VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 26 November. The Deputy Chair of Committees (Hon Adele Farina) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 23: First assessment —

Progress was reported on the following amendment moved by Hon Nick Goiran —

Page 17, line 12 — To delete "criteria." and substitute —

criteria and take into account the medical history of the patient.

The DEPUTY CHAIR: I draw members' attention to supplementary notice paper 139, issue 11, dated Wednesday, 27 November 2019. If members do not have a copy of that, I am sure that one of the attendants will be happy to provide it to them.

Hon STEPHEN DAWSON: Last night, Hon Nick Goiran asked me whether there will be a requirement in the guidelines that the practitioner take into account the medical history of the patient. The answer is yes; it is reasonable to consider that this would be in the guidelines, and I note that this would be done in a manner consistent with section 2, "Providing good care", of the Medical Board of Australia's "Good Medical Practice: A Code of Conduct".

Hon NICK GOIRAN: Given it will be in the guidelines, there should be no problem having it in the statute.

Division

Amendment put and a division taken, the Deputy Chair (Hon Adele Farina) casting her vote with the ayes, with the following result —

Ayes (5)

Hon Adele Farina	Hon Martin Pritchard	Hon Nick Goiran *(Teller)*
Hon Simon O'Brien	Hon Charles Smith	

Noes (28)

Hon Martin Aldridge	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Aaron Stonehouse
Hon Ken Baston	Hon Colin de Grussa	Hon Rick Mazza	Hon Matthew Swinbourn
Hon Jacqui Boydell	Hon Sue Ellery	Hon Kyle McGinn	Hon Dr Sally Talbot
Hon Robin Chapple	Hon Diane Evers	Hon Michael Mischin	Hon Colin Tincknell
Hon Tim Clifford	Hon Donna Faragher	Hon Samantha Rowe	Hon Darren West
Hon Alanna Clohesy	Hon Laurie Graham	Hon Robin Scott	Hon Alison Xamon
Hon Peter Collier	Hon Colin Holt	Hon Tjorn Sibma	Hon Pierre Yang *(Teller)*

Amendment thus negatived.

Hon STEPHEN DAWSON: Honourable members will recall that last evening, in speaking against the amendment that has just been voted down, I indicated that I had an amendment standing in my name on the supplementary notice paper. At that stage, I indicated the reasons I was not supporting Hon Nick Goiran's amendment and why I was obviously supporting the amendment standing in my name. I do not propose to go over that again, but I will point out again that this amendment has been included following consultation with the Western Australian branch of the Australian Medical Association, and the government considers it to be a good amendment. I move —

Page 17, after line 12 — To insert —

(3) Nothing in this section prevents the coordinating practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 24: Coordinating practitioner to have completed approved training —

Hon NICK GOIRAN: Is the reference in clause 24 to "approved training" intended to be a reference to the training approved by the chief executive officer at clause 158?

Hon STEPHEN DAWSON: Yes, that is correct.

Hon NICK GOIRAN: Why does clause 24 not say this, given that the mandatory requirement here is subject to a discretionary power under clause 158?

Hon STEPHEN DAWSON: Under the definitions at clause 5, "approved training" is defined as meaning "training approved by the CEO under section 158".

Hon NICK GOIRAN: The Victorian training module on capacity assessment and screening for undue influence is seriously deficient. I have been advised that the Victorian training module on assessment of decision-making capacity comprises a two minute and 10 second video and a series of slides that take less than three minutes to read, while the training on voluntariness, including assessing the absence of coercion, comprises a two minute and 20 second video and a series of slides that, again, take less than three minutes to read. Given the brevity of the Victorian training, is the government committed to providing a greater level of training in Western Australia?

Hon STEPHEN DAWSON: The government is committed to providing robust training in Western Australia. Although the Victorian model may inform some of the training, the training that will be designed in Western Australia will be designed for Western Australia and our specific circumstances. I further add that we will consult with the Royal Australian College of General Practitioners and the Western Australian branch of the Australian Medical Association on the training that we provide in this state.

Hon NICK GOIRAN: Will the training for Western Australian health practitioners include training on the approved poison to be used, including risks of adverse consequences and what a health professional, layperson or, indeed, a patient should do in the event of any adverse consequences, should they occur?

Hon STEPHEN DAWSON: I am advised that all those things will be considered during the implementation phase.

Hon CHARLES SMITH: Will this training be subject to scrutiny by the Parliament?

Hon STEPHEN DAWSON: No, it will not.

Clause put and passed.

Clause 25: Referral for determination —

Hon NICK GOIRAN: Clause 25 provides for self-referral on the part of the coordinating practitioner. Can the minister explain to us what is meant by the term "unable" in subclause (1)?

Hon STEPHEN DAWSON: I am told it is the ordinary English meaning. If they are unable, they are not able—so, if it is not clear, and if further information is needed.

Hon NICK GOIRAN: Would the use of the word "unable" include the circumstance in which the practitioner has doubts about whether the patient meets the required eligibility criteria?

Hon STEPHEN DAWSON: Yes, it would.

Hon NICK GOIRAN: Would the use of the word "unable" also cover the situation in which the practitioner does not have the appropriate qualifications themselves to make the assessment?

Hon STEPHEN DAWSON: Honourable member, would you repeat that, please?

Hon NICK GOIRAN: We are talking about the use of the word "unable", and the minister has indicated that it would in his view capture the circumstance in which the practitioner has doubts about whether the patient meets the required eligibility criteria. Separate to that, would it also cover the situation in which the practitioner does not have the appropriate qualifications themselves to make that assessment?

Hon STEPHEN DAWSON: The coordinating practitioner has the qualification as per clause 16 of the bill. This would not come down to whether the coordinating practitioner has or does not have formal qualifications. It is about the practitioner's judgement as to whether they are unable to do something.

Hon NICK GOIRAN: If a practitioner does not feel that they are sufficiently skilled, qualified, experienced or trained, would that not be an example of them being unable to determine whether the patient has a particularly rare disease, and would that then be a circumstance in which a referral would be appropriate under clause 25?

Hon STEPHEN DAWSON: If they said for that reason they were unable to make the determination, that is a legitimate reason.

Hon NICK GOIRAN: At clause 25(2), the phrase "appropriate skills and training" is used. Why are these appropriate skills and training not required of the coordinating practitioner? Why is it that under clause 25(2), they are able to proceed as the coordinating practitioner notwithstanding the fact that they do not have the appropriate skills and training?

Hon STEPHEN DAWSON: As I have indicated, what the coordinating practitioner has to demonstrate is in clause 16. This could relate to a coordinating practitioner making the judgement that they are unable to make

a determination, and they can refer to somebody with appropriate skills and training for a particular medical condition. That may well be a specialist in rare neurological conditions, for example.

Hon NICK GOIRAN: If the practitioner themselves recognises that they do not have the appropriate skills and training, should they not bow out at that point and transfer the role to somebody else who does have the appropriate skills and training?

Hon STEPHEN DAWSON: The referral is for one eligibility criterion, not for the whole coordinating practitioner role. It relates to a specific element of the person's eligibility.

Hon NICK GOIRAN: Minister, I agree, albeit that it is not true to say that it relates to only one eligibility criterion, because the minister will see at clause 25(1)(a) and (b) that there are two limbs. They can refer if they are not sure whether the person has a disease that meets the requirements—in other words, are they terminal, do they have only six months to live or not; and, secondly, do they have decision-making capacity? They are two distinct and very different things. In fact, a practitioner might decide to refer to two different practitioners about that. A practitioner might not really be sure whether the person has terminal cancer, so they might send the patient to a particular specialist. With regard to decision-making capacity, they might send them to a psychiatrist for expert determination. I do not think it is quite right for the minister to suggest that there is only one circumstance in which that would apply when clause 25(1) clearly indicates that there are two things. Nevertheless, it troubles me. A coordinating practitioner might recognise, or at least have the self-awareness to realise, that they are out of their depth, yet clause 25(2) says they must refer the patient to another practitioner. I would much rather this subclause say that they must transfer the role to another practitioner who has appropriate skills. That sounds to me like a far stronger and more stringent safeguard than leaving somebody who is ill-equipped to continue to play a role. A coordinating practitioner might say that they do not want to participate anymore. I think the minister said yesterday that because of clause 9, they can pull out at any stage. Would the patient then have to make a new first request to a separate practitioner?

Hon STEPHEN DAWSON: Yes, they would.

Hon NICK GOIRAN: I want to compare and contrast the language in clause 25(2) and (3). Subclause (2) talks about the practitioner referring the patient to another practitioner, whereas subclause (3) talks about referring the patient to another person. That is a much broader category. The context of my question, particularly with regard to subclause (3), is that we are looking here at the issue of coercion. The minister may be aware that the Select Committee into Elder Abuse produced and tabled a report entitled "'I Never Thought It Would Happen to Me': When Trust Is Broken" in this fortieth Parliament. The report noted, particularly at page 15, that elder abuse is often hidden, associated with shame and underreported. At page 16, the report went on to say —

> The fact that elder abuse (mostly) occurs within a family may mean that parents or spouses are inhibited or reluctant to disclose its existence or severity.

There were several pertinent findings in that report that are relevant to clause 25(3). Finding 8 states —

> The majority of people who perpetrate elder abuse are likely to be close family members, including children, grandchildren or spouses of the older person who is experiencing abuse.

Finding 18 of the report states —

> Carer stress or carer fatigue is a risk factor for elder abuse and symptoms of carer stress can be early indicators of an increased risk of elder abuse in a relationship.

Finding 19 of the report states —

> Elder abuse that occurs as a result of carer stress can be a result of not having the necessary skills or support services to provide effective care for an older person.

Finding 20 of the report states —

> Carer stress can arise due to factors related to an older person being cared for, including the person's behaviour, mental or physical health or other circumstances.

Finding 23 of the report states —

> The community in general is not well-educated on the specific signs of elder abuse, nor of the extent of the problem in the community.

At finding 25, the report states —

> There is insufficient training for Western Australian police officers to learn to identify and respond to elder abuse effectively.

Two recommendations were made as a result of that particular finding. Recommendation 10 of the report recommends —

> Western Australia Police develop a separate training module for all police officers that specifically covers the forms, signs and risk factors of elder abuse and how to respond effectively.

Recommendation 17 of the report states —

> Specialist elder abuse units should be created within Western Australia Police.

In light of all those findings and recommendations made by the Select Committee into Elder Abuse in this fortieth Parliament, who does the minister think would be an appropriate "other person" who has appropriate skills and training to make a determination under clause 25(3) in the event that the medical practitioner is concerned about whether the patient is acting voluntarily and without coercion?

Hon STEPHEN DAWSON: This may include experienced registered health practitioners, healthcare workers including social workers, and police officers with the skills and training to determine whether a person is acting voluntarily and without coercion. They may also refer the matter to existing authorities such as WA police if they believe that the patient is being coerced to undergo voluntary assisted dying. The bill makes it a crime to unduly influence a patient in such a manner.

Hon NICK GOIRAN: Is not the coordinating practitioner, by the very definition in this bill, an experienced health practitioner?

Hon STEPHEN DAWSON: Yes, they are, but they may not be able to make the assessment.

Hon NICK GOIRAN: Clause 25(4) does not require that the determination made by the person with appropriate skills and training be adopted by the coordinating practitioner who made the referral. Why is the adoption of the determination optional? For example, can the coordinating practitioner continue to seek as many referrals as necessary until they are satisfied with the determination that has been made?

Hon STEPHEN DAWSON: That is correct, honourable member.

Hon NICK GOIRAN: Section 18(4) of the Victorian legislation requires that when a patient has a disease, illness or condition that is neurodegenerative, referral to a medical practitioner who has appropriate skills and training in that particular disease, illness or medical condition is mandatory. Section 18(5) of the Victorian legislation requires that the determination made by the specialist under section 18(4) must be adopted by the coordinating practitioner. Why is there not a similar provision at clause 25?

Hon STEPHEN DAWSON: We are just checking the Victorian act. Can the honourable member just tell us the sections he referred to again, please?

Hon NICK GOIRAN: It is section 18(4) and (5) of the Voluntary Assisted Dying Act 2017 of Victoria.

Hon STEPHEN DAWSON: The coordinating practitioner may not be satisfied with the advice, so the clause as it stands allows them the opportunity to seek a further opinion.

Hon NICK GOIRAN: On the supplementary notice paper is an amendment standing in my name at 76/25. I indicate that it is consequential on an amendment standing in my name to insert new clause 29A. For those reasons, I do not seek to move it now, but I seek to have it left on the supplementary notice paper in the event that there is a recommittal of the bill.

The DEPUTY CHAIR: That is noted.

Hon MARTIN PRITCHARD: This debate has been edifying for me. It has made me realise that the coordinating practitioner does not necessarily need to be an expert in each area, but should draw together information that, as I have previously said, is probably available to them already. Most people would avail themselves of special advice before they make their first request. The coordinating practitioner would then coordinate that. I note the amendment in the minister's name which was passed at clause 23 and which encourages that.

I have an amendment in my name at 17/25. For those reasons and also because it may, I think, be seen as derogatory to the coordinating practitioner and their expertise, it is not my intention to move it unless the minister believes that my wording at 17/25 improves the bill. Could the minister indicate whether he is in favour of that amendment?

Hon STEPHEN DAWSON: I can indicate that we are not in favour of the amendment.

Hon MARTIN PRITCHARD: It is my intention not to move 17/25.

Hon NICK GOIRAN: Members will be aware that at several points on clause 25 I have taken the time to propose amendments to expand the language so that rather than it simply being a case of whether the practitioner is able or unable to make the determination, the standard would be lifted to make it clear that they should refer in circumstances in which they have any doubt. This picks up on concerns raised by Hon Colin Holt yesterday about the need to refer if there is any doubt in the mind of the practitioner. To that extent, I draw to members' attention

the amendment standing in my name at 77/25. The amendment standing in my name at 76/25, not to be confused with 77/25, also uses that same language—whether the practitioner has any doubt whatsoever. Noting that I have asked for my amendment to remain on the supplementary notice paper until another occasion, it may well be the case that my new clause 25A will not be successful in due course, but I would not want to lose that language because I share the view of Hon Colin Holt that there should be a referral any time that the practitioner has any doubt. In light of that, I move —

> Page 17, line 20 — To insert after "determine" —
>
> or has any doubt as to

The DEPUTY CHAIR (Hon Adele Farina): I ask that the attendants collect that amendment from Hon Nick Goiran, make copies of it and distribute it to members in the chamber. A hard copy of the amendment is being distributed. I will wait until all members have had an opportunity to read that amendment.

Hon STEPHEN DAWSON: I indicate that we do not support this amendment. My advisers tell me that Hon Nick Goiran's addition does not add any value to the clause. As I have already espoused, the term "has any doubt" is subjective on the part of the medical practitioner. The term "unable to determine" is objective and more appropriate in both the legislative and operational context. From a policy perspective, "unable to determine" is appropriate because it retains an outcome focus, which is the whole purpose of assessment, and will be readily understood by medical practitioners.

Hon NICK GOIRAN: This amendment seeks to strengthen the referral policy contained in clause 25. I was particularly guided by the remarks of the Minister for Health in the other place on 4 September this year, at page 6464, when he said —

> … if the medical practitioners have any inkling that the person does not have decision-making capacity, they must refer on to a specialist who can then provide them with assistance in making that assessment … These sorts of cases, in which a GP or a medical practitioner of some form has made a call about a patient's capacity to make a decision, come before the State Administrative Tribunal regularly. It happens all the time. I am sorry if the member feels that there is too great a variation in the skills and qualities of the medical workforce. We have one of the best medical workforces in the world, but I accept that sometimes good decisions are made and sometimes bad decisions, or decisions that would otherwise be reflected on, are made. In health, they are made all the time.

In this instance, the consequence of a bad decision, to use the phrase of the Minister for Health in the other place, by a general practitioner or any medical practitioner about whether the patient has decision-making capacity in relation to voluntary assisted dying would obviously be fatal for the patient. The minister in the other place admits that decision-making capacity assessments come before the State Administrative Tribunal regularly and that this is a difficult area of medical assessment. This type of concern was raised in the debate in the other place, including by the member for Cottesloe, about errors in assessing a patient's decision-making capacity. Those remarks were made on 5 September this year. Dr Honey's concerns related to the appropriateness of assessment of decision-making capacity, particularly via audiovisual means such as telehealth, and the risk of making an error in such a crucial assessment without a face-to-face consultation. That particular concern was responded to by the member for Morley, who said, "They are dying anyway." That was said on 5 September 2019. If anyone wants to see that particular remark in its context, they can find it at page 6642 of the *Hansard*. I find that quite astonishing. I would have thought that the decision-making capacity of all patients, especially ones applying for this particular scheme, should be of concern to every member of Parliament whether or not they support this bill. That somebody may already be dying does not, in my view, reduce the need for an accurate decision-making capacity assessment.

In fact, Dr Gibson, the Chief Psychiatrist in Western Australia, gave evidence on this particular issue to the Joint Select Committee on End of Life Choices on 14 December 2017. He said that the stakes are higher in this particular instance. The correct assessment of the decision-making capacity of a person with a terminal illness who requests access to voluntary assisted dying under this bill is of the utmost importance. The entire policy of the bill is founded upon the patient's autonomy and decision-making capacity. This amendment seeks to make it clear that if a medical practitioner has "any doubt" about the patient's decision-making capacity, they should refer. Likewise, if the coordinating practitioner has any doubt about whether the patient has a disease, illness or medical condition that meets the requirements, they should refer.

As I said earlier, it was instructive to me that in the other place the Minister for Health said that a referral should occur if the medical practitioner has any inkling whatsoever that the person does not have decision-making capacity. I absolutely agree with the health minister: if there is any inkling at all in the mind of the medical practitioner, they should refer. My clause would put beyond doubt that that is when a referral should occur. The minister indicated

that my amendment will not add anything. If it does not add anything, it will do no harm. We can certainly agree that it will not undermine the operation of the bill. In my respectful submission to members, it seeks only to strengthen the specialist referral requirements at clause 25.

The CHAIR: I give the call to Hon Rick Mazza. Members, if you are seeking the call, sing out.

Hon RICK MAZZA: Thank you, Mr Chairman. I will sing out next time.

The CHAIR: Thank you. Singing, incidentally, is a turn of phrase or an expression; you just need to attract the Chair's attention by some sort of audible signal.

Hon Stephen Dawson: And orderly.

The CHAIR: And orderly, if possible.

Hon RICK MAZZA: Through the Chair, the mover of this amendment, Hon Nick Goiran, might be able to help me establish what he is trying to achieve. We are considering "unable to determine", which is what is in the bill, and "or has any doubt". To me, that means the same thing. I am struggling to establish why I would support this amendment when it does not materially change the operation of clause 25. There has been a lot of debate. I have been listening very closely to this debate about clause 25. Hon Nick Goiran has predominantly homed in on the difference between "has any doubt" as opposed to "unable to establish". From the outset, I have been on the record as not supporting the bill. Whether members support this bill or not is not the question during committee; it is about how this bill will operate at the end of the day. I am unable at this point to establish why I would support this amendment because I do not see it making any material difference to improving the operation of this particular clause.

Hon NICK GOIRAN: To the member who raises a legitimate query: the issue is that the minister says that whether the practitioner has any doubt is captured under the expression "unable to determine". Can I put it to members that "unable to determine" something can also be interpreted in a different way. If I am unable to do something, it is not necessarily the same as my having doubts about something. I interrogated the minister about a few different scenarios. If a medical practitioner says, "I don't have the skills to deal with this particular patient; this patient is beyond my level of expertise and experience; I am unable to make the decision", that is different from a medical practitioner saying, "I have the experience, qualifications and training, but you know what? I'm just not sure. I've got some doubts about whether this person qualifies or not." To me, they are two different things. I am concerned that is not definitively captured in this phrase in the bill before us at clause 25(1). If we add the amendment standing in my name, it will put beyond doubt that it is both. I referred earlier to a scenario in which the medical practitioner simply does not have the capacity; they are not sure, they do not have the experience and so forth, but this one here is if they have some doubts, we want them to refer. Members of this chamber would be saying, "If you, medical practitioner, have any doubts about the decision-making capacity of the person, we want you to refer. Sure, you might be able to make a determination, but how sure are you about this determination? Until you're sure, don't proceed. Let us take the cautious approach."

The minister said that my scenario is captured. I think Hon Rick Mazza also said that it is already captured in the expression. Both the honourable member and the minister may well be correct and a court of law may determine it in that way, but rather than leaving it at that, I think it is safer that we put in the clear words that we intend at this time.

Amendment put and negatived.

Hon CHARLES SMITH: Winding back to clause 25(1)(a), does that include referral to a mental health expert for mental health issues?

Hon STEPHEN DAWSON: Yes, it could.

Hon CHARLES SMITH: Is there any particular reason it is not mentioned specifically in paragraph (a)?

Hon STEPHEN DAWSON: There could be a variety of persons to whom the reference could be made, so we did not pick on one.

Hon NICK GOIRAN: I would like to move the amendment standing in my name at 63/25. I move —

> Page 17, line 24 — To delete "section 15(1)(d)." and substitute —
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> section 15(1)(d), for example due to the patient's past or current mental illness.

This amendment seeks to bring clause 25 up to the standard of section 18 of the Victorian legislation. Section 18(1) of the Victorian legislation states —

> If the co-ordinating medical practitioner is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to

a past or current mental illness of the person, the co-ordinating medical practitioner must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.

This amendment complements a further amendment standing in my name at 64/25, which seeks to insert —

matter, such as a psychiatrist if the matter to be determined involves mental illness.

The current amendment, together with the amendment at 64/25, would bring clause 25 up to the Victorian standard found in section 18(1) of that legislation. The amendment makes explicit reference to a patient's past or current mental illness in clause 25(1)(b), making it clear that the coordinating practitioner should turn their mind to the fact that a patient's past or current mental illness might have an impact on that person's decision-making capacity in relation to voluntary assisted dying. If the coordinating practitioner is aware that the patient has a mental illness, or is aware from the patient's medical history that they had previously had a mental illness, that would likely be a circumstance in which it would be proper for that practitioner, who is likely to be a general practitioner, to refer to a psychiatrist for further assessment of the impact of that mental illness on the decision-making capacity of the patient to request voluntary assisted dying. I suggest that there is nothing controversial about this amendment. It does not change the function of clause 25; it simply makes it clearer for coordinating practitioners when a referral under clause 25 might be considered necessary.

We can take some lessons from the experience in some of the international jurisdictions at this point. In Oregon, research commissioned by Linda Ganzini found that, among terminally ill Oregonians who participated in the study and received a prescription for a lethal drug, one in six had clinical depression. The prevalence of depression and anxiety in patients requesting physicians' aid in dying was considered by this study. It is appropriate for the chamber to note that Oregon allows for a similar optional referral for psychiatric assessment as we have in the bill before us. Interestingly, as recently as 2016, fewer than one in 25—that is, 3.75 per cent—people who died by self-administering a lethal drug under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation. That information can be found in the Oregon Public Health Division's own data summary. We have the lesson from Oregon, where one in six patients had clinical depression, but only one in 25 were referred for psychiatric evaluation. If we compare and contrast the experience in Oregon with that in Washington, examination of data from that state's own health department—the Death with Dignity Act annual report as recently as 2019—reveals that in 2018, only 10 of 251 patients were referred for psychiatric and psychological evaluation. In 2017, the number of patients referred was so low in Washington that the figure was redacted.

I dare say that, given that that is the experience in Oregon and in Washington, we can expect a similar low rate of referral for psychiatric assessment in Western Australia, should we legalise the regime set out in the bill. The amendment before us seeks at least to mitigate against those low referral rates by asking practitioners to turn their minds to the presence of current or historical mental illness, and the impact of this upon the patient's decision-making capacity. For those reasons, I seek the support of members for the amendment.

The CHAIR: Members, Hon Nick Goiran has moved his amendment, which is shown as number 63/25 on the supplementary notice paper. I gather, though, from his remarks that this is closely related to proposed amendment 64/25, which, although not formally moved, I think he has been debating cognately.

Hon NICK GOIRAN: Mr Chair, just to clarify that for members, the two amendments complement each other, but they are standalone amendments, and so one can survive without the other.

The CHAIR: Very well. In that case, we are focusing on the amendment formally moved, but if members and the minister feel the need to canvass the other matter as a related one to deal with it more expeditiously, they may do so.

Hon STEPHEN DAWSON: Thank you for that advice, Mr Chair. I am not supportive of the amendment that we are dealing with at the moment; nor am I supportive of the next amendment that stands in the name of Hon Nick Goiran. I am not supportive for the same reasons, so I will indicate now my opposition, and I will give the reasons now, but I will not do it again when we get to the next amendment. The addition of an example is not required. There may be a number of reasons for which a medical practitioner may be unable to make a determination on a patient's decision-making capacity in relation to voluntary assisted dying. Practitioners are already aware that a variety of matters may impact decision-making capacity, such as the impact of certain medications, mental illness, the impact of certain diseases, acquired brain injuries and intellectual impairment. The specific inclusion of the past or current mental illness may create the unwanted effect of limiting the application of the clause. Furthermore, the proposed amendment could imply that persons with a mental illness may not have decision-making capacity. A wide range of conditions and states of being amount to mental illness, and to apply a broad brush, stating that those with mental illness do not have decision-making capacity, is quite a prejudiced view. The Royal Australian and New Zealand

College of Psychiatrists has noted that the capacity test is not diagnosis-specific, but rather focuses on a person's ability to make the decision at hand in the situation.

Hon NICK GOIRAN: The minister indicated that the inclusion of an example is not required. Is an example included in the Victorian legislation?

Hon STEPHEN DAWSON: The answer is yes, but obviously that is a different bill from our own.

Amendment put and negatived.

Hon NICK GOIRAN: I move —

> Page 17, line 27 — To delete "matter." and substitute —
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> matter, such as a psychiatrist if the matter to be determined involves mental illness.

Similar to, but separate from, the previous amendment just considered, this amendment would lift our legislation to the level of the Victorian statute, specifically section 18(1). The amendment seeks to insert the phrase "such as a psychiatrist if the matter to be determined involves mental illness", and I make explicit reference to psychiatrists, making it clear, as the Victorians do, that referral should be made to a psychiatrist to assess the patient's decision-making capacity when the patient has a mental illness or a history of mental illness that may impact upon their decision-making capacity on voluntary assisted dying.

The efficacy in explicit reference to a psychiatrist in clause 25 is perhaps best understood by this evidence given by Western Australia's Chief Psychiatrist to the Joint Select Committee on End of Life Choices on 14 December 2017 when he said —

> The question is: are GPs good at doing capacity? That is one question. The answer is that it is extremely variable. The nature of GP practice is that they often do not have the appropriate time to do this, and they will acknowledge that. They are the people seeing people in nursing homes. They are seeing lots of individuals who are incapacitous or may have capacity or not. So, they are seeing lots of it but they are not always thinking in that paradigm; they are thinking in more broad, holistic paradigms. In the situation where a GP is treating mental illness, assisting with the palliative care and making potential capacity assessments that are not leading to the potential death of the person, that may be reasonable. But the stakes go up when you are saying that someone is going to die.

I think the position of Dr Gibson, Western Australia's Chief Psychiatrist, in the committee hearing was that general practitioners should not be making decision-making capacity assessments for voluntary assisted dying. I think his words remain relevant to this amendment and I seek support for it from members.

Hon AARON STONEHOUSE: I support the amendment put forward by Hon Nick Goiran. From what I can see, it at least makes clearer the obligation on medical practitioners to refer when mental illness may be present. From reading clause 25, without it, there is certainly reference to an obligation on coordinating practitioners to refer. It does not spell out clearly in simple language an obligation for a referral when mental health is in question. In that case, it makes it eminently clear to practitioners and to the public the obligations for referral. For that reason, I support the amendment. It does not seem to interfere in any way in the operation of this scheme or make it any more onerous, but merely clarifies something that should be done anyway; therefore, I support it.

Hon ALISON XAMON: I have a question about how it would be interpreted. Clause 25(2) states that the coordinating practitioner "must" refer the patient, so can I confirm whether the effect of the amendment would be that there is not a requirement to refer someone to a psychiatrist if they have a mental illness or a history of mental illness? Is it still intended to be a discretionary option?

Hon STEPHEN DAWSON: My advice is that it would be mandatory. It would be a requirement.

Hon ALISON XAMON: In that case, I am very concerned about the amendment in front of us. I would like to remind members that it is estimated that throughout the course of their life, 50 per cent of people will experience some sort of mental illness and that at any given point, 20 to 25 per cent of us are experiencing a form of mental illness. Depression and anxiety can often be the most common. However, that by no means suggests that people have impaired capacity or, indeed, that they have a desire to die. It is not necessarily the case that suicidal ideation follows from people who live with depression and anxiety, although certainly it can be very serious. I also want to point out that for the majority of people who live with or experience mental illness during their lifetime, most never see a psychiatrist. Other health practitioners may assist them or they may have other tools to assist them with their mental health issues.

I am really concerned about anything that requires someone who has a history of mental health issues to see a particular type of mental health professional—to prescribe that—when it may be well beyond the regime of how they deal with their mental health issues. I think it is too prescriptive. It is one thing to have an amendment that,

basically, encourages people when they have doubt to look at referring to an appropriate practitioner. However, I do not believe it is appropriate to refer someone to a psychiatrist specifically, considering that half of us at any given point would be subject to a mandatory referral to a mental health practitioner who may not be appropriate.

Hon NICK GOIRAN: The minister has just given advice to Hon Alison Xamon that this would be a mandatory requirement. Can he point to us the language in either the amendment or the clause that makes it mandatory?

Hon STEPHEN DAWSON: My advice is that because 25(2) states "must refer the patient", the amendment would then mean that it must be done—the patient must be referred to a psychiatrist. I have indicated, Mr Chair, on the last amendment that we would not support this amendment, and I have given the reasons for it. We had an extensive debate on this general issue at clause 6 when we addressed the issue of a psychiatrist not being the only person to determine decision-making capacity. At that stage, on 20 November, I tabled some correspondence from the Chief Psychiatrist, Dr Nathan Gibson, that showed a different view from the Chief Psychiatrist from the one Hon Nick Goiran read out from December 2017. I will say again that to suggest that only psychiatrists can assess decision-making capacity mischaracterises the role of psychiatrists. A psychiatrist treats mental illness; they are not general experts on decision-making capacity.

Hon NICK GOIRAN: I am not touching clause 25(2). The minister has said that clause 25(2) uses mandatory language. My amendment does not go to 25(2); it is for clause 25(1). I ask again: where is the language in clause 25(1) or in my amendment that justifies him telling Hon Alison Xamon that my amendment makes it mandatory. I draw to his attention that clause 25(1) is discretionary because it is premised on the practitioner being unable to determine something. There is nothing mandatory in clause 25(1) and nothing mandatory in my amendment. It was wrong for him to suggest otherwise to Hon Alison Xamon and I ask him to correct the record.

Hon STEPHEN DAWSON: To confirm, we are dealing with amendment 64/25, the amendment before the chamber at the moment. That refers to line 27. Clause 25(2) states that "the coordinating practitioner must refer" and the amendment would take effect at the end of that sentence.

Hon NICK GOIRAN: The minister is quite correct. I was out of order, and I apologise for that.

Hon AARON STONEHOUSE: In relation to what is mandatory in this proposed amendment, it is worth bearing in mind that it is triggered only if clause 25(1)(b) comes into play in this instance. It is not saying that anyone suffering from mental illness must be referred to a psychiatrist. Amended clause 25(2) would read —

> The coordinating practitioner must refer the patient to a registered health practitioner who has appropriate skills and training to make a determination in relation to the matter, such as a psychiatrist if the matter to be determined involves mental illness.

What is the matter to be determined? The matter to be determined is whether the patient has decision-making capacity in relation to voluntary assisted dying as required by clause 15(1)(d). There is a mandate there for referral, but it comes into play only if the coordinating practitioner is unsure of the patient's decision-making capacity and if the matter to be determined involves mental illness. I think in those instances it is appropriate. I believe that because of the letter that was sent by Dr Nathan Gibson, the Chief Psychiatrist of WA, to Malcolm McCusker, and tabled in this place. He stated —

> - Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

I think in this very specific circumstance, in which capacity cannot be determined and there is the intersection of mental illness, it is appropriate to require medical practitioners to refer to a psychiatrist. That is why I support this amendment.

Hon ALISON XAMON: I am still trying to get to the bottom of this. The one thing I think everyone in this chamber will possibly agree with is the idea that if a coordinating practitioner is not confident that the person making the request is competent, they will need to refer them on. Likewise, I suspect everyone would agree that if the coordinating practitioner is not confident that the request is not coming as a substantive result of someone's mental illness, as opposed to the physical illness that is killing them, we would want the practitioner to refer them on to ensure that the person's motivations for wanting to avail themselves of voluntary assisted dying are not substantially due to mental illness. I suspect we agree on that. However, I do not see how the way the bill is currently written precludes referrals in those instances—that if a coordinating practitioner is concerned about someone's capacity and that their wish to die is substantively because of their mental illness and not their physical illness, referral can be pursued. That is the whole point of clause 25(2). Again, I am concerned about including in the bill something quite prescriptive about the appropriate practitioner for referral in particular instances. For example, if I have a longstanding relationship with a clinical psychologist whom I have been seeing since I was 11 years old, perhaps they would be best able to make an assessment as to whether my motivation for dying is substantively because of my mental illness

or that I am actually mentally okay, as opposed to some psychiatrist whom I have never seen before in my life, with whom I have no relationship and who knows nothing about my history. I am concerned about prescribing a clinical relationship to that degree within the legislation. But as I say, as I read the bill, if there is a genuine concern, that referral can—in fact, must—occur anyway. I would like to know whether I have misunderstood that.

Hon STEPHEN DAWSON: The honourable member is correct, and was reading it correctly.

Amendment put and negatived.

Hon MARTIN PRITCHARD: I do not propose to move the amendment standing in my name at 18/25.

The CHAIR: We have contemplated a matter dealt with in proposed amendment 77/25 and dispensed with it.

Hon NICK GOIRAN: There is an amendment standing in my name at 77/25 on which we have had a preliminary discussion. It all revolves around the use of the word "unable" and whether that includes the phrase "has any doubt as to". The minister indicated that it did and Hon Rick Mazza earlier indicated that he could not see a need to include it because he shared the minister's view that it incorporated the two. I know there will be an 18-month implementation phase, but will the guidelines that are being developed for provision to medical practitioners ensure that they understand that "unable" includes whether they have any doubts?

Hon STEPHEN DAWSON: I am told yes, they will.

Hon NICK GOIRAN: In light of the view of the chamber on the earlier amendment and the fact that the minister has indicated that the guidelines will include that, I see no need to move amendment 77/25.

Hon MARTIN PRITCHARD: I move —

Page 18, line 5 — To delete "may adopt" and substitute —

must take into account

There has been quite a bit of discussion on this matter already, and I have received a number of briefings on it. As I understand it, the reason it reads "may adopt" is to allow the medical practitioner the right, as he should have, to receive one bit of advice from a specialist, maybe not accept it, and then seek further advice from another specialist—or, indeed, two, three, four or five specialists, if he so wishes. Is that correct?

Hon STEPHEN DAWSON: The honourable member is correct.

Hon MARTIN PRITCHARD: I think they have every right to do that, but my concern is about situations in which a medical practitioner accepts that they are unable to make a determination and seeks advice from a specialist. Given that they have the opportunity to get advice from multiple sources, it would seem to me unreasonable for coordinating practitioners to not at least take into account all the advice they receive. My amendment does not seek to limit the advice that coordinating practitioners get, but to ensure that they take into account all the advice they receive. I have an amendment further on in the bill that would provide for all that information to be passed on to the board, so that the board has some oversight of the advice that is received. It does not, in my view, negate the coordinating practitioner's opportunity to seek advice from multiple sources, as is currently the case under clause 25; it mandates that they take all that advice into account. I seek the minister's support for my amendment.

Hon STEPHEN DAWSON: I indicate that the government does not support this amendment. The clause, as currently drafted, provides that the coordinating and consulting practitioners may adopt the determination obtained from the referral. To state that the practitioner "must" take it into account, as this amendment provides, reflects the same meaning as the current wording because the practitioner, when deciding whether to adopt the determination obtained from the referral, would have to consider the referral report before them.

Hon MARTIN PRITCHARD: Could that also then, for example, open the possibility, however remote it might be, that the coordinating practitioner may admit that they are unable to make a determination and seek advice from a specialist? The specialist might suggest that they are not eligible to advise, for whatever reason, and on that basis the coordinating practitioner could continue, because they would not have to take the advice that they sought from the specialist; is that right?

Hon STEPHEN DAWSON: Yes, that is correct.

Hon ADELE FARINA: I would like to draw the minister's attention to section 18 of the Victorian legislation, which actually uses the word "must". It states —

> (6) If the co-ordinating medical practitioner refers the person to a specialist registered medical practitioner under subsection (4), the co-ordinating medical practitioner must adopt the determination of the specialist registered medical practitioner in respect of the matter in relation to which the person was referred.

I would like to come to some understanding about why we are taking a different approach. I would have thought that if a coordinating practitioner formed the view that they do not have the skills or the knowledge or are unable to

form a decision, they would refer the case to a specialist, and if the specialist came back with a decision, they would simply adopt that decision, because, after all, the practitioner referred the matter to that particular specialist—they could have chosen whichever specialist they wanted—seeking that specialist advice, so why would they then not adopt the advice from that specialist? In addition to that, if the practitioner did not adopt the advice of that specialist, could they be legally liable if, at some future time, there was some question about the decision that they had made?

Hon STEPHEN DAWSON: Could the member please ask the second question again, about the liability?

Hon ADELE FARINA: I just think that if the coordinating practitioner refers the case to a specialist, the specialist comes back with his or her opinion, and the practitioner then chooses to ignore his or her opinion and forms a different decision, they are potentially exposing themselves to liability should that become known down the track. It just seems to me that the Victorian legislation makes it very simple. They refer it to the specialist of their choice. Once they get that advice, they adopt that advice. That seems to me the simplest way of dealing with this issue, rather than continuing to go to specialist shopping.

Hon STEPHEN DAWSON: Again, it is not about specialist shopping or, indeed, doctor shopping. What "must adopt" would do is that even if the opinion is —

Point of Order

Hon MARTIN PRITCHARD: Chair, the amendment does not say "must adopt". We are talking about my amendment, which is "must take into account".

The CHAIR: There is no point of order, but I am sure the minister appreciates the interjection.

Committee Resumed

Hon STEPHEN DAWSON: I was actually responding to the question of Hon Adele Farina, when she referred to the Victorian legislation. As I have answered Hon Martin Pritchard's questions on various topics, I propose to answer Hon Adele Farina's question on this topic now.

What I was saying is that if it were to read "must adopt', that would indicate that even if the opinion was patently an error, the practitioner must adopt it; it does not give them the option of seeking a further opinion. I will make the point, too, that doctors refers to specialists all the time. They then receive reports back from specialists, and they make their assessment based upon consideration of the referral report. The coordinating practitioner needs to be given the option to decide whether to accept the opinion. To go with a different decision is not ignoring the referral report. The coordinating practitioner will consider the report and form their own view based on the information in front of them.

Hon RICK MAZZA: The amendment moved by Hon Martin Pritchard is very sensible. Rather than say that the practitioner "must adopt" the report, he says they "must take into account" the report. There might be some aspects of that report or determination that the coordinating practitioner does not want to consider. It is not a matter of adopting it. I think "must take into account" is a very sensible and practical amendment.

The DEPUTY CHAIR: Members, the question is that the words to be deleted be deleted. All those of that opinion say aye, to the contrary no. I think the ayes have it.

Hon Martin Pritchard: Divide.

The DEPUTY CHAIR: Division called. Ring the bells.

Point of Order

Hon SIMON O'BRIEN: I think the prerogative to call for a division rests with the member whose view has not prevailed, but, if the ayes have it, the honourable member should be well satisfied with that and not call for a division.

The DEPUTY CHAIR (Hon Martin Aldridge): Members, the point of order from Hon Simon O'Brien went to the calling of a division. I draw members' attention to standing order 78, which states —

> (1) After the President has declared an opinion on the resolution of a question (Standing Order 77), a Member may challenge that opinion by calling for a division immediately.
>
> (2) A Member who calls for a division shall not leave the Council, and shall vote with those Members who, in the opinion of the President, were in the minority.
>
> (3) If the President determines that an absolute majority is required, the President shall advise the Council accordingly and conduct a division.

There is not a point of order, because any member can call a division, regardless of the call of the Chair. However, the member calling a division would be obliged to vote with the minority. The Chair called the question with the

ayes. I said that the ayes have it, and then a division was called, and I gave the instruction to ring the bells, at which time the point of order was made.

I also draw members' attention to standing order 80, "Division May Be Cancelled", which states —

> At any time before the Tellers are appointed, a call for a division may be withdrawn by leave of the Council, and the division shall not be proceeded with. The decision of the President which was challenged shall then stand.

Committee Resumed

Hon MARTIN PRITCHARD: Mr Deputy Chair, may I seek leave of the chamber to withdraw my call for a division?

The DEPUTY CHAIR: Hon Martin Pritchard has sought leave. Is leave granted?

Several members interjected.

Hon STEPHEN DAWSON: Mr Deputy Chair, I seek some clarification. If the chamber were to give Hon Martin Pritchard leave to withdraw his call for a division, would it still be open to me or another member of the chamber to call for a division at that stage; or, if leave was given to withdraw, would we then move on from that issue totally?

The DEPUTY CHAIR: Members, might I suggest to the chamber that the easiest way to resolve this matter is for the chamber to reconsider giving leave to withdraw the division, at which point I will put the question again, and we can then resolve the matter with certainty. If there is no dissenting voice, that will be the course of action that I will take. The question is that Hon Martin Pritchard seeks leave to withdraw his call for a division. Is leave granted?

Leave granted.

The DEPUTY CHAIR: The question is that the words to be deleted be deleted.

Division

Amendment put and a division taken, the Deputy Chair (Hon Martin Aldridge) casting his vote with the ayes, with the following result —

Ayes (12)

Hon Martin Aldridge	Hon Nick Goiran	Hon Charles Smith	Hon Colin Tincknell
Hon Donna Faragher	Hon Rick Mazza	Hon Aaron Stonehouse	Hon Alison Xamon
Hon Adele Farina	Hon Simon O'Brien	Hon Dr Steve Thomas	Hon Martin Pritchard *(Teller)*

Noes (23)

Hon Ken Baston	Hon Peter Collier	Hon Colin Holt	Hon Tjorn Sibma
Hon Jacqui Boydell	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Matthew Swinbourn
Hon Robin Chapple	Hon Colin de Grussa	Hon Kyle McGinn	Hon Dr Sally Talbot
Hon Jim Chown	Hon Sue Ellery	Hon Michael Mischin	Hon Darren West
Hon Tim Clifford	Hon Diane Evers	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*
Hon Alanna Clohesy	Hon Laurie Graham	Hon Robin Scott	

Amendment thus negatived.

Hon NICK GOIRAN: I move —

> Page 18, after line 8 — To insert —
>
> (5) A registered health practitioner or other person to whom the patient is referred under subsection (2) or (3) must not be —
>
> (a) a family member of the patient; or
>
> (b) a person who knows or believes that they
>
> (i) are a beneficiary under a will of the patient; or
>
> (ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services in connection with the referral.

This amendment really flows on from the discussion we had yesterday. Members will recall that we had quite a detailed debate as to whether a consulting or coordinating practitioner should be able to be a beneficiary under a will—that is, whether they should be able to profit from the death of the patient—or be a family member of the patient. We had quite an extensive discussion about that. I moved an amendment. Hon Adele Farina moved an

amendment to my amendment. In the end, that was defeated and some wording was provided by the government. Members may recall that we had an extra recess yesterday to enable the government to provide its preferred wording, and members facilitated that. I have used the government's preferred language in my amendment 466/25. The purpose of this amendment is to support the argument that a practitioner obviously should not be able to refer to another practitioner who can benefit under the will or is a family member of the patient. Obviously, if we are going to put these protections in the bill for interpreters, as per clause 160, and coordinating and consulting practitioners, as per clause 16, then plainly we should do the same with regard to medical practitioners or persons who will be referred to under clause 25. I seek the support of all members.

Hon STEPHEN DAWSON: I indicate that the government is not going to support this amendment. The coordinating practitioner will make the referral to a registered health practitioner. It would be unreasonable to expect the coordinating practitioner to screen those referrals. Furthermore, I am advised that this requirement might create operational problems, so we are not supporting it.

Hon ALISON XAMON: What sorts of operational problems would arise from this? It strikes me that this amendment simply enshrines current requirements in many regards, certainly in terms of being a family member of the patient. Secondly, we have already agreed that we do not want people who are involved in this process to potentially be able to benefit financially from a patient's death. I am a little concerned as to why this provision would not be supported.

The DEPUTY CHAIR: The question is that the words to be inserted be inserted.

Hon ALISON XAMON: I asked a question.

Hon Stephen Dawson: And I intend to answer; I am seeking advice.

Hon SIMON O'BRIEN: While the minister is receiving advice, like a lot of members in this place I want to see some progress made on this bill, so I will seek to offer the following right now. Members, if we look back to yesterday's uncorrected *Hansard*, we can see in our contemplation of clause 16 that we held an almost identical debate and, if we are to be consistent, it was resolved in a way that I believe would have us all vote for the amendment that is before the Chair. I say that not to be argumentative, not one bit. In fact, I would like to see the chamber adopt this amendment now unanimously. I think there is merit in it, and indeed the chamber saw merit in the same argument when we contemplated clause 16 yesterday. Clause 16 related to, colloquially, other medical practitioners in the chain, but at an early stage. I refer to yesterday's uncorrected *Hansard* at page 15. I have lost track of which of the 11 previous supplementary notice papers I had this written down on, but it is in our uncorrected *Hansard*—God bless Hansard! At page 15, we see words that appear to me to be identical, intended in the same spirit and as the same sort of safeguard.

I have been making these remarks as the minister is receiving advice, because it needs to be placed on the record, but I do not want to unnecessarily extend our time dealing with this bill. I think I have faithfully encapsulated the gist of an argument, which gives a compelling case in support of the amendment that is before us now as moved by Hon Nick Goiran. With all that in mind, I hope that the minister will see that there is great merit in adopting it for these reasons. Firstly, it is a highly desirable safeguard and one which by its own construction will shoot down some elements of opposition to this bill. It will not shoot them all down, including mine. It would certainly deal with this matter decisively. Of course the medical practitioner involved in a referral should not be a beneficiary in the will of the intended deceased. That is self-evident. It was self-evident when we contemplated clause 16 less than 24 hours ago, and it is thoroughly the case now. The next reason is that it is important to the integrity of the proposed act. A very wise Chairman of Committees once said not long ago that there is no law in the Constitution or the standing orders or anywhere else that says that anything that comes out of this place needs to make sense.

Hon Donna Faragher interjected.

Hon SIMON O'BRIEN: He was a very sage person. Perhaps it will come to Hon Donna Faragher shortly. The horrible thing is that person, who borrowed the phrase from a previous Chairman of Committees—Hon George Cash, back in the day—is absolutely right. However, there is a rider to that. For all members from all eras in the life of this chamber, we also subscribe to the view, which is also not written down, that it is highly desirable that things do come out of here making sense. In many cases, they make a hell of a lot more sense and are far better ordered than the condition in which we perhaps received them from the other place. That is something we also like to underscore and wear as a badge of pride. Warming to the theme that what comes out of this house of review should be legislation that is in good nick, it should also appear to be in good nick. It should have loose ends tied up, it should have frayed ends detected for attending to, and all the rest of it.

It would create a gaping hole if, after having adopted the amendments to make clause 16 what it is now, we failed to amend clause 25 in a near identical and sympathetic fashion. Having been confronted with all that argument and having had that pointed out—I thank Hon Nick Goiran, the mover of this amendment—it would be remiss of all

of us if we were not to recognise that, when it is presented in front of us in the terms that I have just outlined, we failed to take the action that we took previously. Those are the two broad reasons that support for this amendment has a compelling basis. I do not intend to continue my remarks any longer, but I know that the minister has been carefully considering what I have had to say just now as he receives advice. Whatever the government decides to persevere with, this is a conscience vote, so members on all sides might like to bear in mind what I have just said.

Hon STEPHEN DAWSON: Back to the question asked by Hon Alison Xamon, I am advised that the operational issue is that it places unreasonable onus on the coordinating practitioner to check these matters before referring. In saying that, I have had the time to consult and I indicate that we will support the amendment that stands in Hon Nick Goiran's name.

Amendment put and passed.

Clause, as amended, put and passed.

New clause 25A —

Hon CHARLES SMITH: I move —

> Page 18, after line 8 — To insert —
>
> **25A. Referral to psychiatrist**
>
> (1) The coordinating practitioner must refer the patient to a psychiatrist for a psychiatric assessment to determine whether the patient is suffering from treatable clinical depression or another psychiatric condition that may affect the patient's decision-making capacity in relation to voluntary assisted dying.
>
> (2) In determining whether the patient meets the requirements of section 15(1)(d), the coordinating practitioner must take the psychiatric assessment required by subsection (1) into account.

We have heard today that psychiatrists are not required, in the VAD process, to determine whether the patient is eligible to access voluntary assisted dying. We also heard from Hon Aaron Stonehouse today that the Chief Psychiatrist in Western Australia, Dr Nathan Gibson, in his email to Mr Malcolm McCusker stated that "psychiatrists are by far best placed to assess". In light of that, members, new clause 25A will amend the bill to require a patient to be assessed by a psychiatrist as part of the assessments required in order to determine whether the patient is eligible to access VAD. The purpose of the psychiatric assessment is to ensure the patient is not suffering from any treatable clinical depression or other psychiatric condition that may, in turn, affect their decision-making capacity in relation to VAD.

I have quoted that email correspondence from the Chief Psychiatrist of WA. I will quote some more by way of further explanation. The Chief Psychiatrist said the following to the Joint Select Committee on End of Life Choices —

> … if you look at the Mental Health Act, it requires a psychiatrist to determine capacity to make someone involuntary under the Mental Health Act. My feeling would be why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

Further, he said —

> The issue is around when someone actually wishes to accelerate and end their life actively. Then, I think, there is an ethical and professional requirement to really make sure that we exclude mental illness in that situation.

It is a very simple additional safeguard to ensure that a safe decision is made on the patient's journey through VAD.

Hon STEPHEN DAWSON: Hon Charles Smith started to quote correspondence from Dr Nathan Gibson, but let me place on the record exactly what Dr Gibson said. He said —

> - Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

I think it is important to put that whole comment on the record.

I indicate that the government is not supportive of this amendment. To require all patients who wish to participate in voluntary assisted dying to first see a psychiatrist is contrary to the voluntary nature of participating in the process and may be seen as quite offensive to some patients. Hon Charles Smith's proposal fundamentally breaches the legal principle that an adult is presumed to have decision-making capacity. In addition, it does not reflect the policy of the bill and would significantly impede access.

Under the bill, decision-making capacity must be independently assessed by two experienced medical practitioners. If they are unable to make a determination, they are obliged to refer the patient to a health practitioner with appropriate competency to make the assessment. The appropriate health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate; if the concern is decline due to ageing, a geriatrician may be preferable; or maybe a neuropsychologist in the case of an acquired brain injury. The ability to refer the patient to a health practitioner with appropriate skills and training is consistent with the legislative framework of the Joint Select Committee on End of Life Choices. To suggest that only a psychiatrist can assess decision-making capacity mischaracterises the role of psychiatrists. A psychiatrist treats mental illness; they are not general experts on decision-making capacity.

During consultation with registered health practitioners, it was made clear that it would not be appropriate nor necessary for every patient who requested voluntary assisted dying to undergo a psychiatric assessment. The Royal Australian and New Zealand College of Psychiatrists made clear that although the practitioner assessing capacity needs relevant expertise, they do not need to be a specialist and that capacity assessment is not solely in the domain of psychiatrists. Psychiatrists are rarely the most appropriate clinicians to undertake capacity assessments. For those reasons, I indicate we are not supportive of the amendment.

Hon NICK GOIRAN: I also have an amendment standing in my name that seeks to do a similar thing to Hon Charles Smith's amendment that is before us; that is, to mandate a psychiatric referral. The comments that I am about to make are supportive of the amendment moved by the honourable member. I indicate that I will be supporting it, albeit that the model I have proposed in the amendment standing in my name at 78/NC25A is different. It is different to this extent: Hon Charles Smith's amendment is a general referral whereas mine is more prescriptive and is based upon the provisions in the Mental Health Act. I will speak to that, if we get to that amendment.

I am supportive of the thrust of the amendment moved by Hon Charles Smith, which is to mandate psychiatric referral. To me, it strengthens the gatekeeper role that the coordinating practitioner has to make, particularly when we know there have been a number of issues across the various jurisdictions in respect of this issue. But apart from the lived experience in those jurisdictions, I am guided by some of the evidence that was taken by the Joint Select Committee on End of Life Choices. I was the only member of the committee who attended every meeting and every hearing during that yearlong inquiry. I draw to members' attention submission 391, which was given by the Western Australian branch of the Royal Australian and New Zealand College of Psychiatrists. It stated in evidence to the committee —

> In situations where a patient has a terminal condition causing suffering, there is a risk that symptoms of mental ill health may be mistaken by a doctor not trained in psychiatry for an 'understandable' reaction to their condition.
>
> Furthermore, treatment for mental health issues can help to relieve the experience of physical pain, due to the interaction of biological and psychological systems …

That was from the submission provided by the Royal Australian and New Zealand College of Psychiatrists to the Joint Select Committee on End of Life Choices during its one-year inquiry.

In addition, Dr Lisa Miller noted in her evidence to the Joint Select Committee on End of Life Choices that she runs the only specifically funded cancer liaison psychiatry clinic in Western Australia and has a month-long waitlist.

St John of God Health Care also noted in its evidence to the committee that rapid access to psychological and psychiatric services is limited outside the context of inpatient specialist palliative care. It noted that in the absence of adequately addressing psychological distress, requests for assisted dying may be more likely. I refer members to the information provided by St John of God Health Care to the joint select committee in response to questions taken on notice.

In addition, a similar warning was issued to the parliamentary inquiry by the Western Australian branch of the Royal Australian and New Zealand College of Psychiatrists. In its submission, submission 391, it states at pages 4 and 5 —

> Adequate support for consultation–liaison services is essential in ensuring people with chronic and terminal illnesses are able to alleviate or manage psychological suffering. It is arguable that patients are currently able to fully exercise choice regarding end of life care where such services are unavailable or poorly understood.

Despite all of this evidence, from the best experts, given to the Joint Select Committee on End of Life Choices, obviously there has been a continuing push to legislate the scheme that is before us. The amendment that I moved to clause 4, "Principles", to include a reference to consultation–liaison psychiatry and psycho-oncology, failed. Apparently, relieving patient suffering through the provision of consultation–liaison psychiatric services and

psycho-oncology services is not a priority. Instead, the priority is to relieve patient suffering by allowing doctors to terminate the lives of their patients through the administration of a voluntary assisted dying substance. Since this is apparently the priority, it is appropriate that we have mandatory psychiatric assessment before a patient is assessed as eligible to access voluntary assisted dying under this bill. I note that the submission made by the Western Australian Chief Psychiatrist to the Joint Select Committee on End of Life Choices, submission 655, stated —

> While individuals with mental illness must be afforded the same rights as other individuals within society, they are implicitly vulnerable in the potential context of seeking end of life because of issues of stigma, the inherent nature of mental illness (the complexity of determining remediable drivers and the influences on these), and the complexity of determining capacity.
>
> In addition, the Royal Australian and New Zealand College of Psychiatrists gave this evidence during the yearlong inquiry —People suffering from mental disorders may manifest significant fluctuations in their cognitive function over short periods of time and may also vary in decision-making capacity depending on the matter being addressed …
>
> For a person with co-existing physical and mental illnesses, ensuring adequate decision-making capacity in the context of PAS may therefore pose significant challenges.

That was submission 391 to the yearlong inquiry. It appears that the issue of comorbidity as a complicating factor in the assessment of capacity has been raised on multiple occasions during the yearlong inquiry, but it is also well documented in the research papers in this area. I draw to the attention of members a paper written by Dr C.J. Ryan, a consultation–liaison psychiatrist from the department of psychiatry at Westmead, that appeared in a peer-reviewed journal and states —

> Sadness and despair are normal responses to the news that one is gravely ill. However, as many as one in five seriously ill people go beyond this normal response to develop major depression … Major depression is far more than a disorder of emotion; its effects on reason and the intellect may be just as profound.

At page 411 of the article in the *Medical Journal of Australia*, he goes on to state —

> Unfortunately, the diagnosis of major depression in the gravely ill is very difficult. Low spirits are to be expected in serious illness, and many of the other features of major depression (such as weight loss and sleep disturbance) are also common in physical illnesses. The difficulty of diagnosis is reflected in studies that reveal that non–psychiatrically trained doctors miss up to half of cases of major depression in the medically ill.

Another witness who gave evidence during the yearlong inquiry was Dr Best, a palliative care physician and academic. She noted that the incidence of depression is high in terminally ill patients, and up to 80 per cent of depressed patients with cancer are not diagnosed or treated. I encourage members interested in that transcript to look at that session on 1 May 2018. We also heard during the yearlong inquiry from Dr Khorshid, who was at the time the president of the Australian Medical Association in Western Australia. He gave this evidence on 18 May 2018 —

> … the discussion around diagnosis of depression and other mental illnesses that are comorbid with terminal illnesses is very difficult for the average doctor and very difficult for a palliative care physician or any non-psychiatrist, and, in fact, is probably difficult for psychiatrists as well.

This is the AMA evidence to the yearlong inquiry. He continues —

> Our strong recommendation is that a psychiatric assessment be completed for everybody accessing this option, partly around competence … but mainly to exclude significant mental illness. We know those rates of mental illness are extremely high in this population and we would not countenance access to euthanasia because someone is depressed. We feel that would be an inhumane treatment.

This is the advice of the AMA to the yearlong inquiry. In addition, Dr Miller, the only dual trained consultation–liaison psychiatrist in cancer and palliative care in Western Australia, advised the inquiry on 13 December 2017 that around 40 per cent of people in a general hospital setting may be experiencing some degree of significant mental health comorbidity along with their physical health morbidity.

The DEPUTY CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: She also noted that comorbid depression with cancer or other advanced illnesses is common. I will conclude by referring again to the evidence given by Dr Nathan Gibson, Western Australia's Chief Psychiatrist, in his submission to the yearlong inquiry. In submission 655, at page 3, he states —

> While there are robust, internationally-recognised classifications systems, including the ICD-10 and the Diagnostic and Statistical Manual Version 5 (DSM 5), the diagnosis of mental illness still requires an expert clinician to assess for the criteria. While the classification systems seek to objectify this process

> as far as possible, the assessment of criteria for mental illness will still have components of subjective weighting and analysis based on the skill and experience level of the individual clinician. It is not uncommon for clinicians to disagree on the nature of an individual's mental illness.

I will just conclude, if I have it readily available, by referring to the letter that was tabled earlier this week, or recently, by the minister, which was the exchange between the government special adviser, Mr McCusker, and the Chief Psychiatrist on 14 November 2019. I had previously encouraged members to take a look at that letter. It was clear from an earlier exchange that Hon Aaron Stonehouse has done that. If members take a moment to look at that exchange, it is quite clear what he is saying, rather than how he was verballed by the government. I have been quite disappointed during this debate to see the number of occasions on which the Chief Psychiatrist has been verballed by the government. His response to Mr McCusker on 14 November speaks for itself. He ends by stating —

> - Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

We have the option now to either support the amendment moved by Hon Charles Smith, which is consistent with the expert advice given by the Chief Psychiatrist in Western Australia, that psychiatrists and geriatricians are by far best placed to assess capacity, or we can ignore the Chief Psychiatrist's evidence. That is okay—we can do that; there is an option for members to do that. I err on the side of supporting the evidence given by the Chief Psychiatrist, who has repeatedly given this evidence to the Joint Select Committee on End of Life Choices. I thank the government's special adviser for reconfirming that in this exchange on 14 November.

Division

New clause put and a division taken, the Deputy Chair (Hon Robin Chapple) casting his vote with the noes, with the following result —

Ayes (4)

Hon Nick Goiran	Hon Aaron Stonehouse	Hon Colin Tincknell	Hon Charles Smith *(Teller)*

Noes (30)

Hon Martin Aldridge	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Tjorn Sibma
Hon Ken Baston	Hon Colin de Grussa	Hon Rick Mazza	Hon Matthew Swinbourn
Hon Jacqui Boydell	Hon Sue Ellery	Hon Kyle McGinn	Hon Dr Sally Talbot
Hon Robin Chapple	Hon Diane Evers	Hon Michael Mischin	Hon Darren West
Hon Jim Chown	Hon Donna Faragher	Hon Simon O'Brien	Hon Alison Xamon
Hon Tim Clifford	Hon Adele Farina	Hon Martin Pritchard	Hon Pierre Yang *(Teller)*
Hon Alanna Clohesy	Hon Laurie Graham	Hon Samantha Rowe	
Hon Peter Collier	Hon Colin Holt	Hon Robin Scott	

New clause thus negatived.

The DEPUTY CHAIR: Members, we will be dealing with another new clause 25A, proposed by Hon Nick Goiran, to insert certain words after line 8 on page 18. If you will excuse me, I will not read in the whole insertion. I leave it to Hon Nick Goiran to move the motion in his name.

Hon NICK GOIRAN: Noting the length of the amendment, with the minister's concurrence, I will make some general remarks about proposed new clause 25A standing in my name at 78/NC25A, rather than move the entirety of the amendment. I propose to do that because it would be fair to say that if the chamber is not willing to support the amendment moved by Hon Charles Smith —

The DEPUTY CHAIR: Member, I think you need to move the new clause before you start.

Hon NICK GOIRAN: Mr Deputy Chair, I am making general comments under new clause 25A.

The DEPUTY CHAIR: I am advised that you need to put the new clause.

Hon NICK GOIRAN: I indicate to the chamber that I will not move the new clause standing in my name at 78/NC25A. By way of brief explanation, given the chamber was not supportive of the good amendment moved by Hon Charles Smith, it would be impossible to gain support for the new clause standing in my name. I indicate to members that the brief distinction between the two is that this amendment at 78/NC25A sought to mirror the provisions in the Mental Health Act, as I asked parliamentary counsel to try to do. The history of that is simply some evidence provided by the Chief Psychiatrist during the yearlong inquiry. To paraphrase the exchange that

took place between him and me, we were both of one mind that the stakes are higher here. I draw to members' attention this one piece of evidence provided by the Chief Psychiatrist on 14 December 2017, when he said —

> … if you look at the Mental Health Act, it requires a psychiatrist to determine capacity to make someone involuntary under the Mental Health Act. My feeling would be why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

He went on to say —

> … obviously we have said, again in the Mental Health Act, that anyone who is made involuntary has to be seen by a psychiatrist. It is so serious that a psychiatrist must see them to determine capacity, mental illness et cetera. What I would not like to see is a watered down version that would not apply the same rigour to individuals seeking to end their life, notwithstanding that palliative physicians are good at screening for mental illness. Palliative physicians would not call themselves psychiatrists. They would not say that they can, hand on heart, make diagnoses of mental illness in every case. They would screen for it. Except if you are Lisa Miller, you can do both, but most palliative physicians would say that they screen for it but they would ask for specialist advice if it was a complex situation, hence, I am trying to —

The DEPUTY CHAIR: Hon Nick Goiran, I just remind you that we are not talking to any particular clause at this time, so I ask you to keep the debate truncated.

Hon NICK GOIRAN: Indeed. Thank you, Mr Deputy Chair. To conclude the evidence from the Chief Psychiatrist, he continues —

> not have a lesser standard for individuals who are seeking to end their life, even in the case of terminal illness, than we apply already within the Mental Health Act.

It is for those reasons that I asked parliamentary counsel to prepare an amendment that would try to mirror the provisions in the Mental Health Act. However, given the response to the amendment moved by Hon Charles Smith, I think it is prudent at this time not to move the amendment standing in my name at 78/NC25A.

The DEPUTY CHAIR: That takes us to the next amendment from Hon Charles Smith.

Hon CHARLES SMITH: I seek leave to withdraw that amendment.

The DEPUTY CHAIR: We now move to new clause 25B proposed by Hon Nick Goiran.

Hon NICK GOIRAN: I indicate to members that amendment 79/NC25B was a consequential amendment associated with the amendment that I had proposed at new clause 25A. In light of the fact that I have not moved that one, it follows that this one should also not be moved.

Clause 26: Information to be provided if patient assessed as meeting eligibility criteria —

Hon RICK MAZZA: I have an amendment on the supplementary notice paper at 416/26, which is a consequential amendment, and it can remain on the supplementary notice paper.

Hon NICK GOIRAN: I refer to clause 26(1)(a), (b) and (c). How can a medical practitioner who is not required to be a specialist in the patient's disease, illness or medical condition, nor required to be a specialist palliative care practitioner, be expected to deliver the correct information to the patient required under clause 26?

Hon STEPHEN DAWSON: My advice is that it is because a coordinating practitioner such as a GP will have access to a range of information and will be familiar with condensing it.

Hon NICK GOIRAN: Will a general practitioner, if they are a coordinating practitioner, in effect need to seek the advice of a palliative care specialist—even though it is not mandated under the statute—in order to provide the information required under clause 26(1)(c)?

Hon STEPHEN DAWSON: I make the point that palliative care is not just specialist palliative care. It is well recognised that GPs and other practitioners provide palliative care at end of life. Specialist palliative care advice is most usually provided in the most complex cases.

Hon NICK GOIRAN: What are the potential risks of self-administering, or being administered, a voluntary assisted dying substance that is likely to be prescribed under this legislation for the purposes of causing the patient's death, as referred to under clause 26(1)(d)?

Hon STEPHEN DAWSON: Risks would depend on the medical protocol that is appropriate for the patient. That information will be provided to doctors undergoing training. A possible risk may well be the medication not taking effect because it is regurgitated by the patient.

Hon NICK GOIRAN: Would one of the potential risks of self-administration be that the voluntary assisted dying substance is consumed by someone other than the patient?

Hon STEPHEN DAWSON: I am advised that that risk exists with any medication that is dispensed in Western Australia.

Hon NICK GOIRAN: There is reference under clause 26(1)(f) to the method by which the substance referred to is likely to be self-administered. What is the method that is likely to be used?

Hon STEPHEN DAWSON: I am advised that the method will be discussed between the patient and the doctor, and it will depend on the patient's particular circumstances.

Hon NICK GOIRAN: What would be some examples of the methods that are intended to be used in this provision? I can think of several methods that surely would not be intended to be used. There have been some harrowing stories of suicide from members as reasons for their support for this legislation, to avoid some of those harrowing circumstances. I would imagine that those types of methods are not intended to be used under clause 26(1)(f). What are some of the methods that are intended to be used?

Hon STEPHEN DAWSON: In cases of patient self-administration, it would be oral medication in a liquid or tablet form. In relation to practitioner administration, it would be via liquid, tablet, injection, oral tube, nasal tube, intravenous line and stomach peg.

Hon NICK GOIRAN: Why would the patient not be able to have an injection for self-administration?

Hon STEPHEN DAWSON: I am advised that it depends upon the substance; these are just examples, so it could potentially be.

Hon NICK GOIRAN: To be clear, minister, for self-administration, is it the intention of the government to allow patients to take the substance home in the form of an injection, is it the intention of the government that the substance be taken in the form of a liquid to be consumed, or is it the intention of the government that it be taken in the form of a tablet?

Hon STEPHEN DAWSON: The protocols around this will be developed by the clinical panel during the implementation phase, so we are not presupposing one way or another.

Hon NICK GOIRAN: The minister is saying that he is not presupposing, but I am presupposing that a gun will not be one of the methods. I think we would all agree that is the case, so we can rule that out.

Hon Stephen Dawson: By way of interjection, I can indicate that a gun is not one of the proposed methods.

Hon NICK GOIRAN: Indeed. But there are other methods that obviously are under contemplation. There are options that are being actively considered by government. The reason this is important is that I would think that there is a very significant difference in the risks that the practitioner, under clause 26, has to inform the patient about. If they say to the patient, "You take this home and use it as a liquid", the risks are far greater than if they take it in tablet form, because if they share the substance with another person in liquid form, there could be multiple victims as a result of this, whereas that is less likely to be the case if the substance is in tablet form. I imagine that the potential risks that will need to be explained to the patient will very much depend on the method outlined at clause 26(1)(f). I am interested to know what advice the government has sought or obtained from the ministerial expert panel on the methods that could be used under clause 26(1)(f).

Hon STEPHEN DAWSON: I am advised that we have not, because it would be a clinical decision.

Hon NICK GOIRAN: Have any methods been ruled out by the government at this stage?

Hon STEPHEN DAWSON: Earlier, the honourable member mentioned the issue of a gun; of course we are not contemplating guns. The bill refers to a "medication". Therefore, it needs to be a substance. It rules out anything other than a substance.

Hon NICK GOIRAN: What are the clinical guidelines that the minister anticipates will be necessary and that the patient will need to be informed of under clause 26(2)?

Hon STEPHEN DAWSON: I am told that these are matters to be determined by the clinical panel. The clinical guidelines are yet to be established.

Hon NICK GOIRAN: What might "a plan in respect of the administration of a voluntary assisted dying substance" look like, as required under clause 26(2)(b)?

Hon STEPHEN DAWSON: Again, this is a matter that will be determined by the clinical panel. The guidelines are yet to be determined as to what the plan might be. An example of something that might be in a plan is how to manage someone's nausea if they regurgitate particular drugs.

Hon NICK GOIRAN: That sounds horrible, minister. Section 19 of the Victorian legislation provides that a member of the patient's family be provided with information about clinical guidelines and a plan for administration. Why does clause 26 of the WA legislation differ from section 19 of the Victorian legislation?

Hon STEPHEN DAWSON: I am advised that, in practice, this information would be provided to a family member if that is the patient's wish.

Hon NICK GOIRAN: I move —

Page 19, line 13 — To delete "or," and substitute —

and,

Hon STEPHEN DAWSON: I indicate that the government is amenable to this amendment, and will support this amendment, to make it clear.

Hon NICK GOIRAN: I thank the minister for that. I will very briefly explain to members what this amendment actually seeks to do. I need to give due credit to the Leader of the Opposition, Hon Liza Harvey, who moved exactly the same amendment in the other place but was told "No" by the government on that occasion. I am grateful that the government's line of thinking on this issue has evolved. All the amendment does is indicate that the information that is provided must be also provided to the patient. By all means, the information should be provided to somebody else whom the patient asks for it to be given to, but what cannot possibly happen is that the information be provided to a third party and the patient not be informed. This amendment simply ensures that the statute before us is consistent with the explanatory memorandum, which actually deals with this point. I thank the government for its acceptance of the amendment.

Amendment put and passed.

Hon ADELE FARINA: I would like to understand why the coordinating practitioner "must" provide the information listed in clause 26(1), but at subclause (2), the coordinating practitioner "must take all reasonable steps" to fully explain to the patient and a person nominated by the patient, given the amendment we have just made. It just seems to me that if the patient is likely to elect to self-administer, the practitioner will want to be absolutely sure that the patient is aware of all the relevant clinical guidelines and understands the plan for the administration of the substance. I do not understand why the words "take all reasonable steps" are included in this subclause. I would have thought that it would be absolutely critical that the patient and the family member or other person nominated by the patient understands what needs to be done.

Hon STEPHEN DAWSON: We think it actually strengthens the obligation. They have to take all reasonable steps. They cannot just give the information to them; they have to take all reasonable steps to fully explain it to them. We think it strengthens the provision.

Hon NICK GOIRAN: Will the duty at clause 26(3) include informing another treating practitioner of a voluntary assisted dying request, if the practitioner is aware that another practitioner is also treating that patient?

Hon STEPHEN DAWSON: The advice I have been given is no, honourable member.

Hon NICK GOIRAN: Subclause (3) does not provide this, but is there another provision in the bill that will require the practitioner to let another practitioner know that their patient is accessing voluntary assisted dying? Let us imagine, for a moment, that a general practitioner is aware that a patient is receiving treatment from a psychiatrist. The patient comes to see the general practitioner and says, "I would like to request voluntary assisted dying." In those circumstances, I think it would be important, appropriate and maybe ethical—I do not know whether there are some guidelines along this line—for the general practitioner to let the psychiatrist know that their patient has requested voluntary assisted dying, just for the awareness of the psychiatrist and to assist in their general treatment of the patient. Is there a provision along those lines in the bill?

Hon STEPHEN DAWSON: No, there is no provision in the bill.

Hon NICK GOIRAN: Is that seen as a deficiency? Is that going to be addressed in some other way; and, if not, why not?

Hon STEPHEN DAWSON: No, it is not seen as a deficiency. Patient confidentiality exists. If the patient consents, the medical practitioner will be able to advise another practitioner. Otherwise, patient confidentiality is paramount.

Hon NICK GOIRAN: If a Western Australian patient consults a general practitioner and expresses suicidal ideation, and the general practitioner knows that the patient is being seen by a psychiatrist—in fact, the general practitioner may have even referred the person to a psychiatrist—does the general practitioner currently have any obligation or duty, ethical, legal or otherwise, to inform the psychiatrist of those circumstances, or would, as the minister said, patient confidentiality prevail over all, including the welfare of the patient, and there would be no communication between the GP and the psychiatrist?

Hon STEPHEN DAWSON: I am told that it depends on the scope of the duty of confidentiality between patient and doctor. Normal medical practice standards would apply.

Hon NICK GOIRAN: Where can we find the standards that the minister referred to?

Hon STEPHEN DAWSON: I refer the honourable member to the Medical Board of Australia document that has been mentioned previously in this debate.

Hon NICK GOIRAN: I indicate that this is not a reason to oppose clause 26, but it is an assessment that arises as a result of our consideration of clause 26; that is, I am troubled that a Western Australian can make a request for voluntary assisted dying to a medical practitioner in Western Australia, and, even though that practitioner knows that another medical practitioner is treating that patient, there would be no communication between those practitioners. This is a rhetorical question, but I would be very interested to know what medical practitioners in Western Australia think about that. I think they would be troubled and that they would want to have all possible information at their disposal, but that is not contemplated in the bill. The reason I make these remarks on the record now is that, as the minister indicated, there will be an extensive implementation period of at least 18 months. I do hope that those individuals who will participate in that implementation period will contemplate this issue and develop some form of protocol to ensure that this type of situation is addressed.

Hon STEPHEN DAWSON: The honourable member's comments are noted.

Clause, as amended, put and passed.

Clause 27: Outcome of first assessment —

Hon NICK GOIRAN: Section 20 of the Victorian legislation is equivalent to clause 27 before us, and requires that the coordinating medical practitioner is satisfied that the person is acting voluntarily and without coercion and that the person's request for access to voluntary assisted dying is enduring. Why have these requirements been excluded from clause 27?

Hon STEPHEN DAWSON: They have not been excluded. Clause 15 sets out the eligibility criteria. Further, clause 27 requires that the patient understands the information required to be provided under section 26(1) and meets all the eligibility criteria.

Hon NICK GOIRAN: I do not know whether the minister has a copy of the Victorian legislation handy, but I refer the minister to section 20(1)(c) and (d) and ask where we find that in our legislation.

Hon STEPHEN DAWSON: I am advised that it is similar to our clause 15(1)(e) and (f).

Hon NICK GOIRAN: If a patient is assessed by their coordinating practitioner as being ineligible for voluntary assisted dying under this scheme and, as I understand it, the request and assessment process ends, would the Voluntary Assisted Dying Board be informed of this?

Hon STEPHEN DAWSON: Yes, it would.

Hon NICK GOIRAN: Under what provision would that occur?

Hon STEPHEN DAWSON: It is under clause 28.

Hon NICK GOIRAN: Clause 28(3) sets out the information that would be provided in the form. Which section does the minister say ensures that the board is aware that the practitioner has determined that the person is ineligible for access?

Hon STEPHEN DAWSON: It is clause 28(3)(g).

Clause put and passed.

Clause 28: Recording and notification of outcome of first assessment —

Hon ADELE FARINA: I have an amendment standing in my name at clause 28 that I would like to move. The amendment is 469/28.

Point of Order

Hon STEPHEN DAWSON: We have already set a precedent that we would work through the amendments in the order in which they appear on the supplementary notice paper.

Hon ADELE FARINA: No-one stood up. I am more than happy to follow the order.

The DEPUTY CHAIR (Hon Matthew Swinbourn): That is noted.

Committee Resumed

The DEPUTY CHAIR: The next amendment on the supplementary notice paper is by Hon Nick Goiran. Do you wish to move your amendment?

Hon NICK GOIRAN: I do. Perhaps just a few questions —

Hon Stephen Dawson: Perhaps the member does not need to ask questions.

Hon NICK GOIRAN: I move —

Page 20, after line 7 — To insert —

(2A) As soon as practicable after completing the first assessment report form, the coordinating practitioner must give a copy of it to the patient.

Hon STEPHEN DAWSON: I indicate to the chamber that the government will support this amendment standing in Hon Nick Goiran's name. The effect of the proposed amendment is to ensure that in addition to the patient being informed about the outcome of their assessment, they also get a suite of other information, including the assessing practitioner's decision in respect of each of the eligibility criteria. During the implementation stage, the Department of Health will look at the most appropriate way to present this information to the patient. A printable extract may be provided to the patient that will also require provision of printed information to the patient about a State Administrative Tribunal review.

Hon NICK GOIRAN: I am pleased to see the support of the government for this amendment standing in my name. It was based on an amendment moved in the other place by the Leader of the Opposition, Hon Liza Harvey, the member for Scarborough, on 5 September 2019. I feel the duty to inform members that the drafting of this amendment differs slightly from the amendment moved on the floor of the chamber in the other place by the Leader of the Opposition, the member for Scarborough. However, the amendment meets the same objective. The reason that it is slightly different is that I consulted with parliamentary counsel and this was the preferred form of wording, so I seek the support of members.

Amendment put and passed.

Hon ADELE FARINA: I move —

Page 20, after line 14 — To insert —

(v) whether the patient's first language is a language other than English;

(vi) whether the coordinating practitioner engaged an interpreter in accordance with section 160(2) to communicate the information in section 26 to the patient;

In my contribution to the second reading debate, I raised this issue about the need for medical practitioners to be very certain that when they are talking to people whose first language is not English, they are understanding what is being said to them. I also relayed to the chamber an experience with my father when a procedure was performed on him that he clearly did not want and did not consent to. However, his signature was on a consent form and I spoke about the difficulties that arose from that. It is absolutely critical that as part of this process we collect as much information as we possible possibly can about who is applying for voluntary assisted dying and the circumstances. I also think that given the sort of information that is being relayed to the patient through this assessment process, it is fairly important that they understand what is being said to them and the decision that they are making is made with the full knowledge of the consequences of that decision. Inserting these two additional subparagraphs is really a matter of ensuring that an interpreter is used when one is needed and that information is recorded so that we have that statistical information if it is needed.

Hon STEPHEN DAWSON: I indicate that I am happy to support this amendment, too. I think it makes good sense from a policy perspective. The information was intended to be captured on a database anyway, but I have no issue with it being included as an amendment.

Hon ROBIN CHAPPLE: I thank the member for her amendment and I will be supporting that.

Hon AARON STONEHOUSE: I am glad to see this amendment receive support from across the chamber. It addresses in some part a concern that I had around assessing capacity and obtaining consent from people who come from different cultural backgrounds and have different attitudes towards the authority of a medical practitioner, or indeed have language difficulties. Providing a provision for interpreters is sensible and addresses the concern that I raised in my second reading contribution. I am happy to support the amendment.

Amendment put and passed.

The DEPUTY CHAIR: There is another amendment to clause 28 in the name of Hon Nick Goiran. Do you wish to move that amendment?

Several members interjected.

The DEPUTY CHAIR: Members, we will not proceed if we keep having these interjections. Allow Hon Nick Goiran to move his amendment.

Hon NICK GOIRAN: I move the amendment standing in my name at 179/28. I move —

Page 20, after line 19 — To insert —

(ea) a statement outlining the patient's end of life concerns that formed the basis for the first request, for example —

(i) loss of autonomy;

(ii) loss of ability to engage in activities that make life enjoyable;

(iii) loss of dignity;

(iv) loss of control of bodily functions;

(v) being a burden on family members, friends or carers;

(vi) inadequate pain control or fear of inadequate pain control;

(vii) the financial implications of care and treatment (both curative and non-curative);

This amendment seeks to strengthen the data collection in the first assessment report forms to assist the Voluntary Assisted Dying Board in performing its functions under clause 117, particularly the function at paragraph (d), which states —

to conduct analysis of, and research in relation to, information given to the Board under this Act;

I seek to amend clause 28 to include not only the date when the first request was made, as currently required under clause 28(3)(e), but also a statement outlining the patient's end-of-life concerns that form the basis of the first request.

The list of end-of-life concerns in my amendment on the supplementary notice paper is taken from the end-of-life concerns listed in the Oregon Health Authority's Death with Dignity Act annual reports. I draw to members' attention page 12 of the current Oregon Health Authority Death with Dignity Act annual report, which is for the twenty-first year of operation of its scheme, in 2018, in which a similarly worded list appears. The table at page 12 of that Oregon Health Authority annual report reveals that of the deaths that occurred under the Death with Dignity Act in 2018, 91.7 per cent of patients cited concern about losing autonomy in their request for assisted dying; 90.5 per cent of patients cited concern about being less able to engage in activities making life enjoyable; 66.7 per cent of patients cited concern about loss of dignity; 36.9 per cent of patients cited concern about loss of bodily functions; 54.2 per cent of patients cited concern about being a burden on family, friends or caregivers; 25.6 per cent of patients cited inadequate pain control or fear of inadequate pain control; and, finally, 5.4 per cent of patients cited concern about the financial implications of treatment.

I suggest to members that analysis of such data will provide an opportunity to better understand the driving forces behind patient access to voluntary assisted dying. I would further suggest to members that analysis of the data would also provide an opportunity for ongoing improvements in the end-of-life care for patients in our state. I would trust that members agree with me that if 54.2 per cent of patients in Western Australia were to express a concern about being a burden on family members, friends or caregivers before accessing voluntary assisted dying, a government of either persuasion and the community in our state would be motivated to seek ways to better support people at their end of life and better support their family, friends and caregivers.

It is my view that data around financial concerns should also be collected. I trust that we would not support a patient accessing voluntary assisted dying based on their concern about the financial implications of care and treatment, whether that be care and treatment for curative or non-curative purposes.

I also note that the same data is collected in Washington state—another jurisdiction that has assisted suicide or voluntary assisted dying. Assisted dying has been legalised under its Death with Dignity Act. Washington state Department of Health's Death with Dignity Act reports are produced annually and they cite the same statistics. The collection of this data would appear to be best practice in other jurisdictions where assisted dying has been legalised, including the two that I have just referred to. I therefore have moved the amendment in my name to mandate this best practice for our state to ensure that this information is included in the first assessment report forms referred to in clause 28(3). I seek members' support for the amendment.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of this amendment. This amendment requires the patient to make a statement about their reasons for seeking access to voluntary assisted dying and proposes a list of examples. Although the government supports that robust data about voluntary assisted dying should be collected by the board, it does not believe it is appropriate to require the patient to, in effect, justify their request for voluntary assisted dying in addition to undergo assessments for eligibility. The proposed legislative requirement is intrusive for someone who is dying. This information can rightly be ascertained during the clinical process. It is anticipated that during the implementation phase, consultation with end-of-life and palliative care researchers and other jurisdictions would inform the collection of data that may facilitate and enhance the function of the board under clause 117(d) and also balance this with an appropriate client-centred approach to data collection. The inclusion of any agreed data elements can be managed during the implementation phase and is not required to be included in the legislation.

Hon NICK GOIRAN: The minister mentioned that one of his objections to my amendment is that it is intrusive. Has there been any dialogue between the government and jurisdictions such as Oregon that have been collecting this data for 21 years, or indeed Washington state, to ascertain whether, under their very substantial regimes, there is any concern that this is intrusive?

Hon STEPHEN DAWSON: We have not specifically asked the question, but certainly our view is that it is not appropriate and it would be intrusive.

Hon NICK GOIRAN: When the minister said that the government has not specifically asked the question, has there been any dialogue with those in Oregon or Washington in respect of the bill?

Hon STEPHEN DAWSON: I am advised that there certainly has been in respect of the bill, but not in respect of this matter.

Hon ADELE FARINA: Would this not be part of the dialogue that the patient and the coordinating practitioner and the consulting practitioner would have in their whole discussion about accessing VAD? Would it not be easy enough to collect this information as part of that assessment process?

Hon STEPHEN DAWSON: In my answer to Hon Nick Goiran I want to clarify that there was dialogue between Western Australia and other jurisdictions in relation to voluntary assisted dying, not specifically in relation to the bill. I need to clarify that for the chamber.

I think Hon Adele Farina's question was along the lines of: would it not be fairly easy to collect this data?

Hon Adele Farina: I expect the practitioner and the patient to have a discussion along these lines anyway as part of the whole process of asking for voluntary assisted dying and the assessment process.

Hon STEPHEN DAWSON: Discussions may well take place, and it is our intention, during the implementation phase, to work out a way in which data could be collected and provided to the board to help it do the work it is required to do. We think this is intrusive, and we do not think it is appropriate to include it in the bill.

Division

Amendment put and a division taken, the Deputy Chair (Hon Matthew Swinbourn) casting his vote with the noes, with the following result —

Ayes (6)

Hon Adele Farina	Hon Charles Smith	Hon Colin Tincknell
Hon Rick Mazza	Hon Aaron Stonehouse	Hon Nick Goiran *(Teller)*

Noes (28)

Hon Martin Aldridge	Hon Peter Collier	Hon Colin Holt	Hon Robin Scott
Hon Ken Baston	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Tjorn Sibma
Hon Jacqui Boydell	Hon Colin de Grussa	Hon Kyle McGinn	Hon Matthew Swinbourn
Hon Robin Chapple	Hon Sue Ellery	Hon Michael Mischin	Hon Dr Sally Talbot
Hon Jim Chown	Hon Diane Evers	Hon Simon O'Brien	Hon Darren West
Hon Tim Clifford	Hon Donna Faragher	Hon Martin Pritchard	Hon Alison Xamon
Hon Alanna Clohesy	Hon Laurie Graham	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*

Amendment thus negatived.

Hon COLIN TINCKNELL: I move —

Page 20, after line 23 — to insert —

(ga) whether accessible palliative care is or will be available to the patient in regional Western Australia;

I am not going to talk for very long on this. Everyone knows my position on palliative care in regional areas, and what is needed. I see the need for this amendment, and I would like the support of the chamber. Whether accessible palliative care is available to a patient is very important. I have indicated previously that the government has decided to pass this bill, so the government needs to prepare the community to facilitate this bill. Regional people have the right to the same care. There are things that the government can do to assist in making palliative care available. We have heard that voluntary assisted dying will be available to everyone everywhere, and I believe that the same should be happening with palliative care.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of the amendment moved by Hon Colin Tincknell. I draw honourable members' attention to an amendment standing in my name on the supplementary notice paper issue 12 at 402/28. That amendment is to require the coordinating and consulting practitioners, in providing the first assessment report form and consulting assessment report form to the board, to include information about palliative care options available to the patient and the likely outcomes. This is to assist the board to gather data and identify any gaps in health service provision. This would include information such as whether the patient is currently receiving palliative care, and, if not, whether a palliative care service is available to which the patient could be referred, to assist them; whether the patient has been offered a referral to this service; and whether the patient has or has not been referred to this service.

Hon AARON STONEHOUSE: I appreciate the sentiment with which this amendment has been put forward. It is worth noting that nothing in the amendment would improve access to palliative care for regional or other people in Western Australia. However, much like the amendment put forward by Hon Nick Goiran that we considered a moment ago, it would provide a reporting function for the availability of palliative care, which I think is desirable. However, it requires reporting on access to palliative care in regional Western Australia. I think it is too narrow, in that sense. It states —

(ga) whether accessible palliative care is or will be available to the patient in regional Western Australia;

I think that is not really ideal. We would be better off with something along the lines of what the minister has put forward, which would put in place a reporting requirement for palliative care and treatment options available to the patient, regardless of where they reside. As I said, I support the sentiment with which this has been put forward, but I would say that it would be more prudent to vote down this amendment in this case and support, instead, the amendment put forward by the Minister for Environment.

Amendment put and negatived.

The DEPUTY CHAIR: Hon Charles Smith, there is an amendment in your name; do you wish to move that amendment?

Hon Charles Smith: No, Deputy Chair.

The DEPUTY CHAIR: Members, we are now dealing with an additional amendment on the supplementary notice paper in the name of Hon Martin Pritchard.

Hon MARTIN PRITCHARD: We again have the situation in which the singular can refer to the plural. Clause 28(3)(i) states —

if the patient was referred under section 25(2) or (3), the outcome of the referral;

Is it intended that all referrals would be sent to the board. It says "outcome", does that mean the referral information or just the outcome?

The DEPUTY CHAIR: Member, are you moving your amendment or are you just seeking clarification?

Hon MARTIN PRITCHARD: The answer I get back will determine whether I move the amendment.

The DEPUTY CHAIR: We will indulge the member's position if the minister wants to give his response now.

Hon STEPHEN DAWSON: Yes, it refers to all referrals. It is just the outcome.

Hon MARTIN PRITCHARD: Thank you for your indulgence. I will not move my amendment.

The DEPUTY CHAIR: Members, we are still dealing with supplementary notice paper 139, issue 12, and there is another amendment in the name of Hon Nick Goiran. Member, do you wish to move your amendment?

Hon NICK GOIRAN: Certainly, Mr Deputy Chair. I move —

> Page 20, line 27 — To delete "referral;" and substitute —
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> > referral (including a copy of any report given by the registered health practitioner or other person to whom the patient was referred);

Briefly, the amendment standing in my name to clause 28 mandates that the first assessment report form must include not only the outcome of a referral made under clause 25(2) or (3) to another practitioner or other qualified person, but also a copy of the report provided by that practitioner or other qualified person on their assessment of the patient's eligibility to the coordinating practitioner. The government has reiterated the importance of the Voluntary Assisted Dying Board in monitoring the operation of the act. That can be found at clause 117(a). This amendment seeks to better support the Voluntary Assisted Dying Board in this function by ensuring that it has available to it all the relevant information on the assessment of the patient's eligibility to access voluntary assisted dying. It is not apparent to me that there is any reason the amendment should not be supported and I seek the support of members.

Hon STEPHEN DAWSON: I indicate that the government does not support this amendment. There is a further one at 189/39 on which I will also make these comments. Hon Nick Goiran's amendments seek to require the coordinating and consulting practitioners when respectively providing the first assessment report form and consulting assessment report form to the VAD board to include a copy of any referral report given as part of the patient's assessment.

It is not the role of the board to undertake clinical review during the voluntary assisted dying process. The bill already requires that the board is advised of the outcome of any referrals via the first assessment report form or the consulting assessment report form. The board does not need to consider all the assessment documentation by the coordinating consulting practitioner or the person referred to. For those reasons we will not support it.

Hon NICK GOIRAN: If one of the objections is that it is not the role of the board to provide clinical review, what will the board actually do?

Hon STEPHEN DAWSON: The board will have a monitoring role and that is covered in part 9 of the bill.

Hon NICK GOIRAN: If the board is monitoring, should it not receive a copy of any report that is relevant?

Hon STEPHEN DAWSON: We do not believe it is necessary.

Hon NICK GOIRAN: Mr honourable minister, through the Deputy Chair.

Hon Sue Ellery: You're losing it!

Hon NICK GOIRAN: Leader of the House, it is interesting that the role of the Voluntary Assisted Dying Board is to monitor this process, a very important report is available but we do not want the Voluntary Assisted Dying Board to see it. It does not make it much of a monitor.

Hon Sue Ellery: There is a lot of that going about!

The DEPUTY CHAIR: Leader of the House, it is not very helpful.

Hon NICK GOIRAN: It does not make it much of a monitor if it does not have all the information before it. It is not apparent to me how this would create any harm to the bill. On what basis is it a concern that the board would be getting more information? I would have thought that if it was a monitor, it would be a good thing if it got as much information as possible. It is just not at all clear to me what the objection could possibly be about the board receiving information. If a medical practitioner has determined that they are unable to make an assessment, we have previously said on that basis that they should refer to somebody else and we have said that they can adopt that particular report. They might not. As a monitor, they should be aware that a referral has been made and that a separate practitioner with expertise in the field has come to a certain determination and the coordinating practitioner has said, "Look, I've decided not to follow that particular assessment." That is absolutely within the remit of the coordinating practitioner but the monitor should be aware of all that. That is the whole point of supervision and oversight. It is not apparent to me what the genuine objection is, but I conclude in that respect.

Hon STEPHEN DAWSON: Upon further reflection, it would not cause any issues for us, so the government is happy to accept the amendment.

Amendment put and passed.

Hon NICK GOIRAN: Before I consider moving the amendment standing in my name at 82/28, can the minister clarify, in light of the excellent amendment moved by Hon Adele Farina at 469/28, to what extent is amendment 82/28 still required? Is it different or do they simply duplicate each other?

Hon STEPHEN DAWSON: The honourable member's amendment is different; it goes further than Hon Adele Farina's amendment and it requires a greater level of detail to be collected and provided.

Hon NICK GOIRAN: In light of that, I move —

> Page 20, after line 27 — To insert —
>
> (ia) if the patient was assisted by an interpreter when having the first assessment, the name, contact details and accreditation details of the interpreter;

Even though I gave notice of this amendment prior to the excellent amendment moved by Hon Adele Farina earlier today, I think this amendment complements that one. Members will recall that we agreed—as I understand it, without dissent—that it would be appropriate to record whether a coordinating practitioner had engaged an interpreter in accordance with clause 160(2) to communicate the information under clause 26 to the patient. This amendment will ensure that the name, contact details and accreditation details of the interpreter are collected. Clause 160(1)(a) provides for an interpreter to assist the patient in the request and assessment process. Clause 160(2) provides for the accreditation requirements of the interpreter and mandates certain independence standards for the interpreter, including that the interpreter cannot be a family member, a beneficiary under the will of the patient, an owner or manager of a health facility in which the patient is being treated or resides, or a person directly involved in providing health services or professional care services to the patient. As I say, this amendment will ensure that the name, contact details and accreditation details are included in the first assessment forms.

That these details were missing from the first assessment request forms was first identified in the other place by the member for Hillarys, my good and learned friend Mr Katsambanis. This is what he had to say during the debate in the other place —

> The other issue I have here is a matter that the member for Carine touched on in his contribution; that is, there is no requirement for the form to include information about the actual use of a translator or interpreter, as the case may be, or the qualifications or other identifying features of who that translator or interpreter was. I hope that that is included when the form is produced. I think it is a bit of a failing that it is not stipulated as one of the things that must be included in the form. It should apply even if, in the case of many patients, the response of the coordinating practitioner was, "Not applicable." The question might be, "Did you use a translator or interpreter?" The answer would be either yes or no.

I note that there was a good exchange between Mr Katsambanis and the Premier, who indicated that he would give some consideration to the suggestion. I look forward to hearing the government's response.

Hon STEPHEN DAWSON: It has been considered and I am in a position to indicate that we will support this amendment.

Amendment put and passed.

Hon STEPHEN DAWSON: In speaking against Hon Colin Tincknell's amendment earlier on, I indicated that I had an amendment standing in my name on the supplementary notice paper, and I gave the reasons for it. I move —

> Page 20, after line 27 — To insert —
>
> (ia) the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment;

Hon COLIN TINCKNELL: I thank the minister. I did not say much on the last amendment, partly because of this amendment. I appreciate the government putting this through. It is a bit like having some of your cake but not all of it. I am happy about the fact that this must be included as part of the first assessment report. I would have preferred my amendment, but this is a step in the right direction.

Amendment put and passed.

Committee interrupted, pursuant to standing orders.

[Continued on page 9387.]

Sitting suspended from 4.15 to 4.30 pm