VOLUNTARY ASSISTED DYING BILL 2019

Committee

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: Minister, I take it you are still getting advice in respect of the level of penalty. My supplementary question was: why is it appropriate for a penalty of the magnitude of a fine of up to $10 000 to be issued on a medical practitioner simply because they do not send a form to the board within two days, particularly given that we have now learnt that the Victorians have seven days?

Hon STEPHEN DAWSON: The amount of $10 000 was deemed to be a reasonable penalty. I am advised there was liaison with the State Solicitor's Office and the Department of Justice on all penalties. I further state that these practitioners will accept the role after training, so they will be fully aware of the penalties that will apply.

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?

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 that 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. 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 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. 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.

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.

Sitting suspended from 6.00 to 7.00 pm

Hon NICK GOIRAN: Just before the adjournment, the minister was taking advice on the implications for the patient and the coordinating practitioner in the event that the consulting practitioner indicated that they refused to continue to participate.

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. 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 would 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.

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;

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 somewhere in the bill to accelerate that time frame if necessary. This famous board that is going to be providing oversight will need to meet at least every nine days if it is going to be able to do anything. The minister has told me that the board is going to send some information to the CEO and the CEO might get to investigate. There is no point investigating after the patient is dead. We need the CEO to inject himself or herself prior to the wrong occurring.

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 resented 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 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 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 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?

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 Nick Goiran	Hon Simon O'Brien	Hon Aaron Stonehouse	

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 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 Matthew Swinbourn	

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 an 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 loved one. 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.

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 comes to mind when a loved one is in an emergency situation. Family members, who may not know whether they are beneficiaries of a person's will, make decisions about that person's care now. 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 person 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.

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—someone 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 —

> declaration; and
>
> (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.

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 witness 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 that is 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.

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 Donna Faragher	Hon Simon O'Brien	Hon Dr Steve Thomas	
Hon Adele Farina	Hon Robin Scott	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 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, 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.

The DEPUTY CHAIR: We are dealing with the amendment moved by Hon Nick Goiran and I just have to check that I have the words correct. The question is that the word to be deleted be deleted.

Hon STEPHEN DAWSON: With the greatest respect, Mr Deputy Chair, I would not mind having a copy of the amendment before me. It was by having the last version in front of me that I was able to see that the word "declaration" was not included, so I think, just for good practice, that we should have it in front of us and then we can vote on it.

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.

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. 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 defeated 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

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 Darren West
Hon Stephen Dawson	Hon Laurie Graham	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*

Noes (18)

Hon Martin Aldridge	Hon Adele Farina	Hon Martin Pritchard	Hon Colin Tincknell
Hon Jacqui Boydell	Hon Nick Goiran	Hon Robin Scott	Hon Alison Xamon
Hon Jim Chown	Hon Rick Mazza	Hon Tjorn Sibma	Hon Ken Baston *(Teller)*
Hon Peter Collier	Hon Michael Mischin	Hon Charles Smith	
Hon Donna Faragher	Hon Simon O'Brien	Hon Aaron Stonehouse	

Amendment thus negatived.

Progress reported and leave granted to sit again, pursuant to standing orders.