

**VOLUNTARY ASSISTED DYING BILL 2019**

*Consideration in Detail*

Resumed from an earlier stage of the sitting.

**Clause 5: Terms used —**

Debate was interrupted after the clause had been partly considered.

**Ms R. Saffioti:** Look what you did!

*Withdrawal of Remark*

**Mr P.A. KATSAMBANIS:** I seek a withdrawal of that statement by the Minister for Transport.

**The SPEAKER:** I did not hear it.

**Mr P.A. KATSAMBANIS:** The Minister for Transport made a personal imputation against me and I seek a withdrawal.

**Mr D.A. Templeman:** There was no imputation made.

**The SPEAKER:** No, it is not up to you. I did not hear it. If the minister made one, I am sure she —

**Mr P.C. Tinley** interjected.

**The SPEAKER:** Excuse me! Minister.

**Ms R. SAFFIOTI:** I said, “Look what you did!” The member for North West —

**The SPEAKER:** No. I just want to know what you said.

**Ms R. SAFFIOTI:** I said, “Look what you did!”

**The SPEAKER:** What did you say?

**Ms R. SAFFIOTI:** “Look what you did!”

**The SPEAKER:** Is that what you heard? I cannot make a ruling on it. All I can ask is that if the minister has, she should apologise. She said that she has not done anything. I did not hear anything. I was getting out of the chair.

**Mrs L.M. HARVEY:** Acting Speaker, further to the point of order —

**The SPEAKER:** I am not the Acting Speaker; I might look like it.

**Mrs L.M. HARVEY:** I apologise. Further to the point of order —

**Mr P.C. Tinley** interjected.

**The SPEAKER:** Minister for Housing, you do not run this place.

**Mrs L.M. HARVEY:** Further to the point of order, the member for Hillarys just put on the record that he had been dealing with a matter with an individual who had subsequently been convicted of murder —

**The SPEAKER:** What is your point of order?

**Mrs L.M. HARVEY:** The minister has implied that the member for Hillarys was somehow responsible for the actions of the individual whose matters he intervened in.

**The SPEAKER:** No, sit down. That is not a political point. I did not hear it. I asked the minister whether she said something. She said that she has not, so she cannot withdraw it.

Several members interjected.

**The SPEAKER:** What did you say, minister?

**Ms R. SAFFIOTI:** I said, “Look what you did!”

**The SPEAKER:** That, to me, is not —

**Mr P.A. KATSAMBANIS:** I seek your clarification —

**The SPEAKER:** No. I did not hear it. I have one side and the other side. I cannot take one against the other. The minister said that she did not do something. That is all I can go on.

**Mr P.A. KATSAMBANIS:** She just —

**The SPEAKER:** Excuse me! Sit down. Now we are going into consideration in detail. I cannot take one person’s version because I did not hear it myself.

*Debate Resumed*

**Extract from Hansard**

[ASSEMBLY — Wednesday, 4 September 2019]

p6425b-6433a

Mr Peter Katsambanis; Ms Rita Saffioti; Mrs Liza Harvey; Mr Roger Cook; Mr Zak Kirkup; Dr Mike Nahan;  
Mrs Alyssa Hayden; Ms Margaret Quirk; Mr Shane Love

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**Mr R.H. COOK:** Before we go on, Mr Acting Speaker, prior to question time, the member for Hillarys was on his feet and asked a question. I was going to ask whether he could ask it again to refresh our memories, but he is not here.

**Mrs L.M. Harvey:** He'll be back.

**Mr R.H. COOK:** Okay. I am sure that there are other issues.

**Mr Z.R.F. KIRKUP:** All of us here would know that we have just responded to an amendment that was proposed by the member for Girrawheen addressing the lack of a definition of palliative care. As I understand it, as part of those definitions, there is a reference in clause 26 of the bill to palliative care. It specifically states that information must be provided to a patient in respect of their palliative care treatment options and the like. When the member for Girrawheen and a number of members on our side asked about that, the suggestion in response was that, effectively, we could not insert such a clause because there are no real definitions of palliative care in other legislation that exists in the state. Could the minister reiterate that that is the case?

**Mr R.H. COOK:** I do not think that is the case. I think the point the member for Girrawheen made last night was that the Guardianship and Administration Act offers a definition around those issues. My response was in regards to the relevance it has to this bill. It has no material role in the context of this bill.

**Mr Z.R.F. KIRKUP:** Just to satisfy everyone here, “palliative care” is defined in the Guardianship and Administration Act 1990 as —

... a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure;

Although palliative care is not defined in this bill, it is referenced in clause 26. The minister suggested that that reference in the Guardianship and Administration Act does not reflect what would be required under clause 26. Is my understanding correct?

**Mr R.H. COOK:** Yes, that is correct.

**Mr Z.R.F. KIRKUP:** Could the minister provide some context about why that is the case? I am obviously very keen to work with the government to make sure that this bill is in good condition. If information is provided to a patient about their palliative care options, why does that definition not say that? To be perfectly frank, on my reading of it, it seems to be relatively congruent with what would be in the spirit of that clause and thus would warrant definition.

**Mr R.H. COOK:** I am happy to go into detail when we get to clause 26. The definition from the Guardianship and Administration Act is rather outdated. Quite frankly, I think the observation is that it is quite cold. Section 3 of the Guardianship and Administration Act defines palliative care to mean —

... a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure;

In the context of the VAD bill, the term “palliative care” is used in three provisions that do not need defining. I have already described them. We are using the word in a generic sense, not within a defined or specific sense.

**Mr Z.R.F. KIRKUP:** Sure. I am not going to keep labouring the point. I was satisfied with the explanation provided by the minister and the member for South Perth. They suggested it was not defined in the Criminal Code, even though palliative care is also mentioned there. If we are providing information to an individual as per clause 26, it might be a cold definition in the Guardianship and Administration Act, but I do not quite understand why there is no need to prescribe it. Regulations and forms to be approved by the CEO are in a range of clauses in this legislation, so why would we not clarify or encompass what that is? I would imagine that we would want to do that. The spirit of this bill should be to provide a patient with their palliative care options. The Guardianship and Administration Act specifically refers to a medical, surgical or nursing procedure to help relieve a person’s pain, discomfort or distress. I would imagine that is exactly the type of information we would want to try to provide to a patient. There is no reason to try to get too prescriptive here, but if a definition of palliative care already exists at law, especially in something like the Guardianship and Administration Act, which provides the right and ability for someone to act on someone’s behalf due to incapacity, why would we not seek to prescribe that for information that should be provided to somebody if and when they need to access palliative care information that is required under clause 26 and thus, I think, warrants definition?

**Mr R.H. COOK:** This is well-traversed territory now. I appreciate that the member wants to dig a little further. This is not a tick-a-box exercise. This is really providing some context for the conversation and the decisions that a medical practitioner would make. In that sense, it is not necessary for us to define palliative care to work out whether the patient in question has had opportunities to discuss palliative care plus one, and therefore meets a particular threshold. This is about the therapeutic relationship between the practitioner and the patient. There would also be conversations, potentially, with that patient’s palliative care specialist in that context. I do not want to create the impression that somehow there is some threshold over which a patient must pass in order to have been considered familiar with the concept of palliative care and other treatments that might be available. It is

simply directing the medical practitioner to make some observations and have some conversations to satisfy themselves that the patient in this particular case is aware of the range of opportunities available to them.

**Mr Z.R.F. KIRKUP:** Thank you, minister, for that. A number of members from this side of the house have spoken about the Victorian voluntary assisted dying bill—now an act. I have looked at the origin point for the reference to palliative care in the Victorian legislation. In Victoria, palliative care means the provision of food and water. Obviously, not defining palliative care will allow practitioners to make their own interpretation. I think that is right—this legislation will empower practitioners to do a lot. We will It will rely on their good judgement and good character to operate accordingly. If the Victorian legislation defines palliative care as the provision of food and water to sustain life, and we already define that in Western Australian law, does that not leave open the possibility that a practitioner, if they are obliged under a section of the act to provide information about palliative care to a patient, could simply say, “Palliative care is food and water because that’s the definition in other jurisdictions around the commonwealth”? Does the minister think there is a risk at all, in not defining it, that there could possibly be a lower level of information provided to a patient? As the minister would appreciate, a number of elements are prescribed in this legislation—professional care services is one. If we provide a prescription in these definitions for what that looks like, we can at least ensure there is a minimum mandatory requirement to provide information. I point out again that in Victoria, it is simply the provision of food and water. I worry about what that looks like. If food and water is what one interpretation of palliative care looks like in another jurisdiction, at the other end is high-level, high-care and high-intervention clinical services. That lack of surety surely poses a risk if a practitioner simply meets the requirements, under clause 26 of this bill, by saying, “Your palliative care options are that you get food and water and we can end it there.” Does the minister think that a lack of prescription poses any risk at all? Is the minister absolutely comfortable with that? As someone who supports the legislation, can the minister provide me comfort that without the insertion of that definition, there will always be at a minimum a high level of information provided to a patient by a medical practitioner?

**Mr R.H. COOK:** I can give the member that assurance. In some respects I do not accept the characterisation of that relationship between the medical practitioner and the patient in the context of “I simply have to provide the bare minimum.” I do not think that is the appropriate way to describe those conversations. The medical practitioner will obviously be a doctor of some years training, and no doubt some experience, and in addition to that would have received extra training about what their obligations are, both moral and legal, under this bill. In particular, the medical practitioner would be obliged to provide a range of information about palliative care in the generic sense, but also other treatment options. From that perspective, I am happy that we have gone to the extent necessary to provide a safe set of circumstances around that conversation, although we can dig into that further at clause 26. In relation to clause 5, I do not think we need to provide further clarification.

**Mr Z.R.F. KIRKUP:** Thank you, minister; I appreciate that assurance. Just to summarise, and I do not necessarily expect a response: I worry that the term “palliative care” could be considered subjective because there is no definition. It is up to the interpretation of every practitioner as to how they might provide or furnish that information to a patient as per clause 26, for example. I point out that perhaps by providing them with a standard that must be met in these definitions under clause 5, we might be able to provide for a bare minimum level of information that is required. I accept what the minister said—that he expects a high level of information will be provided to a patient. I hope that the board or the CEO can interrogate that further, as this bill is implemented, maybe in its recommendations. Maybe the minister can provide an assurance that that will occur, so that at least the community can be satisfied there will be a minimum level. Disparity does exist in the commonwealth at the moment between, say, the Victorian legislation, which defines palliative care as the provision of food and water, and what our expectations are right now, and what is defined at law under the Guardianship and Administration Act 1990.

**Mr R.H. COOK:** Yes, I can provide the member with that assurance. The implementation phase will involve very careful design and construction.

**Dr M.D. NAHAN:** I am not going to go into the debate about definitions; we have done that enough. This might not be the spot in the bill to debate this, but I would like some clarification for my understanding of the bill’s intent. I envisage voluntary assisted dying as the last stop, when someone is facing imminent death and in immense pain that, in my words, palliative care cannot address. That idea has been sold and promoted in the community, and I have profound sympathy for VAD if that is what is going to happen. From the minister’s response to a question about the definition of palliative care, I have an idea that VAD is actually a substitute for palliative care, left to the choice of the individual. One reason the minister does not want to go into the definition of palliative care is that it is an option out there for the individual to choose, and it is very variable, but what the minister wants to focus on with this bill is another potentially substitute action—VAD—when I thought it would be that a person would go to VAD when palliative care does not work. I think the minister is saying that the individual can step back and consider palliative care and the practitioners have to give that person advice about the options and how

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to access it, but they do not have to take it, and they can choose, even if palliative care could address the pain and make them comfortable, not to take it, and they can then access VAD. Is that the right understanding?

**Mr R.H. COOK:** In short, VAD may not be the last stop. Many patients will access the voluntary assisted dying provisions of the bill without taking a voluntary assisted dying substance. We know from international experience that giving people access to the substance relieves the suffering from which they seek remedy—that knowing that it is there provides them with the comfort to deal with their final days. The member articulated the nub of a lot of this debate, and perhaps one of the key things that separates the two sides in this debate; that is, the member said that in a lot of respects VAD is a substitute for palliative care. I respectfully disagree. Obviously, VAD may be part of an overall palliative care journey, but I do not accept the notion that we play one off against the other in the context of this debate. I understand the point the member is trying to make, but I do not believe that VAD may necessarily of itself replace palliative care, because palliative care will be potentially a very key part of someone’s end-of-life choices.

**Dr M.D. NAHAN:** Let us say a patient is facing imminent death and meets the criteria in the bill, and palliative care, whatever you define it as, can ameliorate the pain—probably not eliminate it, but ameliorate it—however, the patient, because of, let us say, existential trauma, decides not to pursue the palliative care option, but to apply for VAD and use the substance. Will that be possible under this bill?

**Mr R.H. COOK:** Member, we cannot force treatment options on a patient; it is the patient’s right to make these decisions. As the member knows, in many cases at the moment, patients are rejecting palliative care—refusing to take water or food or receive other treatment. In that respect, the issue of voluntary assisted dying is the relief of suffering; it is not, as the member has put, a way that a person can exit a palliative care scenario.

**Dr M.D. NAHAN:** I understand this is voluntary. I put it in the context of the patient making the choice. Let us say that a person has very bad kidney disease and is on dialysis. I am not sure whether that is palliative care, but I think it would fit the definition. I have a sister-in-law who was on dialysis for a long time. I understand that when a person is on dialysis, other parts of their body fade over time. It is pretty bad. However, it does sustain life. I think the member for Hillarys discussed a very personal experience in his time. This bill comes up with voluntary assisted dying for the first time by a person taking a substance that terminates life. Could a person on dialysis choose to take the substance to end their life, even if the dialysis, or palliative care in this instance, could keep the person alive and ameliorate their pain and address most of the symptoms of this disease?

**Mr R.H. COOK:** If death is, on the balance of probabilities, expected within six months and the patient is, in their view, experiencing suffering that is unable to be relieved otherwise, yes.

**The ACTING SPEAKER:** Member, you may find that some of these questions are more appropriate later. This clause is about interpretation. If you have questions regarding this clause, please ask.

**Dr M.D. NAHAN:** I will come back to that later.

A major policy issue in the health system is to set up a person who is called a carer. Often, particularly with disability, people are defined as carers—sometimes it is a relative and sometimes it is not, and sometimes carers are paid and sometimes they are not. I am surprised that the definition, perhaps, but also the reference to carers, is not treated more widely in the bill, because it refers to family members, but, as I think the Leader of the Opposition indicated, about 40 per cent of people in nursing homes do not have visitors and they have become detached from their families. Was the issue of carers, whether professional or otherwise, dealt with in the preparation of the bill? In my experience, particularly as a local member, often people in nursing homes develop a very close relationship with their nurses and their fellow patients—sometimes they leave money to them, too. Was a thought, concept or type of test to define a carer considered in the minister’s discussions?

**Mr R.H. COOK:** I refer the member to clause 4(1)(g), which deals with principles. There is no reference to carers per se in relation to other aspects of the bill, other than a definition around the provision of professional care services. I think in the scenario the member talked about, it would be in the context of an aged-care home, and a person in that context would be a provider of professional care services. There are ways in which that person is treated in the context of other aspects of the bill, but there is not the definition of “carer” as such.

**Dr M.D. NAHAN:** Limits have been put on the involvement of family members as defined. I am not arguing against that. Is there a limit on the role of carers also in terms of subsequent processes?

**Mr R.H. COOK:** I am advised that it is in the context of the materiality provisions of the bill.

**Mr P.A. KATSAMBANIS:** I take the minister back to the issue that remains unresolved.

**Mr R.H. Cook:** Sorry; we could not remember which bit it was.

**Mr P.A. KATSAMBANIS:** It was the definition of “medical practitioner”, which is for all intents and purposes the standard definition that appears in dozens of acts of this Parliament, including the Adoption Act 1994, Combat Sports Act 1987, Firearms Act 1973, Mental Health Act 2014, Prostitution Act 2000, Road Traffic Act 1974 and many, many

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others. That is just a little snapshot. The same definition is used except that bit at the end, “other than as a student”. I seek an explanation as to why that additional bit, “other than as a student”, has been added in the legislation.

**Mr R.H. COOK:** I remember the Combat Sports Act, and the excitement it always generates amongst our friends at the Australian Medical Association. We made the amendments to that act as part of the national law, back in about 2016, I think it was. The member himself made the point that we are relying upon the national definition that is subject to that uniform law, although it is not quite uniform; I think ours is slightly different. In the context of this bill—that is, dealing with voluntary assisted dying—it makes sense that we do not utilise the services of a student medical practitioner as defined under the national law, because we want to make sure that it is a medical practitioner who is either the coordinating or consulting practitioner with some experience and level of seniority.

**Mr P.A. KATSAMBANIS:** I want to clarify that. First of all, does it say that a person can be registered as a student medical practitioner in Western Australia? Is there a possibility for that to occur?

**Mr R.H. COOK:** I am not an expert in the national law, but I think it is possible under the national law, and that is why we have made the distinction in this bill.

**Mr P.A. KATSAMBANIS:** Will our other acts need to be updated to cover that?

**Mr R.H. COOK:** I am not in a position to give the member that advice. If he would like me to get further advice from the department on that, I am happy to do so, but, in the context of this bill, I think the member and I would both agree that we want a medical practitioner other than a student, although it might be in a postgraduate context, which would be the reason they have the designation as a medical practitioner, but we want to make it quite clear that it is someone who is practising.

**Mr P.A. KATSAMBANIS:** Perhaps the minister can take that on board as we go on, but the issue I want to clarify in particular, simply because of the wording, is that, as the minister would be aware, there are medical practitioners across Western Australia undertaking studies in fields that may be either tangentially related to medicine or not related at all. I know medical practitioners who are registered and practising, and who might be undertaking studies for an MBA. One or two of them have taken out bachelors of law. I do not know why doctors would want to go back and do law, but some do.

**Dr M.D. Nahan** interjected.

**Mr P.A. KATSAMBANIS:** Perhaps they are interested in malpractice, member for Riverton—I do not know. It is not an area of law that I have practised in. I just want to know what the limits of this definition are. Obviously, we do not want a student who is studying as a medical practitioner and may have some form of limited registration operating under this legislation, and I think that is the intent, but can the minister clarify that a medical practitioner who is otherwise registered and qualified but is undertaking studies in a completely unrelated field to better themselves, would not be caught up in this unnecessarily?

**Mr R.H. COOK:** The words that will provide comfort for the member are “other than as a student”—that is, a student in the medical profession.

**Mrs A.K. HAYDEN:** I have a final question for the minister to place a clarification on the record. I have been listening to the debate made by the member for Riverton, and also throughout the previous amendment, and it alarms me—I believe I have it right, but if I have it wrong, please correct me—that the minister is saying that palliative care and voluntary assisted dying are two separate identities, and that, in the minister’s opinion, palliative care has no place in this legislation, nor is it required in order to access voluntary assisted dying. Alarm bells go off for me, and I am sure they will go off for 99 per cent of the population, so can I just get clarification from the minister that it is his intent, with this legislation, that someone diagnosed with a terminal illness can, immediately, without seeking palliative care, access voluntary assisted dying? As we have discussed in this place, palliative care can be as simple as a conversation to help with the idea of life coming to an end. Can I get confirmation that the minister is comfortable and the government is comfortable with the intent in this bill that once someone has been diagnosed with a terminal illness, they are able to access voluntary assisted dying without having to contemplate any palliative care services or options?

**Mr R.H. COOK:** No, not to contemplate, but certainly to undergo. As a number of members observed in their second reading contributions, not everyone who is at the end of life is actually in palliative care. Indeed, if someone receives a terminal diagnosis, and it meets all the associated requirements as outlined in this bill, they may refuse palliative care. It is not for us to force someone to undergo palliative care, but we would ordinarily, from a moral standpoint, and I think there are some very good reasons why, want that person to be aware of those options. I think the member used the expression “contemplate”, and I think that is a great expression. We would want them to contemplate palliative care but we cannot force them to take it.

**The ACTING SPEAKER (Mr T.J. Healy):** The question is that clause 5 stand as printed. All those in favour say—my apologies, member for Girrawheen.

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**Ms M.M. QUIRK:** Sometimes people do not realise that I am standing! The definition of “approved training” refers to training approved by the CEO under clause 158. Does the minister prefer that that be dealt with at clause 158, or now?

**Mr R.H. COOK:** As someone who is equally vertically challenged, I commiserate with the member, but yes I think that is probably best left to the consideration of clause 158.

**Ms M.M. QUIRK:** I am sorry to repeat myself, but should we wait until clause 159 to talk about the approved form, and, likewise, the board, under clause 115? I note that clause 115 is completely unenlightening. It does not refer to the composition of the board. I am happy to wait, but, as I said, there is not any additional material.

**Mr R.H. COOK:** I think that would be the appropriate clause to deal with that issue.

**Ms M.M. QUIRK:** I want to spend a bit of time on decision-making capacity, in clause 6(2), and I have just realised that I am now moving an amendment, but there might be some other stuff in clause 5 that we need to talk about first.

### **Clause put and passed.**

#### **Clause 6: Decision-making capacity —**

**Mr Z.R.F. KIRKUP:** I have a number of questions on clause 6(2), so I will go through them. I understand that a sequence of events will need to take place to assess whether a person has decision-making capacity, so that practitioners are certain of a person’s decision-making capacity. With reference to clause 6(2)(a), can the minister provide some advice on how a practitioner would seek to understand how any information or advice on voluntary assisted dying, as required under the legislation, is provided to the patient? What would the process be?

**Mr R.H. COOK:** I think it would be done in the usual manner in which we would try to ascertain whether someone understands the decision they are making. A line of questioning would be associated with that, until we could be satisfied that the person really understood the requirements under the bill. It would obviously be a specific element of the mandatory training that medical practitioners would be required to undertake, because understanding the requirements of clause 6 will be a very important part of the role of the coordinating or consulting practitioner.

**Mr Z.R.F. KIRKUP:** I appreciate that the legislation is quite complex and extensive and has a number of moving parts. The patient will be required to understand the information and advice that has been provided to them about a voluntary assisted dying decision. Am I right to understand that there would be a process by which the practitioner would engage in a conversation with the patient, and that would be recorded and provided to the board as part of the authorised forms? I assume that the nature of the conversation would be prescribed by the CEO during the implementation phase. Would that be right?

**Mr R.H. COOK:** There would certainly be extensive reference to the patient’s medical records. In relation to the decision-making process, the coordinating or consulting practitioner would be required to fill out the authorised forms as prescribed by the CEO, and they are the ones that would be provided to the Voluntary Assisted Dying Board.

**Ms M.M. QUIRK:** In terms of assessing decision-making capacity, there is no requirement that the patient must see a doctor whom they have been seeing for some time; they may see two completely different doctors whom they have never seen before.

**Mr R.H. COOK:** We have contemplated the situation in which a person’s usual GP may be a conscientious objector or not eligible to be a medical practitioner involved in the process, so potentially, yes.

**Ms M.M. QUIRK:** I do not know whether the minister is aware, but certainly Alzheimer’s Australia has said that the time in which to diagnose Alzheimer’s and other forms of dementia, despite more community education for GPs, is stubbornly set at about two to three years. Therefore, there is a very large chance that a GP who might see a patient regularly will miss the fact that the person has lost capacity. Similarly, I do not know whether the minister is aware that there are differing levels of decision-making. Obviously, if a decision is made about voluntary assisted dying, that should be at the highest level of executive decision-making. It is not a decision about whether the person will have strawberry or chocolate ice-cream for dinner. It is a serious matter. Again, the assessment of capacity goes to the ability of the patient to make such a decision. It is not just a question of saying the patient seems lucid, because, as we know, lucidity will ebb and flow. I want to know how the legislation will safeguard against that. My final point is that the person who will do the assessment will not be required to undertake any training other than the training that is contemplated by this legislation. In other words, they will not need to be a specialist.

**Mr R.H. COOK:** Just to go to the member’s final point, the person who would be making the decision would already have had about six years of training as a medical practitioner, with all the obligations and requirements associated with that strenuous process. The member is obviously familiar with post-study work and graduation programs. Therefore, they will be a person of some experience. Yes, they will be required to undertake further mandatory training in order to participate in this process. I would also say that clause 6(2) sets out a range of matters about which the person must have a level of awareness and understanding. That would be ascertained through not only an exhaustive conversation with

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the patient, but also a thorough examination of that patient's records, and, indeed, a conversation with that patient's other specialists. In particular, the patient must make ongoing and continuous requests and be assessed at different stages of the voluntary assisted dying process to ensure that they understand the decision they are making and have the capacity to make that decision, and that their decision is enduring. In addition, one of those requests must be in writing, and it must be certified by two witnesses that the person understands the decision they are making. This is not a process that we are taking lightly. I, like the member, appreciate that this is obviously a very important aspect of the bill. From that perspective, that is why we have provided for that extensive process to determine decision-making capacity.

**Dr M.D. NAHAN:** We are talking about capacity to understand and make this very important decision. We have heard stories in this place and we have talked to people who have had to give the bad news to a person that they have a terminal illness. We have also read some of the reports about that. I admit that I am a layman in this area. As I have mentioned, it is often traumatic for people to be given a death sentence, and they go into existential shock. My brother experienced this when he was diagnosed with Parkinson's disease. His initial diagnosis was that he would live for about two years—I forget what it actually was. He lived for 15 years, by the way, and he passed away not from Parkinson's but from something else. There is deep psychological impact on people when they get the bad news. The question is: would those people have the mental capacity to make a rational decision of this nature? Let us say the medical practitioner has done their best to put all the evidence to the patient. I am sure that 99.9 per cent of practitioners will try their best. In this country, we have a tremendously well-trained and dedicated group of health professionals. I am not worried about that. I am worried about the capacity of a patient who has been given the bad news to process all that information rationally. I do not think I could do that. My brother could not do it. As I have said, the Parkinson's data is made for 65-year-old people. My brother was 41, so the doctor could not use the data, and the doctor said he had no idea about what was going to happen, and that was good. My brother went to a group of other Parkinson's patients, and I went with him. A lot of them were over 65 years of age, and some of them went down very quickly. It is a terrible disease. They were in trauma. The disease accentuated that trauma. They were not rational. They simply were not capable of being rational. How do we identify that? When we deal with mental illness, which has different grades, the process is that there is a psychiatric assessment, and the psychiatrists will use their methodologies to determine the person's capacity to make decisions. I would think in some instances—not all—we would need the same process here. We need to be able to judge the capacity of the person to make rational decisions. That is a really important issue. Could the minister tell us how he will deal with that real issue?

**Mr R.H. COOK:** The member is right. A number of members have made that observation about people who receive bad news. People receive that kind of bad news all the time. Medical practitioners will be very familiar with the scenario in which they say, "Chum, I'm sorry; it's bad news." Indeed, a medical practitioner in that career would frequently be faced with a patient sitting in front of them who is receiving bad news and, quite frankly, that person would not be rational and we cannot expect them to be. In that context, they would not have decision-making capacity, as is defined in this legislation. That is a common scenario, and that is why medical practitioners are well practised and trained in assisting patients to deal with what is essentially a death sentence; that is, they are told, "I'm sorry, but the news is not good." That is not a time that a patient would be demonstrating decision-making capacity. That is a time when that patient would be informed about their treatment options—is it option A or option B? Even though that patient would be in a world of pain at that time, unfortunately, the medical practitioner would then have to assist them to make that decision as well. Obviously, how they manage that patient's state of mind is a very important part of their trade as a medical practitioner, but in that context, having just received the information, the patient would be very distressed. As was the case of the member's brother with Parkinson's disease, this is not someone who has been in touch with a support group, and therefore provided with the full range of options associated with it—it is not for those people. The member very eloquently in his description raised the issue about what medical practitioners face on a regular basis, and the decisions that they have to help that patient make.

**Dr M.D. NAHAN:** Let us deal with this issue. The minister is right; general practitioners and specialists deal with this all the time. It is one reason some of us would not want to be in that position.

**Mr R.H. Cook:** It is much easier being a politician!

**Dr M.D. NAHAN:** We give bad news, but of a different magnitude. Anyway, they do not believe us! I digress.

Will the minister leave it as is or have a methodology about what practitioners will discuss, to vet and say, "Here are your options, but you're not in a position right now to make these. I recommend you go through this, this and this before you make the decision"? It might be to see a psychiatrist or it might be to go through some forms of palliative care. What happens if they say, "No, I decided a long time ago that I want this. I want assisted dying. I want out"? I will give the minister a story about my first experience with this as a member of Parliament. This is a really difficult issue around rationality and what that is. A lot of philosophers have spent their life discussing this, and we are dealing with an issue about death, potentially premature death, and talking about introducing a law that, in my view, fundamentally changes the nature of the state of a human being, and that is why we have to be very careful about walking this way.

**Extract from Hansard**

[ASSEMBLY — Wednesday, 4 September 2019]

p6425b-6433a

Mr Peter Katsambanis; Ms Rita Saffioti; Mrs Liza Harvey; Mr Roger Cook; Mr Zak Kirkup; Dr Mike Nahan;  
Mrs Alyssa Hayden; Ms Margaret Quirk; Mr Shane Love

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**Mr R.H. COOK:** That is why we have opted for six months. This is not for people who are contemplating a longer term end-of-life period. These are people for whom death is imminent, inevitable and, in their view, are experiencing intolerable suffering. If someone received the news that they are going to die within six months, by that stage the person would have already had a pretty rigorous interaction with the health system. They potentially have not, but obviously they will then begin on a very serious journey and it is one that their medical practitioner would want to assist them with. But if death will, on the balance of probabilities, occur within six months, if they have decision-making capacity, and if, in their subjective view, the suffering they are facing in the context of that is too great, but they are appraised of all their treatment options, this bill would contemplate that person having the agency to take matters into their own hands.

**Dr M.D. NAHAN:** Let us say a doctor gives a patient bad news and he says, “I want VAD”. The doctor says to come back in a week or so, cool down, or go talk to somebody such as a psychiatrist or whatever. The patient comes back and says, “No, I want it” and the doctor says that they do not think they are in the right state of mind. The patient then goes to other doctors to find the Nitschkes of the world who believe not in the system the minister is trying to develop here, but something much broader, such as the system Marshall Perron agrees with, and finds somebody who is more lenient in determining the rationality of the patient. Are there some safeguards against that?

**Mr R.H. COOK:** Yes, member. Essentially, the member is referring to the capacity of somebody to doctor shop. I appreciate that that has come up in both parliamentary debates and public discourse. It is not really under clause 6, but I think we should talk about it; I accept the spirit in which the member brings it. If a patient is assessed as being ineligible by a coordinating practitioner, they may commence a new request and assessment with another registered medical practitioner for that person to act as their coordinating practitioner. This is consistent with any person seeking a second or third medical opinion with different doctors. It is a basic component of the Australian healthcare system that patients are able to seek further medical opinions of their own volition. We cannot stop them going to see another doctor, but do not forget that that doctor will say, “I want to look at your records. Who are you currently seeing?” In order to assess a decision-making capacity, that doctor would inevitably go back to that first doctor and say, “Mr Smith is in front of me. I know they have seen you; I want your views on this.” This is the nature of the way in which a person would go about making that assessment.

We could paint a range of doomsday hypothetical situations around this place. I appreciate that that is not what the member is doing here; he is testing the safeguards of the bill. But we could be satisfied that under the current system there are safeguards around people doctor shopping ordinarily, and in this context I think there would be even greater safeguards, particularly around the decision-making provisions and the obligation on the medical practitioner to make that assessment and be abreast of all the issues that would impact upon that patient’s situation.

**Mr R.S. LOVE:** I am looking at both the bill and the explanatory memorandum. The first paragraph of the explanation of “decision-making capacity” in the explanatory memorandum states —

... acknowledges that a person is presumed to have decision-making capacity unless there is evidence that they do not.

That is under clause 6(3), which states that “a patient is presumed to have decision-making capacity”. I wonder, given that there is also capacity later for some of the decisions to be indicated other than verbally, whether there is a requirement or a duty upon the person assessing this capacity to make some inquiry; or it is just enough to say, “Okay, here is a person I assume has capacity, unless someone presents me with an idea or evidence that that is not the case”? What is the requirement for someone to investigate and see whether there is evidence that there is a lack of capacity?

**Mr R.H. COOK:** The definition acknowledges that a person is presumed to have decision-making capacity unless there is evidence that they do not. In Western Australian law, there is a presumption that a person has the capacity to make decisions about their own life. This is reflected in the presumption in the bill. It is assumed that someone comes to the process with agency and it is obviously an important assessment that the medical practitioner must make to assess whether that agency exists. We do not come to it with the assumption that they do not. It is about empowering the patient. From that perspective, the posture of the legislation is upon empowering rather than impeding that patient.

**Mr R.S. LOVE:** Capacity could be lost throughout the course of the patient’s relationship with the medical person who is making this decision. If that person loses capacity at any point, the process stops. What requirement is on the medical practitioner to satisfy himself or herself that the person continues to have the capacity right throughout the process?

**Mr R.H. COOK:** As I observed to the member for Girrawheen, it is an obligation on the medical practitioner; they must assess that decision-making capacity throughout the process by which the voluntary assisted dying is contemplated.

**Mr R.S. Love:** Despite the presumption, there is still a requirement to do an assessment.

**Mr R.H. COOK:** They still have to assess that person.

**Extract from *Hansard***

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Debate interrupted, pursuant to standing orders.

[Continued on page 6458.]