon Jacqui Boydell said, the degree to which the community invested—we would not have brought this matter to a vote and to a conclusion. Although we have worked very hard in this chamber, in the other place and across government to deliver this result, it is clear in my mind that without that massive investment by the people of...
Western Australia and their deep engagement, we would not have got to this point. Of course, I agree that a bill of this nature absolutely deserves and requires rigorous debate. We have managed through the debate to improve the bill. As I often say, we should not be surprised about that. That is what we get paid the shekels to do; to have that debate and to have those compromises made.

It would not normally be my intention to go down this path in this discussion, but in light of the comments that have been made by other members, I think it is really important for us to be clear that we might well not have got to this point where we were having a vote on this bill, and a vote on this bill today, unless there had been some real political pressure placed on some members in this place to —

Hon Jim Chown: That is absolute rubbish.

Hon Peter Collier interjected.

Hon ALANNAH MacTIERNAN: I am sorry—I listened to Hon Peter Collier —

The PRESIDENT: Minister, just wait a second. Order! Right up until now people have conducted themselves in a very mature and respectful manner. We are coming to the close of this debate. The minister is on her feet. She has waited her turn and listened quietly, and without interjection today, to all the other comments that have been made. I ask members to also apply that same level of respect. You may not like what is being said, but I ask you to listen and not make any comment. You will have the opportunity to comment when we put this bill to a vote and you can vote either for or against it.

Hon ALANNAH MacTIERNAN: I probably would not have gone down this path had not the earlier comments been made. However, I think it is important to get the truth as we see this on the record and to defend the role of the Premier. There was an absolute reason for us to have deep concern that this bill would be one of those bills that would not get to a vote. I will not go into the ins and outs, but if we look at past performance and the early clauses of the bill, which took weeks and weeks to progress, without that very public campaign and the raising of those issues at the level of the Premier—indeed, many of us on this side of the debate let the community know what was going on and about the very, very slow progress of the bill—the fact that at the end of the day we got cross-party support for a guillotine is in part a reflection of the pressure that was coming through from the community as they understood how that debate was proceeding. I indeed would not have gone down this path, except that I think a lot of unfair comments have been made. I went out and talked to many hundreds of community members each week to make sure that they were well aware of the progress or lack thereof in the early days of this bill. The whole process, quite aside from the issue at hand, which is an incredibly important one to many, many Western Australians, has in a sense strengthened our democracy with the degree of engagement people had on this issue and the degree to which they have been following the processes of the debate and understanding in more detail how the process of making legislation works. As I said, I totally agree that the bill has been improved. I agree that it was necessary to go through a rigorous process. There have been times when I have been quite conflicted during the margins of the debate on which particular way to go on a decision. There is a good role for the Legislative Council to play but it was really important that we came to a conclusion.

I acknowledge those who have been part of the campaign for choice for many years. Many of these names are not necessarily ones that have been in the public limelight. I acknowledge Murray Hindle, Margo Beilby—who, I think, is in the public gallery—Stephen Walker and Dinny Laurence from Dying with Dignity Western Australia, Lenda Oshalem and the late Clive Deverall, who contributed so much to that group and to our understanding more broadly on the limits of palliative care. I also acknowledge Dr Alida Lancee from Doctors for Assisted Dying Choice, who stood for the seat of Cottesloe at the last election and gained huge publicity for the cause. These people, together with a little bit of help from Hon Robin Chapple and me, made sure that end-of-life choices was well and truly on the political radar going into the 2017 election and an issue to be dealt with on the change of government. I genuinely acknowledge the incredible leadership that Premier Mark McGowan has shown on this matter. Not only was he the Leader of the Opposition facing a critical election, but also he came out with his support for the right to end-of-life choices; and then on coming to government, he acted very decisively and early in the term of the government to lead cabinet to a decision to devote significant political, administrative and legislative capital to progress this legislation.

Amber-Jade Sanderson, MLA, was given the opportunity to move a motion to establish the Joint Select Committee on End of Life Choices and chair the important work of that committee. I recognise the excellent work of that committee, particularly the chair’s leadership. Amber-Jade has continued to be a very passionate and intelligent exponent of the legislative package and it certainly has been a pleasure to appear with her at many public forums to develop the community’s understanding of the legislative and political issues at play. Then the ministerial expert panel was led so ably by Malcolm McCusker. The panel really made sure that we had a system that was properly calibrated to the needs of Western Australia. I acknowledge Noreen Fynn—I know that she has been in the gallery today; I do not have my glasses on so I cannot see everyone—who made a great contribution on the panel and elsewhere. Of course, many people spoke of the tremendous work of Minister Roger Cook, a person of great charm and ability. He has worked with members of this place, the Australian Medical Association, churches and all the interests groups to form a bill that provides a solid and strong choice mechanism, but one that also had realistic
prospects of success. I also need to acknowledge the work of Hon Stephen Dawson. I will use the words of one of my constituents who has been closely following the debate, although she was not necessarily a supporter of the legislation. She wrote to me, “Reading Hansard, I am daily in awe of Stephen Dawson’s unfailing courtesy and patience.” Stephen, we absolutely agree with that. You have done an excellent job. I also acknowledge the very colourful team of advisers that Hon Stephen Dawson had around him to provide that support. Congratulations on a job well done.

Of course, it is important to acknowledge the work of Andrew Denton and the Go Gentle Australia team because they have been a critical part in mobilising public passion for this change and providing counsel to members of Parliament on how the fight would play out. They helped us understand the challenges and techniques that opponents used in every jurisdiction in which such legislation has been introduced. Certainly, being forewarned definitely helped us to be forearmed.

I acknowledge the significance of the film Broken Hearted: Life, Love and Death in WA, which should have been compulsory viewing for everyone in this chamber. The film profiled the experience of a dozen ordinary Western Australian families who had watched a family member die in agony beyond the help of palliative care. I urge anyone who wants to hitch their wagon to the myth that improving palliative care, whilst important, will address all end-of-life problems to please look at the film and watch the suffering that occurs and the intergenerational trauma that follows such bad deaths. Today, I anticipate, we will have made sure that this will not be the fate of Western Australian families into the future.

I am very proud to have been part of this process with all members here. As I said, the outcome has been exceptional. It will add enormously to the quality of life for many people. It will give people such comfort to know that the voluntary assisted dying option is available to them. It will also give comfort to their families. As I said, one of the unexpected benefits of this has been the content and the degree of engagement that the public has had with the process, with many tens of thousands of Western Australians engaged in the work that we do in this place. Thank you all for your contributions.

HON KYLE McGINN (Mining and Pastoral) [2.28 pm]: I will also be brief. Firstly, I am very humbled and privileged to have been a part of this whole process over the past two years. We took on quite an interesting subject and throughout it, I definitely listened and learnt a lot. This debate sets out the thing that I will most remember so far in my term, firstly, because it is such a big piece of legislation and, secondly, because of the amount of interaction I have had with my constituents and the number of community members who have come to Parliament. I have never seen so many people watch us debate in this house, which has been great to see. There have also been a lot of people watching online. Their dedication to seeing this bill go through and the form in which it will go through has been amazing. As I said in my contribution to the second reading debate, I surveyed my electorate and the response was that 80 per cent were in favour of the legislation and 20 per cent were not in favour. Some of the key issues that they raised, including palliative care and Indigenous navigators, have been addressed during the committee stage of the bill. That stage was very long with a lot of debate and amendments, but I am a lot more comfortable now, having gone through that process, that the government is committed to ensuring that regional Western Australia gets this service and that it will also look into palliative care. The announcement from the minister last night about the inquiry was really good news. He briefly touched on what the terms of reference might be. It was very good to hear that the inquiry will be regionally geared and it definitely sounded like it is intended to inquire into how we can improve palliative care in regional Western Australia to the standard found in the metropolitan area, which is a really important thing to do. That is something that my constituents want and I am very glad to say that I believe that the government will deliver on that.

Constituents have been coming into my office, making phone calls and sending emails—as with every other member—since this conversation started. I want to thank all of them. I have not responded to them all yet. I heard from both sides of the debate. It was really good to hear how passionate they are about this legislation and to see people engage in the political process. Before this bill came into Parliament, there was a lot of conversation about how people are disengaged with politicians and politics, with people saying, “It’s just another politician in the paper.” But things were different with this debate. This issue had more engagement from the everyday Joes who through has been amazing. As I said in my contribution to the second reading debate, I surveyed my electorate and throughout it, I definitely listened and learnt a lot. This debate sets out the thing that I will most remember so far in my term, firstly, because it is such a big piece of legislation and, secondly, because of the amount of interaction I have had with my constituents and the number of community members who have come to Parliament. I have never seen so many people watch us debate in this house, which has been great to see. There have also been a lot of people watching online. Their dedication to seeing this bill go through and the form in which it will go through has been amazing. As I said in my contribution to the second reading debate, I surveyed my electorate and the response was that 80 per cent were in favour of the legislation and 20 per cent were not in favour. Some of the key issues that they raised, including palliative care and Indigenous navigators, have been addressed during the committee stage of the bill. That stage was very long with a lot of debate and amendments, but I am a lot more comfortable now, having gone through that process, that the government is committed to ensuring that regional Western Australia gets this service and that it will also look into palliative care. The announcement from the minister last night about the inquiry was really good news. He briefly touched on what the terms of reference might be. It was very good to hear that the inquiry will be regionally geared and it definitely sounded like it is intended to inquire into how we can improve palliative care in regional Western Australia to the standard found in the metropolitan area, which is a really important thing to do. That is something that my constituents want and I am very glad to say that I believe that the government will deliver on that.

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Hon Martin Aldridge interjected.
Hon KYLE McGINN: Okay; I know what the member is laughing about. It has been great to be a part of this process. I withheld my position during the second and third reading debates, but I am very glad to say that after all the process I have gone through with my electorate and in the chamber, I will be supporting the third reading of the bill.

HON NICK GOIRAN (South Metropolitan) [2.33 pm]: I rise as the lead speaker for the opposition on the third reading of the Voluntary Assisted Dying Bill 2019. At the outset, I reiterate what I said during the second reading debate, which is that the Liberal Party does not have a party position on this bill; rather, its members have a conscience vote. I echo the comments made by our leader, Hon Peter Collier, to refute any suggestion by anyone inside or outside the chamber that there has been anything other than a genuine conscience vote by Liberal Party members. That has been ruthlessly adhered to by all my colleagues, and I thank them for that. It is actually one of the elements that makes me proud to be a member of the Liberal Party.

When this bill was before us in a different form during the second reading debate, I asked members two questions. Firstly, is it possible to design and implement a safe euthanasia regime? Secondly, if the answer to that question is yes, is it appropriate to introduce euthanasia and assisted suicide prior to addressing palliative care accessibility?

For reasons that are already on the public record, it is clear that my view on both those questions was a resounding no. It is not possible to design and implement a safe euthanasia regime and, in any event, it is not appropriate to introduce euthanasia and assisted suicide to Western Australia prior to addressing palliative care accessibility. Notwithstanding the fact that that was my view when I delivered my contribution to the second reading debate on 15 October this year, a majority of members of the Legislative Council, as is their right, decided something different. For some of those members the view is, yes, it is possible to design such a scheme. For some of those members the view is that we can at least try to address palliative care concurrently with rolling out voluntary euthanasia. That was the debate that needed to be had at the second reading stage, but not we are at the third reading stage of the bill and a very different question needs to be considered: is the bill that we have before us—the latest version, 139–2, of the Voluntary Assisted Dying Bill 2019, which is not the same bill presented to us at the end of the second reading—a safe bill? That is the question that we now need to answer. If we say that the bill is safe and appropriate, it should be supported, but if it is not safe, we should vote against it. We know the government’s view, because we need only read the remarks of the Minister for Health to understand that its view was that the bill in its form then was safe. I note the comments made by the Minister for Health on 24 September when he said in the other place —

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 disagree 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.

They are very temperate and moderate remarks that were made by the Minister for Health on 24 September 2019, yet on that same day, the chief of government, the member for Rockingham, said —

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.

That day, 24 September 2019, was the beginning of a dramatic shift within government from a temperate and moderate narrative about the passage of this legislation to something quite unprecedented, and several members have already remarked on that. I will simply conclude my remarks about this particular issue by noting the comments made by the Minister for Health on 28 November 2019. Something very radically different happened to the Minister for Health between his temperate and moderate remarks in September and these types of remarks made only a few weeks ago. On that day in The West Australian, he was quoted as having said —

“The fact they have sought the call, moved so many motions and asked so many often repetitive questions really just shows they’ve got contempt for the public,” Health Minister Roger Cook said. “There’s no reason they cannot do a solid piece of analysis and scrutiny of the Bill without unduly delaying it … now is the time they get on with it and finish the job.”

Even at that point a couple of weeks ago, those remarks by the health minister—as factually incorrect as they were and as dramatic a shift as they were from where he was at on 17 September—are still far more moderate and temperate than anything that the Premier of Western Australia has had to say about the passage of this bill.

We know that when the bill was being read for a second time, the government held the view that the legislation required no amendment. We know that because the Premier himself said, “It does not require amendment.” Of course, what transpired after that was this unrelenting campaign by the Premier, with his intemperate remarks suggesting that anyone who wanted to move amendments or ask any questions was simply out to wreck the bill. I understand the motivation for that. I understand that the government, and senior members of government, remain

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very unhappy with me for the outcome of its flawed surrogacy legislation, but the fact that the government is embarrassed by that flawed legislation does not justify the Premier of Western Australia casting an aspersion on all members in this place who wanted to ask questions about this bill.

I want to acknowledge the very sensible and moderate approach taken by Hon Rick Mazza very early in this debate when he sought to refer the matter to a committee, and he was supported by a number of members, including me. If there is any disappointment on my part about the passage of this bill, it is that it did not go to that committee. The reason for that is that I have absolute confidence that had it gone to a committee, further matters would have been identified. Yesterday evening, at almost 11 o’clock, there was clearly a problem with a part of the bill that simply said that if the coordinating practitioner is going to transfer their responsibility to another doctor, he or she can do so without the patient’s consent. We had absolute silence from the champions of autonomy and choice when that flaw was identified, because, as I suspected, when it gets close to 11 o’clock at night, everyone gets too tired and so we just allow things to pass. That would not have happened if the bill had gone to a committee. Had Hon Rick Mazza’s motion been successful, I suspect there would have been a different outcome. Nevertheless, a view held by members—I remember the Leader of the House expressing this view, which I respect, even though I did not agree with her at the time—that on a matter like this it would be far better for all 35 voting members of the chamber to work together in a Committee of the Whole House. That is certainly an option and that is the option that the house ultimately took, but if the house chooses to take that approach, it means we need time.

We cannot expect the same amount of time provided to a committee of five members—the Standing Committee on Legislation, of which Hon Dr Sally Talbot is chair and I am deputy chair—to be provided to 35 members. In that case, there are 35 voices, 35 views and 35 people potentially asking questions and interrogating clauses. It naturally follows that the process is going to take some more time, and that time has been provided by this chamber. That was all that was ever asked for. Any suggestion by Hon Alannah MacTiernan that somehow the guillotine has been applied is false. No guillotine has been applied to this debate. All that has happened is that adequate time has been provided by the house in order for all clauses to be scrutinised. I have scrutinised every single clause—all 184 of them. That was all I ever asked for, and that is what has been granted. I thank the house for that appropriate courtesy, given it was a decision of the house that we would collectively, all 35 voting members on this bill, work together in committee, and that is exactly what we did.

Notwithstanding the comments of the Premier, who said that there was no need for any amendments, what is the outcome of the matter before us? What is the outcome for this bill 139–2, which we now need to determine is safe or not? The outcome is that 55 amendments have been made, which have changed the bill from 139–1 to 139–2. This house has utterly rejected the member for Rockingham’s view that there was no need for any amendments to this bill, and we are sending it back to the other place saying that we think that at least 55 amendments need to be made, with all due respect to the honourable Premier. It may interest members to know that of the 55 amendments, 25 were moved by me and 18 were moved by the government. Eighteen amendments were moved by the government to its own bill. Eighteen amendments were moved to a bill that the Premier, the member for Rockingham, said required no amendments. There were 25 amendments moved by me, 18 by the government, six by Hon Martin Aldridge, four by Hon Adele Farina, one by Hon Martin Pritchard and one by Hon Alison Xamon. That is the outcome of the decision by this house to undertake this rigorous process in the Committee of the Whole House—55 amendments.

The rhetoric of the government over the last 24 hours and, it has been drawn to my attention, some—how would we describe it; I am trying to think of a word that would be as polite as possible, and “facile” comes to mind—facile commentary by Go Gentle Australia is that apparently these 55 amendments are grammatical amendments. If that narrative by the government and these geniuses at Go Gentle Australia were true, we could understand why people would say that we did not need six weeks of the house’s time simply to address 55 grammatical errors. There would have been no need to do all of that. Let us just take a moment to check the bill before us at version 139–2, which is different from the bill at version 139–1, and the 55 amendments. Let us take a moment to check whether they are grammatical amendments. The topics that have been covered by the 55 amendments include the following. Members and people listening outside of the chamber can decide for themselves, examine their consciences and ask themselves whether these are grammatical issues. Firstly, there was the amendment to ensure that regional West Aussies are entitled to the same access to voluntary assisted dying as those in the metropolitan area. People can ask themselves whether the amendment that Hon Martin Aldridge moved was on a grammatical issue or a matter of substance. People can consider the fact that now under the bill before us a healthcare worker in Western Australia is prohibited from initiating a discussion on voluntary assisted dying with a patient. They can ask themselves whether that prohibition, which was in an amendment moved by the government and was not in the bill that the Premier said required no amendment previously, saying that a healthcare worker in Western Australia will not initiate a conversation about voluntary assisted dying, because the government moved the amendment and the house agreed to it, is a grammatical issue. There is the fact that if a doctor raises the topic of voluntary assisted dying, they must do these things. A doctor must inform the patient of the treatment options available, the likely outcomes, the palliative care options available and the likely outcomes of those palliative care treatments. If they are going to initiate the conversation, they have to do all of those things. Are they grammatical errors or matters of substance? There is the fact that a doctor cannot be a family member of the patient, a beneficiary under the will of the patient.

Extracted from finalised Hansard
and cannot financially benefit from the death of the patient. Are they mere grammatical issues? I know that some members love polls and surveys. I suspect that if we poll and survey Western Australians, asking if they think the doctor injecting the patient with a lethal substance to end their life should be a beneficiary in the will of the patient who is about to die, we would blow that 88 per cent out of the water. Are these grammatical issues, or are they matters of substance?

Now, under the version of the bill now before the house, although not the earlier one that the Premier said required no amendment, a request has to occur during a medical consultation. Is that a mere grammatical matter, or is it a matter of substance? Let us just take a moment to consider that. Those who have followed the debate—that does not mean sitting at a computer counting how many times somebody has sought the call; I mean listening to the debate, retaining the information, comprehending and wrestling with it intellectually—will know that this issue was raised during the debate in the other place. There was a concern under the Premier’s bill, which he said was perfect, that a person can make a request to a doctor in any environment—cocktail party, end-of-year function, at the beach. Now, because of the work done by this Council, and also, I think, because of some lobbying by the Australian Medical Association, which deserves some credit here, that will now have to happen during a medical consultation. This will be a relief to medical practitioners in Western Australia, notwithstanding the fact that they do not really have a conscientious objection, for the reasons already articulated by Hon Aaron Stonehouse.

What about the fact that the patient will actually be given a copy of the very forms being distributed between the doctor and the board that will determine whether the person lives or dies? We would think that the patient should perhaps be informed about those things, because the Premier of Western Australia did not think so. He said there was no need for an amendment. I would have thought that if we are really passionate about a patient-centric model we would ensure that the patient had the information. What about the enhanced accountability when interpreters are used, or when patients have been referred because the doctor is not sufficiently skilled to make the assessment? What about the record-keeping of complications when the doctor administers the poison? What about the enhanced responsibility for those signing documents on behalf of the patient? This patient is about to die—they are making a decision to effectively sign their own death warrant—but they cannot sign, so somebody else has to sign for them. Should there be some accountability around a person who is signing those particular forms? The Premier said no, and we as a Council said yes. That was one of our 55 amendments.

What about mandating that the patient be informed of the risks of self-administration? I am going to get back to self-administration, because if there is a part of the bill before us at 139–2 that continues to distress me, it is about self-administration. Nevertheless, because of the work done by this chamber we have now mandated that the patient must be informed of the risks of self-administration—something that the Premier said was unnecessary. What about the privacy protections for doctors formally involved in a case before the tribunal? In the Premier’s version of the bill, practitioners who might have been involved in the care of the patient were not going to be provided with those protections, but because of an amendment that I moved, they will now be provided with the protections that other practitioners would have received.

The last point I make about the 55 alleged grammatical amendments is that we have agreed to ensure that a doctor in Western Australia cannot abdicate their duties by merely claiming that they are acting in good faith. They are now going to have to do more than that. Good faith is not good enough. The doctor will need to demonstrate good faith, and that they were acting with reasonable care and skill. With all those remarks, and the breadth of those amendments, I ask those geniuses in government responsible for perpetuating a narrative that all members have done over the past few weeks is pass grammatical errors, to just pause for a moment and reflect on the seriousness of the matter that we are dealing with. By all means, if they have a view that voluntary assisted dying should be provided to Western Australians, they are entitled to hold that view, as I think those of us who think that it should not be provided are also entitled to hold that view. However they really should be held to account if they are trying to mislead the Western Australian public and tell them that 55 grammatical errors have been passed by the Legislative Council, when we consider the magnitude of that list. Because those 55 amendments have been passed by this house, I am proud of the work that the house has done collectively.

There are nevertheless reasons why I still will not support the Voluntary Assisted Dying Bill 2019 in its current version, 139–2. There are a multitude of reasons, but I will limit my contribution just to these few. In the bill that is before us there is no requirement for a specialist to be involved. I find that reprehensible. If a Western Australian with a terminal illness wants to access their superannuation early—this is a matter of money—because they have been diagnosed with a terminal illness, they need to have a specialist, but if they want to make a decision to end their life, they do not need to have a specialist under Western Australia’s voluntary assisted dying regime. I understand the comments made, particularly by some regional members, about why they were concerned about that. They were concerned that it would provide a form of blockage to access for people in regional Western Australia. I respect their concern and their right to articulate that view, but I simply indicate that, as Hon Colin Tincknell said at one point during the debate, if the government has decided to put this before the people of Western Australia, it has the responsibility to resource it. It is not satisfactory lawmaking to simply say that we do not have confidence that the government is going to be able to provide specialists in regional Western Australia, so we will then lower
the standard and just hope for the best, as if we were totally ignorant of the lessons that have been learnt from the few jurisdictions that have gone down this path. I think, originally, Hon Martin Pritchard put an amendment on the supplementary notice paper looking to involve a specialist. It was picked up by Hon Colin Tincknell and Hon Charles Smith. I thank those members for pursuing that issue. I am sad that it has not been agreed to and is not in the bill before us. A massive safeguard has been lost. This provision exists in the Victorian legislation, and we are saying no. That reason alone makes the Western Australian legislation more dangerous than the Victorian legislation.

I note that Hon Charles Smith pursued another safeguard, and I also pursued it, albeit with a different mechanism, which was to involve experts in decision-making capacity. That has been rejected. That safeguard was in place in the Northern Territory’s legislation. We know that there were wrongful deaths in the Northern Territory, notwithstanding its safeguards, but we have said that in Western Australia, despite our knowledge of that, we will lower the bar. We will not involve experts in decision-making capacity. We will ignore the evidence provided by the Chief Psychiatrist to the Joint Select Committee on End of Life Choices, and the evidence given by the Chief Psychiatrist to the government’s special adviser on this bill, and we will proceed anyway, without experts in decision-making capacity being involved.

The saddest time for me during the debate was when we considered the amendment moved by Hon Rick Mazza for supervision of self-administration. I could not believe it on Friday and I am still trying to reconcile how we have got to this point in Western Australia. Once we pass this bill, we will send it to the other place for members to consider the 55 amendments, which will horrify them because they did not think there was a need for any amendments, let alone 55 grammatical ones. I am horrified that what we will send them will not include the amendment moved by Hon Rick Mazza that simply sought to provide that if a Western Australian is provided with access to lethal medication, we make sure that somebody is there before they take it. All he wanted was for there to be somebody present to ensure that the person was not alone. Why would the honourable member be motivated to do that? It could only be out of a big-hearted sense of compassion and the knowledge that complications could arise.

I said this last Friday, but I never expected the response to that concern raised by the member, which I share and support. I never expected the response to be, “Well, the patient’s been warned. They’ve been told of the risks, and if they still want to go ahead with self-administration, well, they’ve been warned.” I really struggle with that. I struggle with the idea that we know that there will be complications. Somebody could regurgitate the substance; they could choke or asphyxiate. All those things have happened in other jurisdictions, but we say, “Well, they’ve been warned.” I am sad about certain elements of the bill, but I am distressed about this particular issue. I actually think it is reprehensible. It is reckless lawmaking and it is one of the reasons why I will be voting no. Even if members hold the view that the patient has been warned and if they want to choke or asphyxiate and suffer those complications, that is up to them, surely as lawmakers we have a responsibility to people other than the patient, because this substance is going to be in someone’s home. Who is to say that someone else will not access it? That would not happen if the patient chose practitioner administration because the practitioner would have the substance right up until the final moment of the patient’s life. But we are saying, “No, leave it. Let it go out, unsecured, into the community, and if there are complications for the patient, well, they’ve been warned.” I am troubled by that.

The part that got me the most when we were debating Hon Rick Mazza’s motion for supervision was when I drew to members’ attention, “Look, you can have an argument about complications: ‘You’ve been warned, and so on and so forth’, but how much do we value decision-making capacity?” An entire part of the bill is devoted to decision-making capacity; we said that it was very important. The minister repeatedly told us that it is fundamental to, and at the heart of, the whole bill; that it is about choice and autonomy, and that the person has to make that choice, yet we are going to allow the person to take home the—in the words of the Attorney General—potion, when we do not even know whether they will have decision-making capacity when they take the substance. We will not know that. We will know if it is administered by a practitioner, because the practitioner has a lawful duty to ensure that the person has decision-making capacity, but we will not know that in instances of self-administration. I respect their views of those members who are supportive of voluntary assisted dying and have been passionate about it for a long time, but at the conclusion of this debate, I ask them to think about the self-administration process, because the amendment moved by Hon Rick Mazza was outstanding, and I remain sad and distressed that it was not supported.

Unlike the Victorian and other schemes, no specialist will be involved, and we are going to allow unsupervised use of the lethal medication for self-administration. They are serious flaws in this legislation and the scheme, but to top it all off, the icing on this fatal cake is that we have mandated that in Western Australia, practitioners will be required to falsify the death certificate for these deaths. In some respects, a death certificate is just a piece of paper and what is written on it will not save the life of the dead person, unlike preventing unsupervised access to self-administered lethal drugs or involving a specialist to make sure that the person actually has the terminal illness and will die in the time the first doctor, who may not be experienced with the condition, thinks they will. Those would have saved lives. I acknowledge that preventing the mandatory, statutory falsification of death certificates will not save lives. It is not in the same league as the amendment moved by Hon Rick Mazza and of those who moved amendments about specialists, but I cannot believe that we are going to send a bill to the other place that...
mandates that under no circumstances should medical practitioners write “voluntary assisted dying” on the death certificate, on pain and in fear of being in breach of the law. I would be fascinated if members who love polls would poll their community on that. They should poll their electorate and see whether it thinks voluntary assisted dying should be on the death certificate, but I know they will not do that.

Yesterday, a majority could not agree that we should ensure that medical practitioners be trained in how to identify undue interference. We could not agree to that. That was notwithstanding that under clause 100 I specifically asked the government whether doctors would need to be able to identify undue influence so that they could report it to the police or the CEO for investigation. I was told yes, and said that I would pick it up later in the debate, which I did. I moved an amendment and the majority of members said no. It is, at the very least, if I can use the most charitable word possible, curious lawmaking.

I want to make a last point about the elements of the bill that are not before us that I think would make it a far better and safer bill if included before it went to the place. Apart from the elements I have just spoken of, I raise something that is not a safeguard, but I think it is a statement from this place—and I do not think it is comfortable for members. When Hon Martin Aldridge moved an amendment saying, in effect, that regional Western Australians should have equal access to voluntary assisted dying as those in the metropolitan area, I suggested to members that we should make sure that it is not just voluntary assisted dying that they should have equal access to—it should also be palliative care. That amendment was lost by the barest of margins. It was ironic. I am going to quote from the uncorrected proof of Hansard from 26 November 2019, but I have had the opportunity to verify the corrected proof and it is in identical terms.

Hon Stephen Dawson—who has done a sterling job in his duties in the chamber, as many members have quite rightly remarked, and as I also acknowledge—said this on 26 November 2019—

Proposed new clause 16(3)(d) is not consistent with the intent of the new principle in clause 4(1)(ha) regarding regional areas. That principle is worth repeating for the benefit of honourable members, and I quote—

a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and palliative care as a person who lives in the metropolitan region.

If only that was what the bill actually says. That is exactly what I wanted it to say, and that is what a significant number of members wanted it to say, but that is not what the bill before us says. The bill makes no mention of equal access to palliative care. We have sent the wrong message to the community. We have sent the message to the community that we want people in regional Western Australia to have equal access to voluntary assisted dying but, when it comes to palliative care, the record reflects that the majority of members said no. I think that is uncomfortable, at the very least. I do not think that is the heart and the intent of members. I am confident that the majority of members do not actually think that, but that is what the record reflects, and that is most unfortunate.

Before I move to my conclusion, I want to make some remarks about something that I think is not understood in the Western Australian community—that is, irrespective of the passage of this bill to the other place and regardless of whether it agrees with all, or none, of our 55 amendments, nothing will happen for at least 18 months. Western Australians deserve an explanation about why nothing will happen for at least 18 months. They will have heard the rhetoric from the Premier, and they will say, quite understandably, “We thought this was all going to be ready for Christmas.” Why will it take at least 18 months? There are a few reasons for that. First, we know as a result of some excellent interrogation by Hon Martin Aldridge that there is an issue with the intersection of commonwealth law and the use of telehealth and a carriage service. It will take time for the government to sort that out with the commonwealth. The Joint Select Committee on End of Life Choices was asked by this house, as a term of reference, to look into the intersection with federal law, and, unfortunately, it did nothing. It would be fascinating if those minutes were released. The government had a backstop in the form of the ministerial expert panel. It also did nothing about this issue. It is now left to the government to sort this out over the next 18 months. Therefore, the Premier has some bad news for those who were hoping this would be ready for Christmas. Apparently, it is my fault. The reality is that the Premier and his government need another 18 months to get this process right. One of the reasons for this delay is the government does not know what substance will be used. It knows that it will be a schedule 4 or schedule 8 drug, but it does not know what the combination will be, and it still has to work out the complications. The government is also not sure how the substance will be provided in regional Western Australia. It has given a commitment that care navigators—that is the phrase that has been used—will be used in this process. These care navigators will really be unregulated steers whose job will be to steer a regional West Aussie down a particular path, which is voluntary assisted dying. Another thing that the government needs to sort out over the next 18 months, amongst many things, is the cost. During interrogation of the clauses, the government conceded that, in some cases, a patient would have to make a gap payment. The government cannot tell us how much that will be, because it has not consulted with private health insurers or, indeed, Medicare.

I conclude this journey. It has been more than a two-year journey for me, amongst others who served on the Joint Select Committee on End of Life Choices, which I do not regret serving on for a moment. I knew we
would be up against it the moment the motion was moved, but I indicated yesterday that my philosophy is never to vacate the space. Secondly, if nothing else, at least this has ensured a new level of commitment to palliative care that did not exist before.

I conclude with these statements, which are identical to my final concluding remarks in my contribution to the second reading debate about why I cannot support the Voluntary Assisted Dying Bill 2019. I could not support 139–1 and I cannot support 139–2 for all the reasons I have said, including these in summary. The desire of a significant proportion of confident people for ready access to lethal injections ought never override the rights of the quiet vulnerable to safety and protection. Secondly, if we are intellectually honest and reason through the theory of a euthanasia regime, we should conclude that it is inherently unsafe. The insufficiency of the criminal justice safeguards informs us of this; the prevalence of medical negligence informs us of this; the ease of doctor shopping informs us of this; the reality of doctor bias informs us of this; and the evidence of elder abuse informs us of this. When we engage with the lived experience of the very few jurisdictions that have legalised euthanasia or assisted suicide, we know that the theory of an inherently unsafe regime has resulted in casualties of wrongful deaths. Ultimately, there is another way; there is a better way. There is a safe approach to end-of-life choices. However, it will require all of us to persistently insist that quality palliative care is made available to every Western Australian. When I say quality palliative care, I mean expertly practised specialist palliative care, not palliative care by a doctor who has an interest in palliative care. That is not what we are talking about here. I am reminded of the evidence given by Professor Doug Bridge when he came to the joint select committee. He said that he went into a hospital room one day and saw this patient effectively inflated, blown up, and he was horrified. He said, “What are you people doing?” He went in and rectified the situation. If that was our experience of palliative care, of course we would be horrified. We would say, “If this is the best that palliative care can provide for us, I want the lethal injection as well.” However, that is not the best that can be provided. What can be provided is expertly practised specialist palliative care in our state. It is a great privilege for us to be living in a First World country where that is available.

As legislators, until we have exhausted ourselves in fulfilling this duty to make quality palliative care available to every Western Australian, we should not be contemplating a euthanasia regime, let alone this bill, which is, verifiably, more dangerous than the Victorian legislation and the now inoperative Northern Territory legislation.

I am opposing this bill because the risks in legalising assisted suicide are simply too great, the least of which are that the consequences are final.

HON ADELE FARINA (South West) [3.18 pm]: I would like to join other members in acknowledging the minister, Hon Stephen Dawson, for his handling of a very difficult bill. It is not an easy task and he did it with distinction and a lot of patience. I also acknowledge and thank the advisory officers for their incredible efforts in supporting the minister, the clerks, the chamber staff and Hansard, who support us daily. I would also like to acknowledge the efforts of parliamentary counsel, who were frequently asked to draft amendments at very, very short notice and with very few instructions. I acknowledge all the members who contributed to the debate, listened to contributions and exercised their conscience votes. Through their contributions, they added value to the debate and to the bill. I particularly acknowledge the forensic work of Hon Nick Goiran. We do not always agree, but I have huge respect for his capacity, diligence and integrity. He came under significant external pressure throughout this debate. His efforts ensured that this chamber undertook its scrutiny role in a forensic manner, and as a result we have a much improved bill.

The proponents of voluntary assisted dying argue that we need to support the bill because it is the compassionate and humane thing to do, that it will stop intolerable pain and suffering for people with a terminal illness, and that it will also afford them the dignity of choosing when they die rather than waiting for the disease to take them. Giving a person a lethal substance to self-administer—when there have been no clinical trials of the lethal substance to understand its adverse reactions, and knowing that the ingestion and absorption method is much slower than injection—is not always effective and carries with it a range of complications. To do so without a doctor in attendance to assist if something goes wrong is an entirely different matter to the humane practice of euthanising animals, which is often used as a point of comparison by proponents of voluntary assisted dying. I struggle to see what is humane and compassionate about giving people a large quantity of a lethal substance to drink that is so bitter tasting, people struggle to drink it. They drink it too slowly, falling asleep before they have consumed the full amount, increasing the risk that it will not be effective, or they regurgitate it and do not consume a sufficient amount of the substance to reach the optimum level of unconsciousness before the substance either asphyxiates them or induces a major heart attack. In addition, some people experience seizures and convulsions. These complications cause significant distress for the patient and the family who witness the event. This is not humane; it is not compassionate and I fail to understand how it is dying with dignity. As legislators, in making the decision about whether to support this bill, we cannot ignore this fact or push it to the side. We know from experiences in other jurisdictions that if either of the two main drugs used in other jurisdictions is used in WA, somewhere between five and 17 per cent of people who self-administer the substance will experience these complications. If a different drug is used or if the CEO approved an entirely new drug on the advice of the clinical panel, we know from the experience in
Washington that the outcome may be much worse. In that jurisdiction, a trial of a new drug, DNP, caused severe muscle spasms in patients and burnt the throat of others, causing severe pain when they expected relief. Faced with all this knowledge, the proponents and the drafters of the bill had an opportunity to draft a bill that addressed these issues and concerns, and reassured us that this would not be the experience if this bill passed in WA. Sadly, this is not the case; they failed to do so.

In an effort to make passage of the bill easier, or in an effort to get it to Parliament much sooner, much of the detail and what people may find unpalatable has been left out of the bill. We were told that it will be sorted during the 18-month implementation phase. On no fewer than 77 occasions this was the minister’s answer to questions posed seeking to better understand the bill. As a legislator wanting to make an informed decision, I found this very frustrating and less than satisfactory. Please do not interpret this as criticism of the minister; it is not. It was the position he found himself in and he made every effort to provide answers when he could.

We are being asked to pass a bill that will permit a lethal substance to be prescribed to people without knowing what that lethal substance will be and without knowing its likely side effects and the possible complications that people may experience. It is very likely, based on everything we know, that the lethal substance’s suitability for human use will not have been assessed, much less approved, by the Therapeutic Goods Administration. The bill expressly provides that the substance does not require TGA approval. I sought to amend the bill to require TGA approval, having been assured, despite my initial doubts, that the TGA could assess such a substance, even though its use is not therapeutic. This would have provided me with some comfort, but that amendment was not successful.

In my second reading contribution, I indicated my concern, given the number of complications experienced in other jurisdictions, that the bill did not require a medical practitioner to be in attendance when the drug is self-administered, as is the case in the Netherlands. From my perspective, if we truly want to ensure that people have a peaceful and pain-free death and die with dignity, this is a must. Hon Rick Mazza, sharing this view, moved an amendment to this effect. The majority argued that patient autonomy should be given greater weight than patient safety, even if the patient did not experience the promised peaceful and pain-free death and this caused significant distress to the patient and family members. I am still processing this viewpoint. Some argued that the patient chose voluntary assisted dying knowing the risks, and has a terminal illness, so will die anyway; therefore, we should not concern ourselves that their death may not be peaceful and pain-free as promised. They argue that the person’s autonomy in choosing when to die should be given greater weight and concern than their safety. With all respect to those who have put this argument, I find that argument abhorrent. Medical ethics has as one of its pillars or guiding principles the requirement to do no harm, as does the law. As lawmakers, doing no harm is also an ethical principle that should guide us all. Approving a bill that we know will result in between five per cent and 17 per cent of people who ingest the lethal substance dying a painful death, causing distress to their family, and that this figure may well be higher depending on the prescribed substance, falls well short of this. Implicit in this argument is the devaluation of human life because the person is old or has a terminal illness and will die anyway. This sets a really dangerous direction for society.

We are told that we need to show compassion to those who have a terminal illness and want to avoid suffering a painful death. I understand this, and I have the compassion in me to want to do everything possible to alleviate their pain and suffering. However, my compassion does not end there; it extends to the between five per cent and 17 per cent of people who will not get the promised peaceful and pain-free death due to complications, and to do everything I can to ensure that we eliminate or reduce the number of people who are likely to experience complications.

The drafters of the bill had an opportunity to address this concern but they did not. The rights of this small but significant group of people do not appear to have been considered in the drafting of the bill. The patient autonomy argument won out over Hon Rick Mazza’s amendment, even though this argument ignores the fact that the between five per cent and 17 per cent of people who will experience complications did not choose to ingest a lethal substance in attendance and experience a painful death. Further, the bill denies them the patient autonomy to have a medical practitioner in attendance and for the medical practitioner to hasten their death if needed, as is the case in the Netherlands. My concern and compassion for this small but significant group of people caused me to move two amendments: in the case of practitioner administration, to require that the medical practitioner report any complications to the board; and, in the case of self-administration, because we had already lost Hon Rick Mazza’s amendment, to require that the contact person be present and also report any complications to the board. This would have enabled us to examine and learn from any complications with a view to making whatever adjustments are necessary to ensure that in the future there is not a repeat of the incident with another patient and they do not suffer the same fate. The government agreed to the amendment in the case of practitioner administration but opposed the amendment in the case of self-administration. The chamber, in its wisdom, voted down the amendment in the case of self-administration, arguing that it placed too great an obligation on the contact person. I understand that argument, but without a medical practitioner present, I was looking for other options.

The outcome of this negates the intent of the two amendments because evidence from other jurisdictions indicates that complications occur with self-administration, not practitioner administration. The effect of this decision is that there is no requirement to notify the Voluntary Assisted Dying Board of any complications with self-administration.
In my view, this is a significant deficiency with the bill and compromises patient safety. In the case of Hon Rick Mazza’s amendment and my amendment, the safety of the patient and delivering the promised peaceful and pain-free death rated a poor second place to patient autonomy. A cynic may argue that it was a deliberate attempt to avoid collecting data about complications so it can be argued that no data of any complications exist. If that is the case, it is less than satisfactory, and particularly not satisfactory to the people who are going to experience those complications.

In a last-ditch effort to extend compassion to this group, I moved another amendment, having been motivated by the case of David Prueitt in Oregon when it was discovered that the organisation charged with managing assisted dying in that jurisdiction did not have an investigation function and therefore could not investigate why the lethal substance failed to result in David Prueitt’s death. No-one can think that that was a satisfactory position. My amendment would have provided the Voluntary Assisted Dying Board with a preliminary investigation function and provided that family members and witnesses to a patient’s death via self-administration may report any complications to the board. The amendment was intended to ensure the legislation had provision for a review of instances of complications in the hope of at least collecting some data so that we could evaluate it and learn from it. That would have enabled us to continually improve the system. The amendment was opposed by the government and the chamber. Compassion for people with a terminal illness does not appear to extend to the group of people who will experience complications from self-administering. This aspect of the bill concerns me deeply. It is disappointing that the government refused to support a mechanism in the bill to ensure relevant data is collected and analysed so that we can learn from these experiences and improve the voluntary assisted dying scheme to prevent a repeat of a similar complication occurring in the future.

In my second reading contribution, I flagged my concern that laws passed by Parliament should not require people to falsify state records by directing medical practitioners not to record on a death certificate that the person died from voluntary assisted dying. Amendments to this effect were moved by Hon Colin Tincknell and Hon Nick Goiran. These were opposed by government and defeated. This is despite the fact that in cases of suicide, this is recorded on the death certificate. Death certificates are used for a range of invaluable research purposes. We will no longer be able to rely on the information on death certificates being accurate, which, in turn, will impact on the efficacy of research work. The impact of this decision cannot be understated. In my view, it was a bad decision and completely unjustified.

Getting back to the issue of intolerable pain and suffering, we know from data collected in other jurisdictions that pain scores low in the reasons given by people accessing voluntary assisted dying, or the equivalent on offer in other jurisdictions. We also know that the collection of this data, including the reasons people elect voluntary assisted dying, forms a critical part of the medical practitioner’s evaluation about whether the patient is acting voluntarily and without coercion, and assessing other eligibility criteria. An amendment moved by Hon Nick Goiran for the collection of this data was deemed unnecessary and too onerous by the government and the chamber. I think this is a significant failing in this bill. It is critically important for this data be collected and it is concerning that we are opposed to collecting data that can inform us to make better decisions.

The lack of a clear mechanism for reviewing failings in capacity assessment, as exists in the Netherlands, is another significant shortfall in the bill. There is much to be learnt by reviews such as these and that would enable us to continuously improve the scheme. As stated in my second reading contribution, in principle, I am not opposed to the concept of voluntary assisted dying; however, as a legislator, I need to scrutinise the bill and be satisfied that the bill strikes a balance between patient autonomy and patient safety, provides sufficient safeguards that protect the vulnerable and does not protect the rights of one group by trampling over the rights of others. My concerns with the bill are not based on religious beliefs; they are based on good science, medical and legal ethics, good lawmaking and a genuine concern that we do not harm and do not advance the rights of some while trampling over the rights of others.

Under this bill, medical practitioners will be forced to participate in voluntary assisted dying despite their conscientious objection. They are going to have to provide information. The rights of vulnerable people who may be coerced to access voluntary assisted dying are not sufficiently protected, in my view. The small but significant group of people we know will experience complications as a result of self-administration of the substance have, in my view, been sacrificed by the bill. The engineering of the bill, which leaves much of the detail to be sorted out during the implementation phase, and the stated intention to do things by executive directions rather than regulations also concerns me. The effect is to censor Parliament’s lawmaking power and scrutiny function, and we should all be concerned about this. At every step of the process I have made my own evaluations based on the facts, having regard to the contributions of other members and the representations I have received. I have tried to make the right decision. Many people will not agree with the decisions that I have made.

Exercising a conscience vote and being a member of the government is not an easy or comfortable position. There is considerable pressure, both subtle and overt. I supported the bill in its second reading as I hoped my concerns and those of others could be addressed by amendments to the bill. Although a significant number of amendments have improved the bill, not all my concerns at the second reading stage have been addressed, placing me in a very difficult position. I concur with other speakers that the conflict of interest amendment is

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a very important amendment that has significantly improved the bill, as has the need for medical practitioners to advise patients about the risks of self-administration. The other significant amendment is the regional access standard, and it will be interesting to see whether that actually delivers the intended outcome, but it is a positive amendment to the bill.

It has been suggested to me that because there is clear support for the bill and the bill will pass regardless of how I vote, my vote is irrelevant to the outcome that we will see today and that I should put my concern aside and support the bill. It has been explained to me that this will be an easier route for me personally. It has also been suggested to me that if I cannot support the bill, I should abstain from voting on the third reading because as a government member this is what is expected of me. I have struggled in my consideration of these suggestions, wanting to do the right thing by the government and wanting to do what I believe to be the right thing. Taking the easy path would indeed be easier. Taking the path that would be easier for me personally, despite my continuing concerns with the bill, is simply not in my DNA. My life would have been a lot easier if it were.

There is no doubt that the bill is a much better bill as a result of the amendments that have been passed and the good work of the members in this place. The question for me is whether those amendments are sufficient. The question I put to myself was: can I, in all good conscience, support a bill that approves the prescribing of a lethal substance that has not been approved by the Therapeutic Goods Act for human use and that I know will result in between five per cent and 70 per cent or more patients experiencing anything but a peaceful and pain-free death, with no mechanism in the bill for investigation, review or improvement by the Voluntary Assisted Dying Board and insufficient protection for the vulnerable? When I put that question to myself, I came to the answer that I just cannot do it. I know that a lot of people will be very disappointed by that, but I cannot put people in harm’s way. In the full knowledge that my vote will make no difference to the bill passing, I have decided to err on the side of protection of the vulnerable and those who will not get the promised peaceful and pain-free death and to vote against the bill at the third reading.

HON ALISON XAMON (North Metropolitan) [3.40 pm]: I rise to reflect on the process of deliberation of the Voluntary Assisted Dying Bill 2019. As I indicated in my second reading speech, I will be supporting the third reading of the legislation, as I did the second reading. The Greens have a longstanding commitment to the principle of voluntary assisted dying, which is also enshrined as a specific policy of the party. In my almost seven years in this place, I have never gone against a Greens policy and I do not intend to start now. Respecting Greens policies is a core responsibility of the parliamentarians who have been entrusted by our party to represent them.

I also reiterate my personal commitment to the principle of voluntary assisted dying. I remain strongly of the view that too often modern medicine keeps people alive far beyond their time and that the capacity to die peacefully when one’s life is otherwise up is a compassionate and loving response to an inevitable death. But that does not mean that I feel completely confident that the legislation before us has hit the right balance, even though I will be supporting it. Crafting legislation around issues of life and death is a sombre and onerous responsibility. We do not craft legislation for those families and people who are loving, supportive and committed to doing the right thing, and whose hearts and motives are pure. To try to pretend that this is the whole purpose of this legislation solely to facilitate access is, I think, at best facile, but at worst dangerous. We legislate because we are trying to mitigate the damage that can be wrought by those people who, through maliciousness or greed or even just because they are exhausted and frustrated, do not do the right thing. Members, that is why we have a Criminal Code—for people who will not do the right thing, and we have literally hundreds of statutes on the book to try to address harmful behaviours of the minority within this community that would do us harm.

I know that I have attempted to engage, in good faith, in the process of amendment, as I made clear in my speech on the second reading that I was determined to. I have not caucused with any group. At no point could my vote on any amendment be taken for granted. I did not turn up to Parliament with the intention of sleeping through this debate on life and death. Instead, I committed to listening to the whole debate and voting accordingly to both my conscience and some fundamental principles. The fundamental principles in this legislation that I have committed to are ensuring that the eligibility to VAD was not limited any further than the bill currently provides, nor that access was limited. Indeed, I voted for amendments that I believe would have increased the capacity for regional Western Australians to have access to both VAD and palliative care—amendments that were not supported by the majority of this house. I also remain committed to the capacity for people to avail themselves of VAD by self-administering. Indeed, I am of the view that this is a critical safeguard to be better assured that consent has actually been achieved. But I was fully prepared to commit to supporting amendments that I believed would improve transparency, oversight and clarity to the process. I remain concerned that many of those sensible amendments were not supported for no clear reason other than a concern as to who had moved the amendment as opposed to the substance of the amendment itself. I also remain concerned that the safeguards are insufficient. However, with all my heart I hope that my concerns are proven to be without foundation because it will weigh very heavily on my conscience if my concerns ever come to fruition.

This is a regime that many in the community have lobbied long and hard for over decades. Many of us have personal stories of people we have loved who might have wanted to be able to access voluntary assisted dying or
who we believe would have wanted to be able to access VAD. I urge those who are celebrating the likely passage of this legislation, which ushers in a serious change to how we, as a state, deal with death, to consider what is at stake should the insufficient safeguards within this bill result in a coerced death, the death of someone who it turns out is not dying, or a family member being wrongly accused of murder. These occurrences could be catastrophic for those people and families, but also catastrophic for this reform. Opposing safeguards, opposing the capacity to uphold the integrity of this regime, could have the perverse effect of undermining everything that has been fought for. I know that I have engaged in good faith to try to maximise transparency, oversight, safeguards and genuine choice, despite coming under some pressure not to engage intelligently and thoughtfully with the debate. At the end of the day, I have to be able to live with myself. I have resisted this pressure and I do so without apology. I am of the firm belief that the amendments that have been agreed to and that have been passed have greatly improved the bill.

This legislation marks a significant shift in how we as a community view death and the state’s role in the deaths of its citizens. I hope we continue to scrutinise the way this legislation and the associated regime rolls out. I hope that we are able to extract as much transparency as we can about how it is operating, despite in my view the limited provisions in the bill and despite the Council’s decision to not support many measures that would have provided additional transparency. With all my heart, I hope that the efforts to ensure that we have world’s best practice in the availability of palliative care continues to be fought for so that all Western Australians have genuine choice at their end of life and that voluntary assisted dying is never sought simply because people have been left without any other option.

I acknowledge the exemplary conduct of Hon Stephen Dawson in his handling of this very sensitive legislation and for treating it with the seriousness that it deserves. I also want to acknowledge the very measured way in which the Minister for Health has endeavoured to engage both with members and in his public commentary. I wish all government members could demonstrate such restraint.

Finally, I want to give a thank you to the literally thousands of people who have contacted me over the course of this year, many telling me their deeply personal stories and, just as importantly, many expressing their deep distress at the introduction of this legislation. I recognise that although many, if not most, within this state will welcome the passage of this bill, there will also be those who are desperately disappointed and concerned, and those again who welcome the bill but with significant trepidation. We all have hopes as to how this legislation will work in practice. My fervent hope is that it does prove to work as intended.

HON COLIN HOLT (South West) [3.48 pm]: I will be relatively brief. I want to work on two themes: one is to congratulate all members of the chamber, especially the Minister for Environment, Hon Stephen Dawson, supported by the Leader of the House, for the way they have conducted the Committee of the Whole process in a calm, respectful manner that came through in every debate. That was extended to every member who contributed to the debate and who raised questions and moved amendments. I would also like to say a thank you to members of the Joint Select Committee on End of Life Choices—Hon Robin Chapple, Hon Dr Sally Talbot and Hon Nick Goiran—who joined me on that committee that started this process two and a half years ago. That was a major moment in the development of this bill and the delivery of this policy. I have nothing but respect for the views of all members in this chamber, as I am sure they respect my views, and that has been demonstrated over and again throughout the two-and-a-half-year period of working with the members of the committee and also members of Parliament. I think we can agree that we disagree, and that is okay. As Hon Peter Collier said, members come from a broad spectrum of communities and we reflect a broad spectrum of views, not only our own, but also those of our communities. I am definitely one of those. I am not a lawyer and I do not come to this chamber with a legal background, but that does not mean that I and everyone else do not have something to offer in Parliament. In fact, that is exactly what should happen. I congratulate all those who brought their views to the table, debated without fear or favour and moved amendments that I may or may not have agreed with. But, again, that was the will of the chamber and the will of my vote in my role as a member of this chamber.

I have always said, and I said in my second reading contribution, that I would look at this bill from the viewpoint of a patient who is terminally ill. I went to great lengths to describe my viewpoint in that sense. I have considered every amendment that was put forward and every debate that ensued from the viewpoint of someone who is terminally ill and wants to relieve their suffering. As it happened, by either circumstance, irony or synergy, when I was driving around Bunbury on Monday, I got a phone call from a friend of mine who said that their brother-in-law, whom I knew very well from my time in Halls Creek, was dying of cancer and he had very few days left. Some members in this chamber will know him because he was a very prominent policeman. He was transferred to a hospice and obviously put into palliative care to make him feel as comfortable as possible. I am sure that his palliative care was of an absolute standard; it was in metropolitan Perth. However, from the reports I have received, it did not relieve his suffering in his final days and hours. His birthday was yesterday. He passed away at 7.30 this morning. His birthday was yesterday. He passed away at 7.30 this morning.

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I am not of that opinion. I think the bill has plenty of safeguards in providing an opportunity, and probably a difficult opportunity for my friend who died this morning, to access it in a timely manner. To give some context, three weeks ago he was feeling unwell. He went to the doctor and the doctor said that the cancer had spread throughout his body and into his lymph nodes. That was three weeks ago and he died this morning. His pain was not relieved in the manner that he expressed to his family, and that is why I have come to the decision to support this bill.

HON TIM CLIFFORD (East Metropolitan) [3.53 pm]: I was not going to speak, but after hearing the contributions of everyone else, I thought it was worth putting forward my views. I did not say much throughout the committee stage, as I stated my support for the Voluntary Assisted Dying Bill at the outset in my contribution to the second reading debate. I reiterate my support during the third reading stage and take my hat off to the people who were involved in this process, including the minister, who I think conducted himself really well. I liked to see the amount of questioning and the scrutiny of this bill to the nth degree. Although I do not agree with the views of Hon Nick Goiran, I respect the way he conducted himself during the process and the scrutiny he put on the minister and his advisers, who did an amazing job. Before I came to this place, I did not realise the amount of work and time that is put into drafting legislation, especially on a bill such as this. I did not realise the work that my colleague Hon Robin Chapple has done since the early days of advocating for voluntary assisted dying in this place. The historical significance of this bill is not lost on me. I read every one of the amendments put forward. I did my homework and I asked questions. Once I made up my mind, I did not feel as though I had to stand up to reiterate my support. Where I voted was where I stood. That is pretty much where I am with this. We are very close to the end of contributions today. This is a really good example of democracy being played out.

I was disappointed with the rhetoric I heard outside the chamber and the way the media portrayed this debate, which fuelled a lot of the views in emails that landed in my inbox. People were misguided by the rhetoric in the public space. Even though a lot of myths were clarified as the committee stage went on, there was still a ramping up of those views. We need to look at the way the media has operated in this space. I cannot express my gratitude enough to my colleagues for not allowing that rhetoric to enter this chamber. No matter what we did, we managed to get through the process. We voted in a way that was steered by our conscience and we managed to get to the end by standing on our own two feet. I thank the chamber. I thank the Minister for Environment. This goes back to the people of WA and to those who will face the end of their lives in a way we wish on nobody. This bill will give them a choice. Thank you.

HON STEPHEN DAWSON (Mining and Pastoral — Minister for Environment) [3.57 pm] — in reply: From the outset, I commend all members of this place for their careful and thoughtful consideration of the Voluntary Assisted Dying Bill 2019. On this journey many members have shared deeply personal stories about their families and those of their constituents. Although we have not agreed on every issue, opposing views have largely been exposed respectfully.

I place on the record my thanks to the Premier. It is due to his resolve and indeed his leadership that we are dealing with this bill at all. I thank him for that. I acknowledge the contribution to the debate by Hon Nick Goiran and others. They may have different views from me, but I respect their right to speak. 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 a respectful death without unnecessary suffering. Published polls suggest that 88 per cent of Western Australians are in favour of voluntary assisted dying, yet only a small number of people will be eligible to access voluntary assisted dying at the end of their life. I believe that Western Australians should be supported in making informed decisions about their medical treatment. They should be able to choose to spend their last days surrounded by loved ones, ideally at home, coherent and without pain. This is a 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. A great deal of work has happened since that time. There has been a comprehensive and careful process to ensure that we had the benefit of the best advice for this bill.

I would like to acknowledge the members of the joint select committee for their considerable efforts and to recognise the extensive work undertaken by the committee. The committee’s report paved the way for this landmark piece of legislation. In particular, I would like to acknowledge the outstanding efforts of the chairperson, the member for Morley, Amber-Jade Sanderson, and the deputy chairperson, Hon Colin Holt, for their dedication and their leadership. I also thank Hon Dr Sally Talbot for her role in the committee and other roles throughout the debate, and, of course, Hon Nick Goiran who was part of that committee too. I would also like to thank the members of the Ministerial Expert Panel on Voluntary Assisted Dying for their hard work and dedication. They listened to widespread community views on this important and significant issue, and reviewed a broad range of research from both 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 chairman of the panel and for his continued advice during the parliamentary debate.

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I would like to specifically acknowledge the tireless efforts of my advisers, including Daphne Fernandes, Marion Huntly, Amanda Bolleter, Lisa Furness and Carol Conley. Thank you. Of course, many others are working behind the scenes at the Department of Health who also deserve a mention for their contributions; this has been a genuine team effort. Other members have mentioned the parliamentary draftpeople and others, and I thank them too. I also want to add my thanks to the Chair of Committees and the Deputy Chairs for the role that they played in and their stewardship of the debate. I also place on the record the gratitude of this house to the hardworking staff at Parliament, including the clerks and all the chamber staff, catering, security, Hansard and building management, all of whom have kept the house running as we considered the legislation during the debate. They are some of the tireless people who do not get to stand in front of cameras and who do not have people saying to them, “Thank you” and “Good job” on a daily basis, so thank you on behalf of the 36 of us in this place.

The bill was introduced to the house on 26 September. I am told it took 78 hours and 43 minutes to consider and debate the 184 clauses contained in the bill. It has properly undergone extensive scrutiny. Throughout the course of this debate, the Minister for Health and the government listened carefully to members and stakeholders regarding what would constitute an acceptable legal framework for voluntary assisted dying. In the end, as we have heard, the house made 55 amendments, many of which codify what is already good medical practice or make explicit what was already implicit in the bill. We considered the Victorian approach and we believe we have come up with a better outcome for Western Australians. I pause to note, in particular, the substantive amendment at new clause 9A, which provides a sensible, balanced approach to the initiation of a conversation about voluntary assisted dying by a medical practitioner or nurse practitioner in specific circumstances. This is what good governments do; they listen. The bill before the house is robust and contains appropriate safeguards whilst ensuring a compassionate approach to those who are dying. The safeguards ensure that all members can have confidence in this final bill.

Members, much has been said in this place about the importance of palliative care. Palliative care should be a genuine choice for Western Australians. This 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. I think our recent commitments in the budget show that too. It is also important to note that in the context of this debate members are not considering voluntary assisted dying instead of palliative care; we are considering the compassion we should show to those people for whom palliative care does not relieve their suffering. 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.

Voluntary assisted dying is a significant issue for Western Australia, and I sincerely thank every member of the Legislative Council for sharing their personal experiences with the chamber and for their valuable contributions to this crucial debate. Amongst the many supporters of voluntary assisted dying in this place, I would like to take a moment to acknowledge two—Hon Alannah MacTiernan and Hon Robin Chapple—both of whom have been at the vanguard of support for voluntary assisted dying over many years, and each is testament to the truth that perseverance is the secret of all triumphs. Without their tireless commitment over the years, this bill would never have advanced to this point. Their continued support means that a choice is possible for those who want it in the face of their intolerable suffering at the end of their life. All Western Australians owe them a debt of gratitude. Many people across the community who have had their parents or a loved one pass away in agony want something face of their intolerable suffering at the end of their life. All Western Australians owe them a debt of gratitude.

I want to thank all those who have campaigned for this legislation. Of course, some of them are in the gallery this afternoon and have been here over the past weeks as we have debated this. Thank you to each and every one of you for the role that you have played; it has been a very important role. I am confident that this bill will now receive the endorsement of the Legislative Council and move to the other place for final consideration.

I, too, commend this bill to the house and I urge honourable members to support it.

Members: Hear, hear!

**The President:** Before I put the question, I remind members again that we will conduct this vote in the same way that we have managed the whole of the debate in this chamber on this very significant piece of legislation. I ask that when I put the question, and possibly we may or may not go to a division, that we handle this in a very calm and mature way and a quiet and respectful manner. I also ask our visitors in the gallery if they can observe this vote in a very respectful and calm manner as well, acknowledging the diversity of views that exist in this chamber today on this issue.

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Division

Question put and a division taken with the following result —

Ayes (24)

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

Noes (11)

Hon Ken Baston  Hon Adele Farina  Hon Simon O’Brien  Hon Colin Tincknell
Hon Peter Collier  Hon Rick Mazza  Hon Charles Smith  Hon Nick Goiran (Teller)
Hon Donna Faragher  Hon Michael Mischin  Hon Dr Steve Thomas

Question thus passed.

Bill read a third time and returned to the Assembly with amendments.